Solicitation 12702-525

Group DHMO and DPPO Dental Plan Benefits

Bid Designation: Public

CITY OF FORT LAUDERDALE

City of Fort Lauderdale

Bid 12702-525
Group DHMO and DPPO Dental Plan Benefits

Bid Number	**12702-525**
Bid Title	**Group DHMO and DPPO Dental Plan Benefits**
Bid Start Date	**Jun 6, 2022 9:20:34 AM EDT**
Bid End Date	**Jun 30, 2022 2:00:00 PM EDT**
Question & Answer End Date	**Jun 13, 2022 5:00:00 PM EDT**
Bid Contact	**John Torrenga** **Procurement Administrator** **Finance** **jtorrenga@fortlauderdale.gov**
Contract Duration	**3 years**
Contract Renewal	**3 annual renewals**
Prices Good for	**120 days**
Bid Comments	**The City of Fort Lauderdale, Florida (City) is seeking proposals from qualified, single source experienced and licensed firm(s) to provide group DHMO and DPPO coverages for the City's Benefits Section of the Human Resources Department, in accordance with the terms, conditions, and specifications contained in this Request for Proposal (RFP).** **Added on Jun 6, 2022:** **Addendum 1: Exhibit 15 - Current Dental Providers Utilization DHMO PPO has been added.** **Added on Jun 13, 2022:** **Addendum 2:** **1. RFP_Dental_2022_Final, Sections 5.2.5 and VIII have been revised to remove language requiring CDs, thumb drives and flash drives to be provided.** **2. Exhibit 16 - Business Associate Agreement Sample has been added.** **3. Exhibit 17 - Benefit Summary DPPOF CoFL has been added.** **Added on Jun 14, 2022:** **Addendum 3:** **1. Exhibit 18 - 2020 Dental Rates For Q/A 21 has been added.** **2. Exhibit 19 - 36-Month Detailed Experience Report for Q/A 21 has been added.** **3. Exhibit 20 - 24-month Dental CAP Report For Q/A 21 has been added.** **4. Exhibit 21 - Dental Utilization Review For Q/A 21 has been added.**

Addendum # 1

New Documents	**Exhibit 15 - Current Dental Providers Utilization DHMO PPO.xlsx**

Addendum # 2

New Documents	**Exhibit 16 - Business Associate Agreement Sample.pdf** **Exhibit 17 - Benefit Summary DPPOF CoFL.pdf**

	RFP Dental 2022_Final_Revised 6-13-22.pdf
Removed Documents	**RFP Dental 2022_Final.pdf**

Addendum # 3

New Documents	**Exhibit 18 - 2020 Dental Rates For Question 21.pdf** **Exhibit 19 - 36 Month Detailed Experience Report For Question 21.pdf** **Exhibit 20 - 24 month Dental CAP Report For Question 21.pdf** **Exhibit 21 - Dental Utilization Review For Question 21.pdf**

Item Response Form

Item	**12702-525--01-01 - Group DHMO and DPPO Dental Plan Benefits**
Quantity	**1 lump sum**

Prices are not requested for this item.

Delivery Location **City of Fort Lauderdale**

No Location Specified

Qty 1

Description
Proposers to provide information on the Cost Proposal Sheet

City of Fort Lauderdale
Group DHMO and DPPO Dental Plan Benefits
RFP #12702-525

SECTION I – INTRODUCTION AND INFORMATION

1.1 Purpose

The City of Fort Lauderdale, Florida (City) is seeking qualified, experienced, and licensed firm(s) to provide fully insured group DHMO and DPPO coverages for the City's Benefits Section of the Human Resources, in accordance with the terms, conditions, and specifications contained in this Request for Proposal (RFP).

1.2 Point of Contact

For information concerning procedures for responding to this solicitation, contact Procurement Administrator John Torrenga at (954) 828-5949 or email at jtorrenga@fortlauderdale.gov. Such contact shall be for clarification purposes only.

For information concerning technical specifications, please utilize the question / answer feature provided by BidSync at www.bidsync.com. Questions of a material nature must be received prior to the cut-off date specified in the RFP Schedule. Material changes, if any, to the scope of services or bidding procedures will only be transmitted by written addendum. (See addendum section of BidSync Site). Proposers please note: Proposals shall be submitted as stated in PART IV – Submittal Requirements. No part of your proposal can be submitted via FAX. No variation in price or conditions shall be permitted based upon a claim of ignorance. Submission of a proposal will be considered evidence that the Proposer has familiarized themselves with the nature and extent of the work, and the equipment, materials, and labor required. The entire proposal must be submitted in accordance with all specifications contained in this solicitation. The questions and answers submitted in BidSync shall become part of any contract that is created from this RFP.

1.3 Pre-proposal Conference

There will not be a pre- bid/proposal conference or site visit for this Request for Proposal.

It will be the sole responsibility of the Proposer to become familiar with the scope of the City's requirements and systems prior to submitting a proposal. No variation in price or conditions shall be permitted based upon a claim of ignorance. Submission of a proposal will be considered evidence that the Proposer has familiarized themselves with the nature and extent of the work, equipment, materials, and labor required.

1.4 BidSync

The City of Fort Lauderdale uses BidSync (www.bidsync.com) to administer the competitive solicitation process, including but not limited to soliciting proposals, issuing addenda, posting results, and issuing notification of an intended decision. There is no charge to register and download the RFP from BidSync. Proposers are strongly encouraged to read the various vendor Guides and Tutorials available in BidSync well in advance of their intention of submitting a proposal to ensure familiarity with the use of BidSync. The City shall not be responsible for a Proposers inability to submit a Proposal by the end date and time for any reason, including issues arising from the use of BidSync.

It is the sole responsibility of the Bidder/Proposer to ensure that their bid/proposal is submitted electronically through BidSync at www.bidsync.com no later than the time and date specified in this solicitation. PAPER BID/PROPOSAL SUBMITTALS WILL NOT BE ACCEPTED. BIDS/PROPOSALS MUST BE SUBMITTED ELECTRONICALLY VIA WWW.BIDSYNC.COM.

1.5 Electronic Bid Openings/Proposal Closings

Please be advised that effective immediately, and until further notice, all Invitation to Bids, Request for Proposals, Request for Qualifications, and other solicitations led by the City of Fort Lauderdale will be opened electronically via BIDSYNC.COM at the date and time indicated on the solicitation. All openings will be held on the BIDSYNC.COM platform.

Anyone requesting assistance or having further inquiry in this matter must contact the Procurement Administrator indicated on the solicitation, via the Question-and-Answer forum on Bidsync.com before the Last Day for Questions indicated in the Solicitation.

1.6 Agent, Broker or Consultant Participation

The City of Fort Lauderdale has contracted with the Gehring Group to serve as the consultant in reference to the City's group benefit plans. Renumeration for these consulting services are paid directly by the City to the Gehring Group under a separate contract. No other consultant, agent, or broker services are requested nor anticipated for this RFP. All proposed prices shall not include any remuneration to a third party.

END OF SECTION

SECTION II - SPECIAL TERMS AND CONDITIONS

2.1 General Conditions

RFP General Conditions (Form G-107, Rev. 02/20) are included and made a part of this RFP.

2.2 Addenda, Changes, and Interpretations

It is the sole responsibility of each firm to notify the Buyer utilizing the question / answer feature provided by BidSync and request modification or clarification of any ambiguity, conflict, discrepancy, omission, or other error discovered in this competitive solicitation. Requests for clarification, modification, interpretation, or changes must be received prior to the Question and Answer (Q & A) Deadline. Requests received after this date may not be addressed. Questions and requests for information that would not materially affect the scope of services to be performed or the solicitation process will be answered within the question / answer feature provided by BidSync and shall be for clarification purposes only. Material changes, if any, to the scope of services or the solicitation process will only be transmitted by official written addendum issued by the City and uploaded to BidSync as a separate addendum to the RFP. Under no circumstances shall an oral explanation given by any City official, officer, staff, or agent be binding upon the City and should be disregarded. All addenda are a part of the competitive solicitation documents, and each firm will be bound by such addenda. It is the responsibility of each to read and comprehend all addenda issued.

2.3 Changes and Alterations

Proposer may change or withdraw a Proposal at any time prior to Proposal submission deadline; however, no oral modifications will be allowed. Modifications shall not be allowed following the Proposal deadline.

2.4 Proposer's Costs

The City shall not be liable for any costs incurred by Proposers in responding to this RFP.

2.5 Pricing/Delivery

All pricing should be identified on the Cost Proposal page provided in this RFP. No additional costs may be accepted, other than the costs stated on the Cost Proposal page. Failure to use the City's Cost Proposal page and provide costs as requested in this RFP may deem your proposal non-responsive.

Prices proposed shall be valid for at least One-Hundred and Twenty (120) days from time of the RFP opening unless otherwise extended and agreed upon by the City and Proposer.

2.6 Price Validity

Prices provided in this Request for Proposals (RFP) shall be valid for at least One Hundred and Twenty (120) days from time of RFP opening unless otherwise extended and agreed upon by the City and Bidder/Proposer. The City shall award contract within this time period or shall request to the recommended awarded vendor an extension to hold pricing, until products/services have been awarded.

2.7 Invoices/Payment

The City will accept invoices no more frequently than once per month. Each invoice shall fully detail the related costs and shall specify the status of the particular task or project as of the date of the invoice with regard to the accepted schedule for that task or project. Payment will be made within forty-five (45) days after receipt of an invoice acceptable to the City, in accordance with the Florida Local Government Prompt Payment Act. If, at any time during the contract, the City shall not approve or accept the successful proposer's work product, and agreement cannot be reached between the City and the successful proposer to resolve the problem to the City's satisfaction, the City shall negotiate with the successful proposer on a payment for the work completed and usable to the City.

2.8 Related Expenses/Travel Expenses

All costs including travel are to be included in your bid/proposal. The City will not accept any additional costs.

2.9 Payment Method

The City of Fort Lauderdale has implemented a Procurement Card (P-Card) program which changes how payments are remitted to its vendors. The City has transitioned from traditional paper checks to payment by credit card via MasterCard or Visa. This allows you as a vendor of the City of Fort Lauderdale to receive your payment fast and safely. No more waiting for checks to be printed and mailed. Payments will be made utilizing the City's P-Card (MasterCard or Visa). Accordingly, firms should presently have the ability to accept credit card payment or take whatever steps necessary to implement acceptance of a credit card before the commencement of a contract. See Contract Payment Method form attached.

2.10 Mistakes

The proposer shall examine this RFP carefully. The submission of a Proposal shall be prima facie evidence that the proposer has full knowledge of the scope, nature, and quality of the work to be performed; the detailed requirements of the specifications; and the conditions under which the work is to be performed. Ignorance of the requirements will not relieve the proposer from liability and obligations under the Contract.

2.11 Acceptance of Proposals / Minor Irregularities

2.11.1 The City reserves the right to accept or reject any or all proposals, part of proposals, and to waive minor irregularities or variances to specifications contained in proposals which do not make the proposal conditional in nature and minor irregularities in the solicitation process. A minor irregularity shall be a variation from the solicitation that does not affect the price of the contract or does not give a respondent an advantage or benefit not enjoyed by other respondents, does not adversely impact the interests of other firms, or does not affect the fundamental fairness of the solicitation process. The City also reserves the right to reissue a Request for Proposal.

2.11.2 The City reserves the right to disqualify Proposer during any phase of the competitive solicitation process and terminate for cause any resulting contract upon evidence of collusion with intent to defraud or other illegal practices on the part of the Proposer.

2.13 Sample Contract Agreement

A sample of the formal agreement template, which may be required to be executed by the awarded vendor can be found at our website:
https://www.fortlauderdale.gov/home/showdocument?id=1212 .

2.14 Responsiveness

In order to be considered responsive to the solicitation, the firm's proposal shall fully conform in all material respects to the solicitation and all its requirements, including all form and substance.

2.15 Responsibility

In order to be considered as a responsible firm, firm shall be fully capable to meet all of the requirements of the solicitation and subsequent contract, must possess the full capability, including financial and technical, to perform as contractually required, and must be able to fully document the ability to provide good faith performance.

2.16 Minimum Qualifications

In order to be considered, a Proposer must, as of the proposal return date specified in this RFP and throughout the duration of its program, meet the following applicable minimum qualifications. Proposer

must provide documentation of existing qualifications in the proposal.

Dental Maintenance Organization

- Authorized by the Florida Department of Financial Services to provide goods and services requested in this RFP.
- Comply with any requirements imposed upon the Proposer by the Florida Department of Insurance with respect to quality assurance.

Insurance Company and PPO Dental Plan

- Licensed by the State of Florida Department of Insurance to provide goods and services requested in this RFP; and
- All insurance policies shall be from insurers authorized to write insurance policies in the State of Florida and that possess an A.M. Best rating of "A-" VII or better. All insurance policies are subject to approval by the City's Risk Manager.

Proposers shall satisfy each of the following requirements cited below. Failure to do so may result in the proposal being deemed non-responsive.

2.16.1 Before awarding a contract, the City reserves the right to require that a Proposer submit such evidence of qualifications as the City may deem necessary. Further, the City may consider any evidence of the financial, technical, and other qualifications and abilities of a firm or principals, including previous experiences of same with the City and performance evaluation for services, in making the award in the best interest of the City.

2.16.2 Firm or principals shall have no record of judgments, pending lawsuits against the City or criminal activities involving moral turpitude and not have any conflicts of interest that have not been waived by the City Commission.

2.16.3 Neither firm nor any principal, officer, or stockholder shall be in arrears or in default of any debt or contract involving the City, (as a party to a contract, or otherwise); nor have failed to perform faithfully on any previous contract with the City.

2.16.4 Firm and those performing the work must be appropriately licensed and registered in the State of Florida.

2.17 Lobbying Activities

ALL PROPOSERS PLEASE NOTE: Any proposer submitting a response to this solicitation must comply, if applicable, with City of Fort Lauderdale Ordinance No. C-11-42 & Resolution No. 07-101, Lobbying Activities. Copies of Ordinance No. C-11-42 and Resolution No. 07-101 may be obtained from the City Clerk's Office on the 7th Floor of City Hall, 100 N. Andrews Avenue, Fort Lauderdale, Florida. The ordinance may also be viewed on the City's website at: http://www.fortlauderdale.gov/home/showdocument?id=6036.

2.18 Local Business Preference – N/A

2.19 Disadvantaged Business Enterprise Preference – N/A

2.20 Protest Procedure

2.20.1 Any Bidder/Proposer who is not recommended for award of a contract and who alleges a failure by the city to follow the city's procurement ordinance or any applicable law, may follow the protest procedure as found in the city's procurement ordinance within five (5) days after a notice of intent to award is posted on the city's web site at the following link: https://www.fortlauderdale.gov/government/departments-a-h/finance/procurement-services/notices-of-intent-to-award.

2.20.2 The complete protest ordinance may be found on the city's web site at the following link: https://library.municode.com/fl/fort_lauderdale/codes/code_of_ordinances?nodeId=COOR_CH2AD_ARTVFI_DIV2PR_S2-182DIREPRAWINAW.

2.21 Public Entity Crimes

Proposer, by submitting a proposal, certifies that neither the Proposer nor any of the Proposer's principals has been placed on the convicted vendor list as defined in Section 287.133, Florida Statutes (2018), as may be amended or revised. A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity in excess of the threshold amount provided in s. 287.017 for CATEGORY TWO for a period of 36 months following the date of being placed on the convicted vendor list.

2.22 Insurance Requirements

2.22.1 As a condition precedent to the effectiveness of award of this solicitation and subsequent agreement, during the term and any renewal or extension, the successful proposer, at its sole expense, shall provide insurance of such types and with such terms and limits as noted below. Providing proof of and maintaining adequate insurance coverage are material obligations of the successful proposer. The successful proposer shall provide the City a certificate of insurance evidencing such coverage. The successful proposer's insurance coverage shall be primary insurance for all applicable policies. The limits of coverage under each policy maintained by the successful proposer shall not be interpreted as limiting the successful proposer's liability and obligations under this Agreement. All insurance policies shall be through insurers authorized or eligible to write policies in the State of Florida and possess an A.M. Best rating of A-, VII or better, subject to approval by the City's Risk Manager.

2.22.2 The coverages, limits, and/or endorsements required herein protect the interests of the City, and these coverages, limits, and/or endorsements shall in no way be relied upon by the successful proposer for assessing the extent or determining appropriate types and limits of coverage to protect the successful proposer against any loss exposures, whether as a result of this Agreement or otherwise. The requirements contained herein, as well as the City's review or acknowledgement, are not intended to and shall not in any manner limit or qualify the liabilities and obligations assumed by the successful proposer under this Agreement.

2.22.3 The following insurance policies and coverages are required:

Commercial General Liability

Coverage must be afforded under a Commercial General Liability policy with limits not less than:

- $1,000,000 each occurrence and $2,000,000 aggregate for Bodily Injury, Property Damage, and Personal and Advertising Injury

- $1,000,000 each occurrence and $2,000,000 aggregate for Products and Completed Operations

Policy must include coverage for contractual liability and independent contractors.

The City, a Florida municipal corporation, its officials, employees, and volunteers are to be covered as an additional insured with a CG 20 26 04 13 Additional Insured – Designated Person or Organization Endorsement or similar endorsement providing equal or broader Additional Insured Coverage with respect to liability arising out of activities performed by or on behalf of the successful proposer. The coverage shall contain no special limitation on the scope of protection afforded to the City, its officials, employees, and volunteers.

Cyber Liability
Coverage must be afforded in an amount not less than $1,000,000 per claim for negligent retention of data as well as notification and related costs for cyber incidents.

Business Automobile Liability
Coverage must be afforded for all Owned, Hired, Scheduled, and Non-Owned vehicles for Bodily Injury and Property Damage in an amount not less than $1,000,000 combined single limit each accident.

If the successful proposer does not own vehicles, the successful proposer shall maintain coverage for Hired and Non-Owned Auto Liability, which may be satisfied by way of endorsement to the Commercial General Liability policy or separate Business Auto Liability policy.

Workers' Compensation and Employer's Liability
Coverage must be afforded per Chapter 440, Florida Statutes. Any person or entity performing work for or on behalf of the City must provide Workers' Compensation insurance. Exceptions and exemptions will be allowed by the City's Risk Manager, if they are in accordance with Florida Statute.

The Contractor waives, and the Contractor shall ensure that the Contractor's insurance carrier waives, all subrogation rights against the City, its officials, employees, and volunteers for all losses or damages. The City requires the policy to be endorsed with WC 00 03 13 Waiver of our Right to Recover from Others or equivalent.

The Contractor must be in compliance with all applicable State and federal workers' compensation laws. For additional information contact the Department of Financial Services, Workers' Compensation Division at (850) 413-1601 or on the web at www.fldfs.com.

Limits: Workers' Compensation – Per Florida Statute 440 Employer's Liability $500,000.

Covering premises-operations, products-completed operations, independent contractors and contractual liability.

Limits: Combined single limit bodily injury/property damage $1,000,000. This coverage must include, but not limited to:

a. Coverage for the liability assumed by the contractor under the indemnity provision of the contract.
b. Coverage for Premises/Operations
c. Products/Completed Operations
d. Broad Form Contractual Liability

e. Independent Contractors

Automobile Liability
Covering all owned, hired, and non-owned automobile equipment.
Limits: Bodily Injury $250,000 each person, $500,000 each occurrence
Property Damage $100,000 each occurrence

Professional Liability
Coverage must be afforded for Wrongful Acts in an amount not less than $1,000,000 each claim and $2,000,000 aggregate.

Contractor must keep the professional liability insurance in force until the third anniversary of expiration or early termination of this Agreement or the third anniversary of acceptance of work by the City, whichever is longer, which obligation shall survive expiration or early termination of this Agreement.

Insurance Certificate Requirements

- **a.** The successful proposer shall provide the City with valid Certificates of Insurance (binders are unacceptable) no later than ten (10) days prior to the start of work contemplated in this Agreement.
- **b.** The successful proposer shall provide to the City a Certificate of Insurance having a thirty (30) day notice of cancellation; ten (10) days' notice if cancellation is for nonpayment of premium.
- **c.** In the event that the insurer is unable to accommodate the cancellation notice requirement, it shall be the responsibility of the successful proposer to provide the proper notice. Such notification will be in writing by registered mail, return receipt requested, and addressed to the certificate holder.
- **d.** In the event the Agreement term or any surviving obligation of the successful proposer following expiration or early termination of the Agreement goes beyond the expiration date of the insurance policy, the successful proposer shall provide the City with an updated Certificate of Insurance no later than ten (10) days prior to the expiration of the insurance currently in effect. The City reserves the right to suspend the Agreement until this requirement is met.
- **e.** The Certificate of Insurance shall indicate whether coverage is provided under a claims-made or occurrence form. If any coverage is provided on a claims-made form, the Certificate of Insurance must show a retroactive date, which shall be the effective date of the initial contract or prior.
- **f.** The City shall be named as an Additional Insured on all liability policies, with the exception of Workers' Compensation.
- **g.** The City shall be granted a Waiver of Subrogation on the Contractor's Workers' Compensation insurance policy.
- **h.** The title of the Agreement, Bid/Contract number, event dates, or other identifying reference must be listed on the Certificate of Insurance.

The Certificate Holder should read as follows:
City of Fort Lauderdale
100 N. Andrews Avenue
Fort Lauderdale, FL 33301

The successful proposer has the sole responsibility for all insurance premiums and shall be fully and solely responsible for any costs or expenses as a result of a coverage deductible, co-

insurance penalty, or self-insured retention; including any loss not covered because of the operation of such deductible, co-insurance penalty, self-insured retention, or coverage exclusion or limitation. Any costs for adding the City as an Additional Insured shall be at the successful proposer's expense.

If the successful proposer's primary insurance policy/policies do not meet the minimum requirements, as set forth in this Agreement, the successful proposer may provide evidence of an Umbrella/Excess insurance policy to comply with this requirement.

The successful proposer's insurance coverage shall be primary insurance as respects to the City, a Florida municipal corporation, its officials, employees, and volunteers. Any insurance or self-insurance maintained by the City, a Florida municipal corporation, its officials, employees, or volunteers shall be non-contributory.

Any exclusion or provision in any insurance policy maintained by the successful proposer that excludes coverage required in this Agreement shall be deemed unacceptable and shall be considered breach of contract.

All required insurance policies must be maintained until the contract work has been accepted by the City, or until this Agreement is terminated, whichever is later. Any lapse in coverage shall be considered breach of contract. In addition, successful proposer must provide to the City confirmation of coverage renewal via an updated certificate should any policies expire prior to the expiration of this Agreement. The City reserves the right to review, at any time, coverage forms and limits of successful proposer's insurance policies.

The successful proposer shall provide notice of any and all claims, accidents, and any other occurrences associated with this Agreement to the successful proposer's insurance company or companies and the City's Risk Management office, as soon as practical.

It is the successful proposer's responsibility to ensure that any and all of the successful proposer's independent contractors and subcontractors comply with these insurance requirements. All coverages for independent contractors and subcontractors shall be subject to all of the applicable requirements stated herein. Any and all deficiencies are the responsibility of the successful proposer.

Security Breach

The successful proposer agrees to provide electronic and physical security to personal information, as defined in Section 501.171, Florida Statutes (2021), as may be amended or revised, ("Section 501.171"), that is obtained from the City, in accordance with the standard set forth in Section 501.171. As provided in Section 501.171, the successful proposer shall take reasonable measures to protect and secure data in electronic form containing personal information. The successful proposer shall notify the City within twenty-four (24) hours after having reason to believe or becoming aware of any breach of security to a system maintained by the successful proposer. Upon receiving the initial notice, the successful proposer shall provide a detailed incident report within five (5) days. Such incident report shall include all information necessary to comply with the notice requirements set forth in Section 501.171.

The successful proposer, as the City's third-party agent, as defined in Section 501.171, shall comply with and perform all of the requirements set forth in Subsections 501.171(3) and (4), Florida Statutes (2021), as may be amended or revised, in the event the successful proposer experiences a breach of security involving unauthorized access of the City's data in electronic form containing

personal information. In addition to complying with Subsections 501.171(3) and (4), Florida Statutes (2021), as may be amended or revised, the successful proposer shall provide credit monitoring and identity theft protection to affected persons, establish and operate a call center for affected persons, and perform other functions and provide other services as required by law. The successful proposer shall ensure that the City is in compliance with all legal requirements and laws associated with the breach of security or the potential breach of security.

In addition, successful proposer shall immediately take such actions as may be necessary to preserve forensic evidence and eliminate the cause of the breach of security. successful proposer shall provide the City all information reasonably necessary to enable the City to understand the nature and scope of the breach of security. In such case, successful proposer shall provide information to the City about what actions successful proposer has taken to mitigate any deleterious effect of the unauthorized use or disclosure of, or access to, City data. The City may suspend any services or products provided by successful proposer until the City determines that the cause of the breach of security has been sufficiently mitigated.

Indemnification
Notwithstanding anything to the contrary contained in the Agreement and in addition to, these data Security Terms and Conditions, the successful proposer shall defend, indemnify, and hold harmless the City from and against any loss, liability, damage, costs, or expenses, including, but not limited to, reasonable attorneys' fees (collectively, "Damages"), to the extent arising from third-party claims or actions against the City as a result of any breach of security involving City data. The indemnification provided above shall include where applicable, the full cost of, forensic analysis, system remediation to eliminate the cause of the breach of security, notice letters to potentially affected individuals, credit monitoring services, identity theft protection services, call center costs and expenses, notification letters to regulatory authorities, reasonable attorney's fees, civil penalties, and any cost and expenses associated with other functions or services as required by law (collectively, "Damages").

2.30 Award of Contract

A Contract (the "Agreement") may be awarded by the City Commission. The City reserves the right to execute or not execute, as applicable, a contract with the Proposer(s) that is determined to be in the City's best interests. The City reserves the right to award a contract to more than one Proposer, at the sole and absolute discretion of the City.

2.31 Uncontrollable Circumstances ("Force Majeure")

The City and successful proposer will be excused from the performance of their respective obligations under this agreement when and to the extent that their performance is delayed or prevented by any circumstances beyond their control including, fire, flood, explosion, strikes or other labor disputes, act of God or public emergency, war, riot, civil commotion, malicious damage, act or omission of any governmental authority, delay or failure or shortage of any type of transportation, equipment, or service from a public utility needed for their performance, provided that:

2.31.1 The non-performing party gives the other party prompt written notice describing the particulars of the Force Majeure including, but not limited to, the nature of the occurrence and its expected duration, and continues to furnish timely reports with respect thereto during the period of the Force Majeure;

2.31.2 The excuse of performance is of no greater scope and of no longer duration than is required by the Force Majeure;

2.31.3 No obligations of either party that arose before the Force Majeure causing the excuse of performance are excused as a result of the Force Majeure; and

2.31.4 The non-performing party uses its best efforts to remedy its inability to perform. Notwithstanding the above, performance shall not be excused under this Section for a period in excess of two (2) months, provided that in extenuating circumstances, the City may excuse performance for a longer term. Economic hardship of the successful proposer will not constitute Force Majeure. The term of the agreement shall be extended by a period equal to that during which either party's performance is suspended under this Section.

2.32 News Releases/Publicity

News releases, publicity releases, or advertisements relating to this contract, or the tasks or projects associated with the project shall not be made without prior City approval.

2.33 Contract Period

The initial contract term shall commence upon date of award by the City or January 1, 2023, whichever is later, and shall expire 3 years from that date. The City reserves the right to extend the contract for three, additional one-year terms, providing all terms conditions and specifications remain the same, both parties agree to the extension, and such extension is approved by the City. The selected proposer must be able to have the plan(s) in place by October 1, 2022, in preparation for the City's Open Enrollment period for a benefit effective date of January 1, 2023.

In the event services are scheduled to end because of the expiration of this contract, the successful proposer shall continue the service upon the request of the City as authorized by the awarding authority. The extension period shall not extend for more than 270 days beyond the expiration date of the existing contract. The successful proposer shall be compensated for the service at the rate in effect when this extension clause is invoked by the City.

2.34 Substitution of Personnel

In the event the successful proposer wishes to substitute trained, qualified, personnel for those listed in the proposal, the City shall receive prior notification and have the right to review, test and approve such substitutions, if deemed necessary. If the City has reasonable evidence to believe that an employee of the successful proposer is incompetent, or has performed his or her employment in an objectionable manner, the City shall have the right to require the successful proposer to resolve the situation to the City's satisfactions, provided, however, that the successful proposer shall not be required to institute or pursue to completion any action if to do so would violate any law, state statute, city ordinance, contract or employment or union agreement.

2.35 Service Organization Controls

The successful proposer shall provide a current SSAE 19, SOC 2, Type I report with their proposal. Awarded proposer will be required to provide SSAE 19, SOC 2, Type II report annually during The term of this contract. If the Proposer cannot provide the SSAE 19, SOC 2 or Type I report at the time of proposal submittal, a current SOC 3 report will be accepted.

2.36 Business Associate Agreement

The City shall require recommended awarded Proposer, and possibly any sub-contractor to execute a Business Associate Agreement. A Sample Business Associate Agreement is attached as Exhibit 14. The sample document does not need to be executed and provided with your RFP but will need to be executed upon award of the contract.

END OF SECTION

City of Fort Lauderdale
Group DHMO and DPPO Dental Plan Benefits
RFP #12702-525

SECTION III - TECHNICAL SPECIFICATIONS/SCOPE OF SERVICES

3.1 Overview

The City of Fort Lauderdale is issuing this Request for Proposal for group Dental DHMO & DPPO coverages for its 1,682 active employees, 420 firefighters and 270 retirees enrolled in these plans as of May 2022. City police (FOP) are not covered under these plans.

Cigna currently provides these benefits on a fully insured basis since January 1, 2018. There are three plans currently provided:
DPPO only plan for firefighters and DHMO and DPPO plan for all other eligible employees.

Coverage Tier	DHMO	DPPO	Total
Employee Only	283	511	794
Employee + Spouse	84	250	334
Employee + Children	75	146	221
Family	67	266	333
Total	509	1,173	1,682

Firefighters	DPPO
Employee Only	151
Employee + Spouse	48
Employee + Children	55
Family	166
Total	420

The negotiated DPPO plan for firefighters has lower benefits than the City plan and is being kept separate as a distinct PPO plan.

3.2 Objectives

It is the City's objective to contract with a single-provider, managed care TPA that will provide the City with the following components:

a. Obtain an agreement with a single source dental provider capable of providing all of the services and benefits required.
b. Minimize displacement of existing providers and maximize choice of network providers.
c. Maintain or enhance existing benefits as specified.
d. Lower the City and employee cost of dental benefits.

3.3 Scope of Services

The City is requesting a single source dental provider capable of providing all plan options, as well as integrated member services for members and the City. Proposals for stand-alone DHMO and DPPO plans will not be considered. Independent dental companies who partner with another dental company to provide DHMO and DPPO benefits will not be considered.

A single source dental provider is one that bears the risk for both the DHMO and the DPPO plans. Partnership arrangements between two unrelated companies to split the risks are not acceptable.

The City is requesting a dedicated toll-free number for its employees to address service and

benefit questions. Proposers who are not able to offer this benefit must clearly indicate this in the Deviations section of your proposal.

Fully insured Cost Proposals are requested for the following:

a. DHMO Plan for all eligible employees
b. DPPO Plan for all eligible employees
c. DPPO Plan for eligible firefighters
d. DHMO and DPPO for all eligible retirees

No other plan options or configurations are requested at this time.

3.4 Agent and Broker Participation

The City of Fort Lauderdale has contracted with the Gehring Group to serve as the consultant in reference to the City's group benefit plans. Remuneration for these consulting services are paid directly by the City to the Gehring Group under a separate contract. No other consultant, agent, or broker services are requested nor anticipated for this RFP. All proposed prices shall not include any remuneration to a third party.

3.5 Existing Employer Contributions

The City contributes 100% of the selected plan premium for employees and dependents of management, supervisory, and professional employees. Confidential City employees pay 50% of the premium. General employees pay 100% of the selected plan premium.

The City contribution for Firefighters DPPO plan is $39 monthly no matter the coverage tier.

END OF SECTION

SECTION IV – GENERAL PLAN PROVISIONS

4.1 Retirees

Retirees and their spouses and eligible dependents can continue coverage for as long as they choose. These options are available only at the time of retirement. If they opt out, they cannot reenter coverage. Covered spouses of retirees may continue coverage after the death of the retiree under COBRA. Retirees pay 100% of the premium for the plan selected.

4.2 Waiting Period

The waiting period is defined in the employee benefits handbook included in the 2022 Benefit Handbook.

4.3 Dependent Coverage

Eligible dependents shall include a covered employee's spouse (if not divorced or legally separated)/domestic partner and a covered employee's domestic partner's child(ren) to the end of the year in which the child(ren) reaches age 26, regardless of student status.
This definition shall apply to any and all plans offered by the city.

4.3.1 Eligibility for Pediatric Dentistry

Minor dependents up to age 13 will be able to utilize a pediatric dentist.

4.4 Plan Year Defined

The plan year shall be on a calendar year basis.

4.5 ID Cards, Documents, Communication to Members

The proposer shall provide identification cards, master plan documents (summary plan description) and communications regarding the network and various utilization review, disease management, and wellness services. ID cards and welcome packet must be mailed directly to plan enrollees. The City must approve all communications to members.

4.6 Communication Costs

The successful Proposer shall provide $3,000 annually to the City for the purpose of printing the City's benefit brochure. Summary plan descriptions, certificates of coverage, plan riders, and benefit plan outlines shall be made available online.

Printed directories are not required. All members will be directed to use the online directory provided by the selected company.

An implementation credit including adding a new plan into Selerix and COBRA is requested in the amount of $15,000.00.

4.7 Performance Guarantees

Implementation Performance Guarantee	Performance Commitment	Liquidated Damages % Amount
Identification Card Delivery Performance Standard	98% of Identification Cards mailed within 10 business days of receipt of complete and accurate eligibility data	0.25% of annual Administrative Fee
Call Readiness Performance Commitment	Service Center(s) ready to respond to customer inquiries as of Plan effective date	0.25% of annual Administrative Fee
Secure Internet Portals Commitment	Employer and member portals fully functional and available to City and participants on effective date	0.25% of annual Administrative Fee
Overall Satisfaction with Implementation Services Performance Standard	Based on a mutually agreed upon Satisfaction Survey (standard will be measured and reported to Employer annually after open enrollment implementation).	0.25% of annual Administrative Fee
ID Card Production (ongoing)	98% of Identification Cards mailed within 10 business days of receipt of complete and accurate eligibility data (standard will be measured and reported to Employer quarterly)	0.25% of annual Administrative Fee
Claims Processing	Time to Process: 94% of claims processed in 10 business days from the date a claim is received to the date it is processed (i.e., paid, pended or denied) excluding weekends and holidays (clean claims only). Standard will be measured and reported to Employer quarterly Financial Accuracy: 98% Financial Accuracy (Defined as claim dollars paid correctly divided by claim dollars paid based on all claims paid in the audit sample. Claim dollars paid correctly are calculated by subtracting the gross, not net, payment errors from total claim dollars paid). Standard will be measured and reported to the Employer quarterly. Procedural Accuracy: 98% (Defined as number of correct claims reviewed in the audit sample divided by the total number of claims reviewed in the audit	0.25% of annual Administrative Fee 0.25% of annual Administrative Fee

	sample. A “correct claim” is free of any errors including, but not limited to, spelling, coding, financial, typographical, or numerical. Standard will be measured and reported to Employer quarterly	0.25% of annual Administrative Fee

Ongoing Performance Guarantees	Measure Method	Liquidated Damages % Amount
Member Services Hold Time	Toll-free telephone line: Established and operational 30 days prior to the effective date of plan and 95% functional at all times. Standard will be measured and reported to Employer quarterly	0.25% of annual Administrative Fee
Average Speed of Answer	Average Speed of Answer: Guarantee that 85% of calls answered by live representative within 30 seconds or less. Standard will be measured and reported to Employer quarterly	0.25% of annual Administrative Fee
Abandonment Rate	Abandonment Rate: Guarantee that call abandonment rate will be 3% or less. Standard will be measured and reported to Employer quarterly	0.25% of annual Administrative Fee
Resolution of Eligibility Issues	Response rate of 2 business days to correct eligibility issues	0.25% of annual Administrative Fee
Service Manager Performance Standard	Response within 24 hours	0.25% of annual Administrative Fee

Liquidated damages amount is not to exceed $12,000 per quarter, $48,000 per year.

End of Section

SECTION V – SUBMITTAL REQUIREMENTS

5.1 Instructions

5.1.1 The City of Fort Lauderdale uses BidSync (www.bidsync.com) to administer the competitive solicitation process, including but not limited to soliciting proposals, issuing addenda, responding to questions / requests for information. There is no charge to register and download the RFP from BidSync. Proposers are strongly encouraged to read the various vendor Guides and Tutorials available in BidSync well in advance of their intention of submitting a proposal to ensure familiarity with the use of BidSync. The City shall not be responsible for a Proposer's inability to submit a proposal by the end date and time for any reason, including issues arising from the use of BidSync.

5.1.2 Careful attention must be given to all requested items contained in this RFP. Proposers are invited to submit proposals in accordance with the requirements of this RFP. Please read entire solicitation before submitting a proposal. Proposers must provide a response to each requirement of the RFP. Proposals should be prepared in a concise manner with an emphasis on completeness and clarity. Notes, exceptions, and comments may be rendered on an attachment, provided the same format of this RFP text is followed.

5.1.3 All information submitted by Proposer shall be typewritten or provided as otherwise instructed to in the RFP. Proposers shall use and submit any applicable or required forms provided by the City and attach such to their proposal. Failure to use the forms may cause the proposal to be rejected and deemed non-responsive.

5.1.4 Proposals shall be submitted by an authorized representative of the firm. Proposals must be submitted in the business entities name by the President, Partner, Officer or Representative authorized to contractually bind the business entity. Proposals shall include an attachment evidencing that the individual submitting the proposal, does in fact have the required authority stated herein.

5.1.5 All proposals will become the property of the City. The Proposer's response to the RFP is a public record pursuant to Florida law, which is subject to disclosure by the City under the State of Florida Public Records Law, Florida Statutes Chapter 119.07 ("Public Records Law"). The City shall permit public access to all documents, papers, letters, or other material submitted in connection with this RFP and the Contract to be executed for this RFP, subject to the provisions of Chapter 119.07 of the Florida Statutes. Any language contained in the Proposer's response to the RFP purporting to require confidentiality of any portion of the Proposer's response to the RFP, except to the extent that certain information is in the City's opinion a Trade Secret pursuant to Florida law, shall be void. If a Proposer submits any documents or other information to the City which the Proposer claims is Trade Secret information and exempt from Florida Statutes Chapter 119.07 ("Public Records Laws"), the Proposer shall clearly designate that it is a Trade Secret and that it is asserting that the document or information is exempt. The Proposer must specifically identify the exemption being claimed under Florida Statutes 119.07. The City shall be the final arbiter of whether any information contained in the Proposer's response to the RFP constitutes a Trade Secret. The city's determination of whether an exemption applies shall be final, and the Proposer agrees to defend, indemnify, and hold harmless the city and the city's officers, employees, and agent, against any loss or damages incurred by any person or entity as a result of the city's treatment of records as public records. In the event of Contract award, all documentation produced as part of the Contract shall become the exclusive property of the City.

IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT PRRCONTRACT@FORTLAUDERDALE.GOV, 954-828-5002, CITY CLERK'S OFFICE, 100 N. ANDREWS AVENUE, FORT LAUDERDALE, FLORIDA 33301.

Contractor shall:

1. Keep and maintain public records required by the City in order to perform the service.

2. Upon request from the City's custodian of public records, provide the City with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes (2018), as may be amended or revised, or as otherwise provided by law.

3. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the contract term and following completion of this contract if the Contractor does not transfer the records to the City.

4. Upon completion of the Contract, transfer, at no cost, to the City all public records in possession of the Contractor or keep and maintain public records required by the City to perform the service. If the Contractor transfers all public records to the City upon completion of this Contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of this Contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the City, upon request from the City's custodian of public records, in a format that is compatible with the information technology systems of the City.

5.1.6 By submitting a response Proposer is confirming that the firm has not been placed on the convicted vendors list as described in Section §287.133 (2) (a) Florida Statutes; that the only person(s), company or parties interested in the proposal as principals are named therein; that the proposal is made without collusion with any other person(s), company or parties submitting a proposal; that it is in all respects fair and in good faith, without collusion or fraud; and that the signer of the proposal has full authority to bind the firm.

5.2 Contents of the Proposal

The City deems certain documentation and information important in the determination of responsiveness and for the purpose of evaluating proposals. Proposals should seek to avoid information in excess of that requested, must be concise, and must specifically address the issues of this RFP. The City prefers that proposals be no more than 100 pages in one complete pdf document. The proposals should be organized, divided, and indexed into the sections indicated herein. These are not inclusive of all the information that may be necessary to properly evaluate the proposal and meet the requirements of the scope of work and/or specifications. Additional documents and information should be provided as deemed appropriate by the respondent in proposal to specific requirements stated herein or through the RFP.

5.2.1 Table of Contents

The table of contents should outline in sequential order the major areas of the submittal, including enclosures. All pages should be consecutively numbered and correspond to the Table of Contents.

5.2.2 Executive Summary

Each offeror must submit an executive summary that identifies the business entity, its background, main office(s), and office location that will service this contract. Identify the officers, principals, supervisory staff, and key individuals who will be directly involved with the work and their office locations. The executive summary should also summarize the key elements of the proposal.

5.2.3 Experience and Qualifications

Indicate the firm's number of years of experience in providing the professional services as it relates to this RFP. Provide details of past projects for agencies of similar size and scope. Indicate business structure, IE: Corp., Partnership, LLC. Firm should be registered as a legal entity in the State of Florida; Disadvantaged Business Enterprise (DBE). Company address, phone number, fax number, e-mail address, web site, contact person(s), etc. Relative size of firm, including management, technical and support staff, licenses, and any other pertinent information that should be included.

5.2.4 Approach to Scope of Work

Provide a concise narrative from, your understanding of the City's needs, goals, and objectives as they relate to the solicitation, and you overall approach to accomplishing the solicitation requirements. Give an overview of your proposed visions, ideas, and methodology. Describe your proposed approach. As part of the project approach, the proposer shall propose a scheduling methodology (timeline) for effectively managing and executing the work in the optimum time. Also provide information of your firm's current workload and how this project will fit into your workload. Describe available facilities, technological capabilities, and other available resources you offer for the required services specified herein.

Additionally, the proposal should specifically address the following items. Each should be presented in the requested order, separated by tabs, and listed in the table of contents.

5.2.5 Benefit Plans

Proposers must provide complete benefit descriptions of the plans being proposed, including the proposed DHMO schedule with CDT codes and brief explanation of service. These descriptions must include all exclusions and limitations. In addition, an Excel file is attached DHMO Copay Procedure Comparison, which lists dental procedures. Please fill in the copay for each procedure for the plan or plans you are proposing. You must indicate which procedures are not covered. If you**r** plan covers procedures that are not listed, please add them to the file and highlight your entry. ~~Provide this in Excel format on CD or thumb drive~~. Please review current benefit specifications. If your proposed plans do not meet these specifications, please include a description of all deviations in this tab.

5.2.6 Rate and Premium Forms

Proposers must complete the rate forms included in Section VIII of this RFP.

5.2.7 Network Forms

Proposers must complete the network forms provide in this RFP. These forms include the network summary found in Section VII of this document and the specific provider file which

is attached as providers.xlsx. This file includes lists of the DHMO and DPPO providers utilized by City members. Indicate which are included in your company's network.

5.2.8 National DHMO and DPPO Networks/Geo Access Reports

Proposers must provide a complete listing of all national markets in which you have DHMO and DPPO networks that would be available to City retirees. Include a Geo Access report based on the census provided which includes zip codes. The geo access report is required only for retirees living outside of the South Florida area.

5.2.9 Questionnaire

Proposers must respond to the questionnaire attached to this RFP as *dental proposal questionnaire.*

5.2.10 Deviations from RFP

Proposers should provide a list of any deviations to the general provisions and requested benefits and provisions outlined in this RFP. If there are no deviations, a statement to this effect must be provided. Deviations to the City's requirements may deem the Proposer non-responsive, as determined by the City.

5.2.11 Grievance and Appeal Process

Proposers must provide a description of the grievance and appeal procedure to be conducted on behalf of the City's DHMO and DPPO plan. Be specific in terms of timeline and expected turnarounds.

5.2.12 DHMO and DPPO Quality Assurance

Provide a detailed description of your DHMO and DPPO provider Quality Assurance program.

5.2.13 Incorporation/Licensing

Proposers must provide proof of State of Incorporation and State in which licensed.

5.2.14 Authorization to Provide Services

Proposers must provide certification from the appropriate State offices that the firm is authorized to provide the services contracted in this proposal.

5.2.15 References

Proposers should provide a list of four (4) group clients with more than 500 covered employees located in the State of Florida, preferably public sector employers. Also, include names of persons who may be contacted for references, along with their phone numbers and email addresses. Also include contact information for two (2) former clients.

5.2.16 Proposing Company History

Proposers indicate number of years the company has offered group dental plans.

5.2.17 Statement of Minimum Qualification

Proposer must provide documentation of minimum qualifications as outlined in this RFP.

5.2.18 Sample Contracts

Proposer must include samples of any and all contracts and certificates of coverage that would be executed by the City under the proposed plans. This information should be

included in Tab 9 of your proposal. NOTE: If your terms and conditions conflict with the City's terms and conditions, Proposer may be deemed NON-RESPONSIVE.

5.2.19 Sample Administration Forms

Proposers should include a sample identification card, claim forms, enrollment forms, and explanation of benefits.

5.2.20 Required Forms

a. Proposal Certification

Complete and attach the Proposal Certification provided herein.

b. Non-Collusion Statement

This form is to be completed, if applicable, and inserted in this section.

c. Local Business Preference (LBP)

This form is to be completed, if applicable, and inserted in this section.

d. Contract Payment Method

This form must be completed and returned with your proposal. Proposers must presently have the ability to accept these credit cards or take whatever steps necessary to implement the acceptance of a card before the start of the contract term, or contract award by the City.

e. Sample Insurance Certificate

Demonstrate your firm's ability to comply with insurance requirements. Provide a previous certificate or other evidence listing the Insurance Companies names for the required coverage limits.

END OF SECTION

SECTION VI – EVALUATION AND AWARD

6.1 Evaluation Procedure

6.1.1 Bid/Proposal Tabulations/Intent to Award

Notice of Intent to Award Contract/Bid/Proposal, resulting from the City's Formal solicitation process, requiring City Commission action, may be found at: https://www.fortlauderdale.gov/government/departments-a-h/finance/procurement-services/notices-of-intent-to-award. Tabulations of receipt of those parties responding to a formal solicitation may be found at: https://www.fortlauderdale.gov/government/departments-a-h/finance/procurement-services/bid-results, or any interested party may call the Procurement Services Division at 954-828-5933.

6.1.2 Evaluation of proposals will be conducted by an Evaluation Committee, consisting of at least a minimum of three members of City Staff, or other persons selected by the City Manager or designee. All committee members must be in attendance at scheduled evaluation meetings. Meetings may be in person or virtual. Proposals shall be evaluated based upon the information and references contained in the responses as submitted.

6.1.3 The Committee may short list Proposals that it deems best satisfy the weighted criteria set forth herein. The committee may then conduct virtual interviews and/or require virtual oral presentations from the short-listed Proposers. The Evaluation Committee shall then re-score and re-rank the short-listed firms in accordance with the weighted criteria.

6.1.4 The City may require visits to the Proposer's facilities to inspect record keeping procedures, staff, facilities and equipment as part of the evaluation process.

6.1.5 The final ranking and the Evaluation Committee's recommendation may then be reported to the City Manager for consideration of contract award.

6.2 Evaluation Criteria

6.2.1 The City uses a mathematical formula to determine the scoring for each individual responsive and responsible firm based on the weighted criteria stated herein. Each evaluation committee member will rank each firm by criteria, giving their first ranked firm a number 1, the second ranked firm a number 2, and so on. The City shall multiply that average ranking by the weighted criterion identified herein to determine the total the points for each Proposer. The lowest average final ranking score will determine the recommendation by the evaluation committee to the City Manager.

6.2.2 Weighted Criteria

Size & Adequacy of Provider Network Size, accessibility, adequacy, and quality of DHMO and DPPO networks in Broward, Miami-Dade, Palm Beach, and Monroe Counties, with minimal displacement of existing network providers National DHMO and DPPO network for retirees	**30%**
Level of Benefits DHMO The satisfaction level of existing employer clients, members, and network providers. The ability to provide the requested experience and utilization data.	**20%**
Level of Benefits DPPO The satisfaction level of existing employer clients, members, and network providers. The ability to provide the requested experience and utilization data.	**20%**
Total Cost Total premium cost including rate guarantees and renewal caps	**30%**
TOTAL PERCENTAGE AVAILABLE	**100%**

6.3 Contract Award

The City reserves the right to award a contract to that Consultant who will best serve the interest of the City. The City reserves the right, based upon its deliberations and in its opinion, to accept or reject any or all proposals. The City also reserves the right to waive minor irregularities or variations of the submittal requirements and RFP process.

END OF SECTION

City of Fort Lauderdale
Group DHMO and DPPO Dental Plan Benefits
RFP #12702-525

Section VII – Cost Proposal Page

Proposer Name: _____

	Fully Insured DHMO	**Fully Insured DPPO**	**Fully Insured DPPO for Firefighters**
Employee Only			
Employee + Spouse			
Employee + Child(ren)			
Family			

The premiums listed above are guaranteed for:

1 Year ____ 2 Years ____ 3 Years ____ 4 Years ____ 5 Years ____ 6 Years ____

Rate cap and details for any renewal not guaranteed:

_____

_____

Multi-year guarantees (especially 3 years) are preferred and will be factored into the evaluation.

Submitted by:

_____ _____
Name (printed) Signature

_____ _____
Date Title

Version 12-2021

City of Fort Lauderdale
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SECTION VIII – Network Information

Network Summary
Indicate the number of **DHMO and DPPO dentists, not dental offices** by category. For, general dentists, list only those accepting new patients. **If a provider has more than one office, he or she should be counted only once.**

DHMO Network	**Broward**	**Miami-Dade**	**Palm Beach**	**Martin**	**Monroe**
General Dentists					
Pediatric Dentists					
Oral Surgeons					
Endodontists					
Periodontists					
Orthodontists					
Prosthodontists					
DPPO Network					
General Dentists					
Pediatric Dentists					
Oral Surgeons					
Endodontists					
Periodontists					
Orthodontists					
Prosthodontists					

Specific Dentist Network

We have attached an Excel file, specific providers.xlsx, with two lists of providers:

- DHMO providers with members assigned
- DPPO providers utilized by City members.

Please indicate which of these providers participate in your company's DHMO and DPPO networks.

Include the completed form in your proposal. ~~Also provide the completed form in Excel format on a Flash Drive.~~

Section IX - References

Current Clients

Provide references for **four (4) current clients**. We would prefer that these be Florida public sector employers with more than 500 subscribers.

1. Name of Company _____
   Total Number of Full Time Employees _____
   Name & Title of Contact _____
   Email address _____
   Telephone number _____
   Fax number _____
   Type of benefits provided _____
   Number of employees covered _____
   Plan inception date _____
2. Name of Company _____
   Total Number of Full Time Employees _____
   Name & Title of Contact _____
   Email address _____
   Telephone number _____
   Fax number _____
   Type of benefits provided _____
   Number of employees covered _____
   Plan inception date _____
3. Name of Company _____
   Total Number of Full Time Employees _____
   Name & Title of Contact _____
   Email address _____
   Telephone number _____
   Fax number _____
   Type of benefits provided _____
   Number of employees covered _____
   Plan inception date _____

4. Name of Company _____

   Total Number of Full Time Employees _____

   Name & Title of Contact _____

   Email address _____

   Telephone number _____

   Fax number _____

   Type of benefits provided _____

   Number of employees covered _____

   Plan inception date _____

Terminated Clients

Please provide two (2) references from former clients with whom your company may no longer have the contract or contract expired within the past 12 months. We would prefer these be Florida public sector employers with more than 500 subscribers.

1. Name of Company _____

   Total Number of Full Time Employees _____

   Name & Title of Contact _____

   Email address _____

   Telephone number _____

   Fax number _____

   Type of benefits provided _____

   Number of employees covered _____

   Contract term _____

2. Name of Company _____

   Total Number of Full Time Employees _____

   Name & Title of Contact _____

   Email address _____

   Telephone number _____

   Fax number _____

   Type of benefits provided _____

   Number of employees covered _____

   Contract term _____

City of Fort Lauderdale
Group DHMO and DPPO Dental Plan Benefits
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Section X – Underwriting Information

DHMO and DPPO Monthly Rates

2022 Monthly Rates	Plan Year 01/01/2022 – 12/31/2022
Cigna	**DHMO**
Employee Only	$18.11
Employee + Spouse	$31.71
Employee + Child(ren)	$38.06
Family	$53.34
Cigna	**DPPO**
Employee Only	$56.88
Employee + Spouse	$106.57
Employee + Child(ren)	$109.56
Family	$138.09
Cigna	**Firefighters DPPO**
Employee Only	$49.07
Employee + Spouse	$59.19
Employee + Child(ren)	$58.67
Family	$72.76

2021 Monthly Rates	Plan Year 01/01/2021 – 12/31/2021
Cigna	**DHMO**
Employee Only	$17.52
Employee + Spouse	$30.20
Employee + Child(ren)	$36.25
Family	$50.80
Cigna	**DPPO**
Employee Only	$54.17
Employee + Spouse	$101.50
Employee + Child(ren)	$104.34
Family	$131.52
Cigna	**Firefighters DPPO**
Employee Only	$47.52
Employee + Spouse	$56.36
Employee + Child(ren)	$56.16
Family	$68.32

City of Fort Lauderdale
Group DHMO and DPPO Dental Plan Benefits
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Dental PPO Experience

The DPPO experience report has been attached.

DHMO Utilization

Utilization for the DHMO has been attached.

Census

A census has been attached reflecting the following:

- All eligible active employees and an indication of their dental plan selections
- Retirees covered under the dental plan (once retirees leave the plan, they are no longer eligible to come back into the plan).

Benefit Descriptions

- Details of the City's current dental benefits are found in the following files:
  - DHMO Patient Charge Schedule.pdf (non-firefighters)
  - DPPO Benefit Summary (City Population) .pdf (non-firefighters)
  - DPPO Firefighters Benefit Summary.pdf
  - Ben Sum TX DPPO City Plan.pdf
  - Ben Sum TX DPPO Fire Plan.pdf
  - DHMO Summary Plan Description.pdf
  - DPPO Summary Plan Description – City Population.pdf
  - DPPO Summary Plan Description – Firefighters.pdf

City of Fort Lauderdale
Group DHMO and DPPO Dental Plan Benefits
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BID PROPOSAL CERTIFICATION

Please Note: All fields below must be completed. If the field does not apply to you, please note N/A in that field. If you are a foreign corporation, you may be required to obtain a certificate of authority from the department of state, in accordance with Florida Statute §607.1501 (http://www.dos.state.fl.us/).

Company:(Legal Registration) _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. _____ FAX No._____ Email: _____

Does your firm qualify for MBE or WBE status (section 1.09 of General Conditions): MBE _____ WBE _____

ADDENDUM ACKNOWLEDGEMENT - Proposer acknowledges that the following addenda have been received and are included in the proposal:

Addendum No.	Date Issued	Addendum No.	Date Issued
_____	_____	_____	_____
_____	_____	_____	_____

VARIANCES: If you take exception or have variances to any term, condition, specification, scope of service, or requirement in this competitive solicitation you must specify such exception or variance in the space provided below or reference in the space provided below all variances contained on other pages within your response. Additional pages may be attached if necessary. No exceptions or variances will be deemed to be part of the response submitted unless such is listed and contained in the space provided below. The City does not, by virtue of submitting a variance, necessarily accept any variances. If no statement is contained in the below space, it is hereby implied that your response is in full compliance with this competitive solicitation. If you do not have variances, simply mark N/A. **If submitting your response electronically through BIDSYNC you must also click the "Take Exception" button.**

The below signatory hereby agrees to furnish the following article(s) or services at the price(s) and terms stated subject to all instructions, conditions, specifications addenda, legal advertisement, and conditions contained in the bid/proposal. I have read all attachments including the specifications and fully understand what is required. By submitting this signed proposal, I will accept a contract if approved by the City and such acceptance covers all terms, conditions, and specifications of this bid/proposal. The below signatory also hereby agrees, by virtue of submitting or attempting to submit

a response, that in no event shall the City's liability for respondent's direct, indirect, incidental, consequential, special or exemplary damages, expenses, or lost profits arising out of this competitive solicitation process, including but not limited to public advertisement, bid conferences, site visits, evaluations, oral presentations, or award proceedings exceed the amount of Five Hundred Dollars ($500.00). This limitation shall not apply to claims arising under any provision of indemnification or the City's protest ordinance contained in this competitive solicitation.

Submitted by:

_____	_____
Name (printed)	Signature
_____	_____
Date	Title

City of Fort Lauderdale
Group DHMO and DPPO Dental Plan Benefits
RFP #12702-525

Proposer's Identification

Name of Organization: _____

Address: _____

_____

_____

Contact Person: _____

Telephone Numbers

Daytime: _____

After Hours/Mobile: _____

Fax: _____

Email: _____

PROPOSER'S GROUP REPRESENTATIVE OR ACCOUNT EXECUTIVE

Name of Firm: _____

Address: _____

_____

Group Representative or Account Executive: _____

Telephone Numbers

Daytime: _____

After Hours/Mobile: _____

Fax: _____

Email: _____

City of Fort Lauderdale
Group DHMO and DPPO Dental Plan Benefits
RFP #12702-525

Proposer's Warranty

The undersigned person by the undersigned's signature affixed hereon warrants that:

A. The undersigned is an officer, partner, or a sole proprietor of the firm and the enclosed proposal us submitted on behalf of the firm:
B. The undersigned has carefully reviewed all the materials and data provided on the firm's proposal on behalf of the firm, and, after specific inquiry, believes all the material and data to be true and correct;
C. The proposal offered by the firm is in full compliance with the Minimum Qualifications of Proposer set forth in this RFP
D. The firm authorizes the City of Fort Lauderdale, its staff or consultants to contact any of the references provided in the proposal and specifically authorizes such references to release either orally or in writing any appropriate data with respect to the firm offering this proposal;
E. The undersigned has been specifically authorized to issue a contract in full compliance with all requirements and conditions, as set forth in this RFP other than those deviations noted above;
F. If this proposal is accepted, the contract will be issued as proposed.

_____

Name of Firm

_____

Signature of Authorized Representative

_____

Title of Authorized Representative

_____

Date Signed by Authorized Representative

City of Fort Lauderdale
Group DHMO and DPPO Dental Plan Benefits
RFP #12702-525

No Bid Form

NO BID COMMENTS: If you are unable to respond to our Request for Proposal, we would appreciate your comments as to your reason for submitting a NO BID. Please insert your comments in the space that follows and return this form to:

Procurement Services Department
City of Fort Lauderdale, 6th Floor
100 North Andrews Avenue
Fort Lauderdale, FL 33301

Your response will assist us in future solicitations.

_____

_____

_____

_____

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_____

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City of Fort Lauderdale

CIGNA Dental Network Disruption

2204-1870352

04/27/2022

Submitted Amount		Cigna Dental Care Access		Cigna Advantage		Cigna DPPO		Total Cigna DPPO	
# of Provider Access Points	1,291	442	34%	968	75%	202	16%	1,170	91%
Submitted Amount	$ 3,510,259	$ 1,165,301	33%	$ 2,576,111	73%	$ 637,367	18%	$ 3,213,478	92%
Payable Amount	$ 1,327,865	$ 432,977	33%	$ 891,146	67%	$ 280,477	21%	$ 1,171,623	88%
# of Services	21,595	7,949	37%	16,047	74%	3,808	18%	19,855	92%

Provider Access Point Match Criteria Results

Pass #	Disruption Passes	DCA	Adv	DPPO	Total	Match %
1	Name, Facility, Addr, City, State, Zip	187	455	82	537	42%
2	Name, Addr, City, State, Zip	154	398	88	486	38%
3	Lic Nbr, Addr, City, State, Zip	4	6	4	10	1%
4	NPI, Addr, City, State, Zip	8	15	5	20	2%
5	TIN, Addr, City, State, Zip	53	60	13	73	6%
6	Name, Facility, City, State, Zip	3	8	1	9	1%
7	Facility, Addr, City, State, Zip	-	-	-	-	0%
8	Name, Facility, City, State	1	1	-	1	0%
9	Name, City, State, Zip	2	7	1	8	1%
10	Facility, City, State, Zip	9	2	-	2	0%
11	Name, Facility, Zip	-	-	-	-	0%
12	Name, City, State	3	2	3	5	0%
13	Facility, City, State	12	1	2	3	0%
14	NPI, Zip	-	-	-	-	0%
15	Lic Nbr, Zip	-	-	-	-	0%
16	TIN	6	13	3	16	1%
	Total Matches	442	968	202	**1,170**	91%

Methodology:

Name (is based on First Name & Last Name; Limited First Name to 1 character)

Facility (is Limited to the first 9 characters, and no Punctuation)

Utilized Providers (pages 40-53) have been redacted.

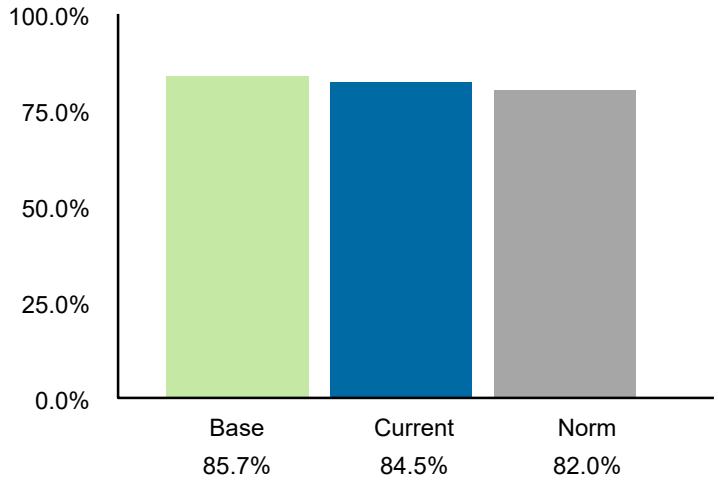
Dental Care - Summary

City of Fort Lauderdale

Demographic Summary	Base	Current	Trend
Average Number of Employees	554	515	-7.1%
Average Number of Members	1,006	952	-5.4%

Key Statistics	Base	Current	Trend	Norm
Services	2,024	2,063	1.9%	
Services per 1,000	2,012.4	2,168.2	7.7%	2,760.8
Total Patient Copays	$52,613	$59,202	12.5%	
National Average Charges	$368,573	$381,344	3.5%	
Savings on Dental Services	$315,978	$322,143	2.0%	
Savings Percentage	85.7%	84.5%	-1.2%	82.0%

Savings percentage



Comments

- Dental Care reporting is limited to encounter data submitted by providers, therefore service counts can be understated when utilization detail is not provided
- Savings percentage decreased from 85.7% to 84.5%, and compares to a norm of 82.0%
- Cigna DHMO is also known as Cigna Dental Care and includes Cigna Dental Care Access and Cigna Dental Care Access Plus

Current Period reflects claims incurred between Jan. 2021 and Dec. 2021, paid through Mar. 2022
Base Period reflects claims incurred between Jan. 2020 and Dec. 2020, paid through Mar. 2021

Dental Care - Utilization by Type of Service

City of Fort Lauderdale

Gross Services by Type	Base		Current		Trend	Norm
	Count	Percent of Total	Count	Percent of Total		Percent of Total
Diagnostic/Preventive	1,107	54.7%	1,177	57.1%	6.3%	69.4%
Basic Restorative	184	9.1%	132	6.4%	-28.3%	7.4%
Major Restorative	79	3.9%	104	5.0%	31.6%	4.1%
Endodontics	20	1.0%	29	1.4%	45.0%	1.2%
Periodontics	261	12.9%	287	13.9%	10.0%	7.2%
Oral Surgery	125	6.2%	96	4.7%	-23.2%	3.6%
Orthodontics	143	7.1%	156	7.6%	9.1%	4.5%
Other Services	105	5.2%	82	4.0%	-21.9%	2.6%
Total	**2,024**	**100.0%**	**2,063**	**100.0%**	**1.9%**	**100.0%**

Services per 1,000 Members by Type	Base		Current		Trend	Norm	
	Count	Percent of Total	Count	Percent of Total		Count	Percent of Total
Diagnostic/Preventive	1,100.7	54.7%	1,237.0	57.1%	12.4%	1,915.1	69.4%
Basic Restorative	182.9	9.1%	138.7	6.4%	-24.2%	205.4	7.4%
Major Restorative	78.5	3.9%	109.3	5.0%	39.2%	112.2	4.1%
Endodontics	19.9	1.0%	30.5	1.4%	53.3%	32.1	1.2%
Periodontics	259.5	12.9%	301.6	13.9%	16.2%	198.8	7.2%
Oral Surgery	124.3	6.2%	100.9	4.7%	-18.8%	100.4	3.6%
Orthodontics	142.2	7.1%	164.0	7.6%	15.3%	124.1	4.5%
Other Services	104.4	5.2%	86.2	4.0%	-17.5%	72.7	2.6%
Total	**2,012.4**	**100.0%**	**2,168.2**	**100.0%**	**7.7%**	**2,760.8**	**100.0%**

Comments

- There is an increase in utilization per thousand in 5 categories and a decrease in utilization per thousand in 3 categories for an overall utilization trend of 7.7%
- High utilization for Diagnostic/Preventive services can lead to lower usage of other service categories

Current Period reflects claims incurred between Jan. 2021 and Dec. 2021, paid through Mar. 2022
Base Period reflects claims incurred between Jan. 2020 and Dec. 2020, paid through Mar. 2021

Census (pages 56-121) redacted to remove City employees personal information.

CIGNA DENTAL CARE® (*DHMO) PATIENT CHARGE SCHEDULE

This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Cigna Dental as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialty Periodontist or Oral Surgeon. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental. Prior authorization is not required for specialty referrals for Pediatric, Orthodontic and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 13 by calling Customer Service at 1.800.Cigna24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 13th birthday.
- Procedures not listed on this Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or nitrous oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- Cigna Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Important Highlights (Continued)

- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
Office visit fee – (per patient, per office visit in addition to any other applicable patient charges)		
	Office visit fee	$0.00
Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145).		
D9310	Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$7.00
D9430	Office visit for observation – No other services performed	$3.00
D9450	Case presentation – Detailed and extensive treatment planning	$0.00
D0120	Periodic oral evaluation – Established patient	$0.00
D0140	Limited oral evaluation – Problem focused	$0.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation – New or established patient	$0.00
D0160	Detailed and extensive oral evaluation - Problem focused, by report *(limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$0.00
D0170	Re-evaluation – Limited, problem focused (established patient; not post-operative visit)	$0.00
D0171	Re-evaluation – Post-operative office visit	$0.00
D0180	Comprehensive periodontal evaluation – New or established patient	$0.00
D0210	X-rays intraoral – Complete series of radiographic images *(limit 1 every 3 years)*	$0.00
D0220	X-rays intraoral – Periapical – First radiographic image	$0.00
D0230	X-rays intraoral – Periapical – Each additional radiographic image	$0.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D0240	X-rays intraoral – Occlusal radiographic image	$0.00
D0250	X-rays extraoral – 2D projection radiographic image created using a stationary radiation source, and detector	$0.00
D0251	Extra-oral posterior dental radiographic image (*limit 1 per calendar year*)	$0.00
D0270	X-rays (bitewing) – Single radiographic image	$0.00
D0272	X-rays (bitewings) – 2 radiographic images	$0.00
D0273	X-rays (bitewings) – 3 radiographic images	$0.00
D0274	X-rays (bitewings) – 4 radiographic images	$0.00
D0277	X-rays (bitewings, vertical) – 7 to 8 radiographic images	$0.00
D0330	X-rays (panoramic radiographic image) – *(limit 1 every 3 years)*	$0.00
D0350	2D oral/facial photographic images obtained intra-orally or extra-orally	$0.00
D0351	3D photographic image	$0.00
D0364	Cone beam CT capture and interpretation with limited field of view – Less than one whole jaw *(only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)*	$200.00
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – Mandible *(only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)*	$220.00
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – Maxilla, with or without cranium *(only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)*	$220.00
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium *(only covered in conjunction*	$240.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
	with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)	
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures *(limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$240.00
D0415	Collection of microorganisms for culture and sensitivity	$0.00
D0425	Caries susceptibility tests	$0.00
D0431	Oral cancer screening using a special light source	$50.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00
D0472	Pathology report – Gross examination of lesion (only when tooth related)	$0.00
D0473	Pathology report – Microscopic examination of lesion (only when tooth related)	$0.00
D0474	Pathology report – Microscopic examination of lesion and area (only when tooth related)	$0.00
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0.00
D1110	Prophylaxis (cleaning) – Adult *(limit 2 per calendar year)*	$0.00
	Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year	$45.00
D1120	Prophylaxis (cleaning) – Child *(limit 2 per calendar year)*	$0.00
	Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year	$35.00
D1206	Topical application of fluoride varnish *(limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.*	$0.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
	Additional topical application of fluoride varnish in addition to any combination of two (2) D1206s (topical application of fluoride varnish) and/or D1208s (topical application of fluoride - excluding varnish) per calendar year	$15.00
D1208	Topical application of fluoride - Excluding varnish (*limit 2 per calendar year*) *There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.*	$0.00
	Additional topical application of fluoride - Excluding varnish - In addition to any combination of two (2) D1206s (topical applications of fluoride varnish) and/or D1208s (topical application of fluoride - excluding varnish) per calendar year	$15.00
D1310	Nutritional counseling for control of dental disease	$0.00
D1320	Tobacco counseling for the control and prevention of oral disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant – Per tooth	$7.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth	$7.00
D1353	Sealant repair – Per tooth	$5.00
D1354	Interim caries arresting medicament application	$0.00
D1510	Space maintainer – Fixed – Unilateral	$17.00
D1515	Space maintainer – Fixed – Bilateral	$17.00
D1520	Space maintainer – Removable – Unilateral	$25.00
D1525	Space maintainer – Removable – Bilateral	$25.00
D1550	Re-cement or re-bond space maintainer	$3.00
D1555	Removal of fixed space maintainer	$3.00
D1575	Distal shoe space maintainer – Fixed – Unilateral	$19.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
Restorative (fillings, including polishing)		
D2140	Amalgam – 1 surface, primary or permanent	$0.00
D2150	Amalgam – 2 surfaces, primary or permanent	$0.00
D2160	Amalgam – 3 surfaces, primary or permanent	$0.00
D2161	Amalgam – 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite – 1 surface, anterior	$0.00
D2331	Resin-based composite – 2 surfaces, anterior	$0.00
D2332	Resin-based composite – 3 surfaces, anterior	$0.00
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle, anterior	$0.00
D2390	Resin-based composite crown, anterior	$30.00
D2391	Resin-based composite – 1 surface, posterior	$45.00
D2392	Resin-based composite – 2 surfaces, posterior	$55.00
D2393	Resin-based composite – 3 surfaces, posterior	$65.00
D2394	Resin-based composite – 4 or more surfaces, posterior	$70.00

Crown and bridge – All charges for crowns and bridges (fixed partial dentures) are per unit (each replacement or supporting tooth equals 1 unit). Coverage for replacement of crowns and bridges is limited to 1 every 5 years.
For single crowns, retainer ("abutment") crowns, and pontics: The charges below include the cost of predominantly base metal alloy. You may be charged up to these additional amounts, based on the type of material the dentist uses for your restoration:
• No more than $150.00 per tooth for any noble metal alloys, high noble metal alloys, titanium or titanium alloys
• No more than $75.00 per tooth for any porcelain fused to metal (only on molar teeth)
• Porcelain/ceramic substrate crowns on molar teeth are not covered.
In addition, you may be charged up to these additional amounts:
• No more than $100.00 per tooth if an indirectly fabricated ("cast") post and core is made of high noble metal alloy
• No more than $150.00 per tooth/unit for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) services. Same day

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
in-office CAD/CAM (ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine. Complex rehabilitation – An additional $125 charge per unit for multiple crown units/ complex rehabilitation (6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)		
D2510	Inlay – Metallic – 1 surface	$130.00
D2520	Inlay – Metallic – 2 surfaces	$130.00
D2530	Inlay – Metallic – 3 or more surfaces	$130.00
D2542	Onlay – Metallic – 2 surfaces	$130.00
D2543	Onlay – Metallic – 3 surfaces	$130.00
D2544	Onlay – Metallic – 4 or more surfaces	$130.00
D2610	Inlay – Porcelain/ceramic, 1 surface	$130.00
D2620	Inlay – Porcelain/ceramic, 2 surfaces	$130.00
D2630	Inlay – Porcelain/ceramic, 3 or more surfaces	$130.00
D2642	Onlay – Porcelain/ceramic, 2 surfaces	$130.00
D2643	Onlay – Porcelain/ceramic, 3 surfaces	$130.00
D2644	Onlay – Porcelain/ceramic, 4 or more surfaces	$130.00
D2650	Inlay – Resin-based composite, 1 surface	$130.00
D2651	Inlay – Resin-based composite, 2 surfaces	$130.00
D2652	Inlay – Resin-based composite, 3 or more surfaces	$130.00
D2662	Onlay – Resin-based composite, 2 surfaces	$130.00
D2663	Onlay – Resin-based composite, 3 surfaces	$130.00
D2664	Onlay – Resin-based composite, 4 or more surfaces	$130.00
D2710	Crown – Resin-based composite, indirect	$130.00
D2712	Crown – 3/4 resin-based composite, indirect	$130.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D2720	Crown – Resin with high noble metal	$130.00
D2721	Crown – Resin with predominantly base metal	$130.00
D2722	Crown – Resin with noble metal	$130.00
D2740	Crown – Porcelain/ceramic substrate	$220.00
D2750	Crown – Porcelain fused to high noble metal	$130.00
D2751	Crown – Porcelain fused to predominantly base metal	$130.00
D2752	Crown – Porcelain fused to noble metal	$130.00
D2780	Crown – 3/4 cast high noble metal	$130.00
D2781	Crown – 3/4 cast predominantly base metal	$130.00
D2782	Crown – 3/4 cast noble metal	$130.00
D2783	Crown – 3/4 porcelain/ceramic	$130.00
D2790	Crown – Full cast high noble metal	$130.00
D2791	Crown – Full cast predominantly base metal	$130.00
D2792	Crown – Full cast noble metal	$130.00
D2794	Crown – Titanium	$130.00
D2799	Provisional crown	$100.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0.00
D2920	Re-cement or re-bond crown	$0.00
D2929	Prefabricated porcelain/ceramic crown - Primary tooth	$95.00
D2930	Prefabricated stainless steel crown – Primary tooth	$17.00
D2931	Prefabricated stainless steel crown – Permanent tooth	$17.00
D2932	Prefabricated resin crown	$25.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D2933	Prefabricated stainless steel crown with resin window	$25.00
D2934	Prefabricated esthetic coated stainless steel crown – Primary tooth	$95.00
D2940	Protective restoration	$3.00
D2941	Interim therapeutic restoration - Primary dentition	$3.00
D2950	Core buildup – Including any pins	$40.00
D2951	Pin retention – Per tooth – In addition to restoration	$10.00
D2952	Post and core – In addition to crown, indirectly fabricated	$45.00
D2953	Each additional indirectly prefabricated post – Same tooth	$45.00
D2954	Prefabricated post and core – In addition to crown	$30.00
D2957	Each additional prefabricated post – Same tooth	$25.00
D2960	Labial veneer (resin laminate) – Chairside	$250.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$45.00
D2980	Crown repair, necessitated by restorative material failure	$10.00
D6210	Pontic – Cast high noble metal	$130.00
D6211	Pontic – Cast predominantly base metal	$130.00
D6212	Pontic – Cast noble metal	$130.00
D6214	Pontic – Titanium	$130.00
D6240	Pontic – Porcelain fused to high noble metal	$130.00
D6241	Pontic – Porcelain fused to predominantly base metal	$130.00
D6242	Pontic – Porcelain fused to noble metal	$130.00
D6245	Pontic – Porcelain/ceramic	$130.00
D6250	Pontic – Resin with high noble metal	$130.00
D6251	Pontic – Resin with predominantly base metal	$130.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6252	Pontic – Resin with noble metal	$130.00
D6253	Provisional Pontic	$130.00
D6545	Retainer – Cast metal for resin bonded fixed prosthesis	$130.00
D6600	Retainer inlay – Porcelain/ceramic, 2 surfaces	$130.00
D6601	Retainer inlay – Porcelain/ceramic, 3 or more surfaces	$130.00
D6602	Retainer inlay – Cast high noble metal, 2 surfaces	$130.00
D6603	Retainer inlay – Cast high noble metal, 3 or more surfaces	$130.00
D6604	Retainer inlay – Cast predominantly base metal, 2 surfaces	$130.00
D6605	Retainer inlay – Cast predominantly base metal, 3 or more surfaces	$130.00
D6606	Retainer inlay – Cast noble metal, 2 surfaces	$130.00
D6607	Retainer inlay – Cast noble metal, 3 or more surfaces	$130.00
D6608	Retainer onlay – Porcelain/ceramic, 2 surfaces	$130.00
D6609	Retainer onlay – Porcelain/ceramic, 3 or more surfaces	$130.00
D6610	Retainer onlay – Cast high noble metal, 2 surfaces	$130.00
D6611	Retainer onlay – Cast high noble metal, 3 or more surfaces	$130.00
D6612	Retainer onlay – Cast predominantly base metal, 2 surfaces	$130.00
D6613	Retainer onlay – Cast predominantly base metal, 3 or more surfaces	$130.00
D6614	Retainer onlay – Cast noble metal, 2 surfaces	$130.00
D6615	Retainer onlay – Cast noble metal, 3 or more surfaces	$130.00
D6624	Retainer inlay – Titanium	$130.00
D6634	Retainer onlay – Titanium	$130.00
D6710	Retainer crown – Indirect resin based composite	$130.00
D6720	Retainer crown – Resin with high noble metal	$130.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6721	Retainer crown – Resin with predominantly base metal	$130.00
D6722	Retainer crown – Resin with noble metal	$130.00
D6740	Retainer crown – Porcelain/ceramic	$130.00
D6750	Retainer crown – Porcelain fused to high noble metal	$130.00
D6751	Retainer crown – Porcelain fused to predominantly base metal	$130.00
D6752	Retainer crown – Porcelain fused to noble metal	$130.00
D6780	Retainer crown – 3/4 cast high noble metal	$130.00
D6781	Retainer crown – 3/4 cast predominantly base metal	$130.00
D6782	Retainer crown – 3/4 cast noble metal	$130.00
D6783	Retainer crown – 3/4 porcelain/ceramic	$130.00
D6790	Retainer crown – Full cast high noble metal	$130.00
D6791	Retainer crown – Full cast predominantly base metal	$130.00
D6792	Retainer crown – Full cast noble metal	$130.00
D6794	Retainer crown – Titanium	$130.00
D6930	Re-cement or re-bond fixed partial denture	$0.00
D6950	Precision attachment	$195.00
Endodontics (root canal treatment, excluding final restorations)		
D3110	Pulp cap – Direct (excluding final restoration)	$0.00
D3120	Pulp cap – Indirect (excluding final restoration)	$0.00
D3220	Pulpotomy – Removal of pulp, not part of a root canal	$7.00
D3221	Pulpal debridement (not to be used when root canal is done on the same day)	$35.00
D3222	Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development	$17.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D3230	Pulpal therapy (resorbable filling) – Anterior, primary tooth (excluding final restoration)	$20.00
D3240	Pulpal therapy (resorbable filling) – Posterior, primary tooth (excluding final restoration)	$30.00
D3310	Anterior root canal – Permanent tooth (excluding final restoration)	$65.00
D3320	Bicuspid root canal – Permanent tooth (excluding final restoration)	$95.00
D3330	Molar root canal – Permanent tooth (excluding final restoration)	$195.00
D3331	Treatment of root canal obstruction – Nonsurgical access	$70.00
D3332	Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth	$60.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy – Anterior	$105.00
D3347	Retreatment of previous root canal therapy – Bicuspid	$140.00
D3348	Retreatment of previous root canal therapy – Molar	$220.00
D3351	Apexification/recalcification – Initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$75.00
D3352	Apexification/recalcification – Interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$60.00
D3353	Apexification/recalcification – Final visit (includes completed root canal therapy – Apical closure/calcific repair of perforations, root resorption, etc.)	$60.00
D3410	Apicoectomy/periradicular surgery – Anterior	$85.00
D3421	Apicoectomy/periradicular surgery – Bicuspid (first root)	$90.00
D3425	Apicoectomy/periradicular surgery – Molar (first root)	$90.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$60.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D3427	Periradicular surgery without apicoectomy	$85.00
D3430	Retrograde filling per root	$45.00
D3450	Root amputation – Per root	$65.00
D3920	Hemisection (including any root removal), not including root canal therapy	$70.00
Periodontics (treatment of supporting tissues (gum and bone) of the teeth) - Periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. The relevant procedure codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 teeth (or 8 sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.		
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$100.00
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	$65.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$65.00
D4240	Gingival flap (including root planing) – 4 or more teeth per quadrant	$135.00
D4241	Gingival flap (including root planing) – 1 to 3 teeth per quadrant	$105.00
D4245	Apically positioned flap	$150.00
D4249	Clinical crown lengthening – Hard tissue	$125.00
D4260	Osseous surgery – 4 or more teeth per quadrant	$250.00
D4261	Osseous surgery – 1 to 3 teeth per quadrant	$195.00
D4263	Bone replacement graft – Retained natural tooth - First site in quadrant	$185.00
D4264	Bone replacement graft – Retained natural tooth - Each additional site in quadrant	$90.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95.00
D4266	Guided tissue regeneration – Resorbable barrier per site	$215.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D4267	Guided tissue regeneration – Nonresorbable barrier per site (includes membrane removal)	$255.00
D4270	Pedicle soft tissue graft procedure	$195.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position	$75.00
D4274	Mesial/distal wedge procedure single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$65.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$295.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant or edentulous *(missing)* tooth position in graft	$205.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous *(missing)* tooth position in same graft site	$105.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – Each additional contiguous tooth, implant or edentulous tooth position in same graft site	$38.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor materials) – Each additional contiguous tooth, implant or edentulous tooth position in same graft site	$148.00
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant *(limit 4 quadrants per consecutive 12 months)*	$35.00
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant *(limit 4 quadrants per consecutive 12 months)*	$25.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – Full mouth, after oral evaluation *(limit 1 per calendar year)*	$0.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
	Additional scaling in presence of generalized moderate or severe gingival inflammation – Full mouth, after oral evaluation (*limit 2 per calendar year)*	$45.00
D4355	Full mouth debridement to allow evaluation and diagnosis *(1 per lifetime)*	$35.00
D4381	Localized delivery of antimicrobial agents per tooth	$60.00
D4910	Periodontal maintenance *(limit 4 per calendar year) (only covered after active therapy)*	$25.00
	Additional periodontal maintenance procedures (beyond 4 per calendar year)	$50.00
	Periodontal charting for planning treatment of periodontal disease	$0.00
	Periodontal hygiene instruction	$0.00
Prosthetics (removable tooth replacement – dentures) - Includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years. Characterization is considered an upgrade with maximum additional charge to the member of $200.00 per denture.		
D5110	Full upper denture	$135.00
D5120	Full lower denture	$135.00
D5130	Immediate full upper denture	$145.00
D5140	Immediate full lower denture	$145.00
D5211	Upper partial denture – Resin base (including clasps, rests and teeth)	$135.00
D5212	Lower partial denture – Resin base (including clasps, rests and teeth)	$135.00
D5213	Upper partial denture – Cast metal famework (including clasps, rests and teeth)	$140.00
D5214	Lower partial denture – Cast metal framework (including clasps, rests and teeth)	$140.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D5221	Immediate maxillary partial denture – Resin base (including any conventional clasps, rests and teeth)	$135.00
D5222	Immediate mandibular partial denture – Resin base (including conventional clasps, rests and teeth)	$135.00
D5223	Immediate maxillary partial denture – Cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	$140.00
D5224	Immediate mandibular partial denture – Cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$140.00
D5225	Upper partial denture – Flexible base (including clasps, rests and teeth)	$165.00
D5226	Lower partial denture – Flexible base (including clasps, rests and teeth)	$165.00
D5281	Removable unilateral partial denture – One piece cast metal including clasps and teeth)	$135.00
D5410	Adjust complete denture – Upper	$7.00
D5411	Adjust complete denture – Lower	$7.00
D5421	Adjust partial denture – Upper	$7.00
D5422	Adjust partial denture – Lower	$7.00
D5850	Tissue conditioning – Upper	$7.00
D5851	Tissue conditioning – Lower	$7.00
D5862	Precision attachment – By report	$160.00
Repairs to prosthetics		
D5510	Repair broken complete denture base	$25.00
D5520	Replace missing or broken teeth – Complete denture (each tooth)	$25.00
D5610	Repair resin denture base	$25.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D5620	Repair cast framework	$25.00
D5630	Repair or replace broken clasp - Per tooth	$30.00
D5640	Replace broken teeth – Per tooth	$25.00
D5650	Add tooth to existing partial denture	$25.00
D5660	Add clasp to existing partial denture - Per tooth	$30.00
D5670	Replace all teeth and acrylic on cast metal framework – Upper	$155.00
D5671	Replace all teeth and acrylic on cast metal framework – Lower	$155.00
Denture relining (limit 1 every 36 months)		
D5710	Rebase complete upper denture	$55.00
D5711	Rebase complete lower denture	$55.00
D5720	Rebase upper partial denture	$55.00
D5721	Rebase lower partial denture	$55.00
D5730	Reline complete upper denture – Chairside	$30.00
D5731	Reline complete lower denture – Chairside	$30.00
D5740	Reline upper partial denture – Chairside	$30.00
D5741	Reline lower partial denture – Chairside	$30.00
D5750	Reline complete upper denture – Laboratory	$55.00
D5751	Reline complete lower denture – Laboratory	$55.00
D5760	Reline upper partial denture – Laboratory	$55.00
D5761	Reline lower partial denture – Laboratory	$55.00
Interim dentures (limit 1 every 5 years)		
D5810	Interim complete denture – Upper	$190.00
D5811	Interim complete denture – Lower	$190.00
D5820	Interim partial denture – Upper	$65.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D5821	Interim partial denture – Lower	$65.00
Implant services - Surgical placement of implants (D6010, D6012, D6040, and D6050 have a limit of 1 implant per calendar year with a replacement of 1 per 10 years)		
D6010	Surgical placement of implant body: Endosteal implant	$1,025.00
D6011	Second stage implant surgery	$255.00
D6012	Surgical placement of interim implant body for transitional prosthesis: Endosteal implant	$405.00
D6013	Surgical placement of mini implant	$340.00
D6040	Surgical placement: Eposteal implant	$970.00
D6050	Surgical placement: Transosteal implant	$950.00
D6052	Semi-precision attachment abutment	$195.00
D6055	Connecting bar - Implant supported or abutment supported *(limit 1 per calendar year)*	$1,210.00
D6056	Prefabricated abutment - Includes modification and placement *(limit 1 per calendar year)*	$355.00
D6057	Custom fabricated abutment - Includes placement *(limit 1 per calendar year)*	$455.00
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis *(limit 1 per calendar year)*	$65.00
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure *(limit 2 per implant, per calendar year)*	$5.00
D6090	Repair implant supported prosthesis, by report *(limit 1 per calendar year)*	$135.00
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment *(limit 1 per calendar year)*	$60.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6095	Repair implant abutment, by report *(limit 1 per calendar year)*	$130.00
D6100	Implant removal, by report *(limit 1 per calendar year)*	$255.00
D6101	Debridement of a periimplant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure *(limit 1 per calendar year)*	$105.00
D6102	Debridement and osseous contouring of a periimplant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, flap entry and closure *(limit 1 per calendar year)*	$195.00
D6103	Bone graft for repair of periimplant defect - Does not include flap entry and closure *(limit 1 per calendar year)*	$185.00
D6104	Bone graft at time of implant placement *(limit 1 per calendar year)*	$185.00
D6190	Radiographic/surgical implant index, by report *(limit 1 per calendar year)*	$170.00

Implant/abutment supported prosthetics – All charges for crowns and bridges (fixed partial dentures) are per unit (each replacement on a supporting implant(s) equals 1 unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to 1 every 5 years.

For single crowns, retainer ("abutment") crowns, and pontics: The charges below include the cost of predominantly base metal alloy. You may be charged up to these additional amounts, based on the type of material the dentist uses for your restoration:

• No more than $150.00 per tooth for any noble metal alloys, high noble metal alloys, titanium or titanium alloys

• No more than $75.00 per tooth for any porcelain fused to metal (only on molar teeth)

• Porcelain/ceramic substrate crowns on molar teeth are not covered.

In addition, you may be charged up to these additional amounts:

• No more than $100.00 per tooth if an indirectly fabricated ("cast") post and core is made of high noble metal alloy

• No more than $150.00 per tooth/unit for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) services. Same day in-office CAD/CAM (ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine.

Complex rehabilitation on implant/abutment supported prosthetic procedures – An additional $125 charge per unit for multiple crown units/complex rehabilitation (6 or

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)		
D6058	Abutment supported porcelain/ceramic crown	$560.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$625.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$475.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$625.00
D6062	Abutment supported cast metal crown (high noble metal)	$580.00
D6063	Abutment supported cast metal crown (predominantly base metal)	$430.00
D6064	Abutment supported cast metal crown (noble metal)	$580.00
D6065	Implant supported porcelain/ceramic crown	$560.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$625.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$580.00
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	$460.00
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture (high noble metal)	$610.00
D6070	Abutment supported retainer for porcelain fused to metal fixed partial denture (predominantly base metal)	$460.00
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal)	$610.00
D6072	Abutment supported retainer for cast metal fixed partial denture (high noble metal)	$580.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6073	Abutment supported retainer for cast metal fixed partial denture (predominantly base metal)	$430.00
D6074	Abutment supported retainer for cast metal fixed partial denture (noble metal)	$580.00
D6075	Implant supported retainer for ceramic fixed partial denture	$460.00
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (titanium, titanium alloy, high noble metal)	$610.00
D6077	Implant supported retainer for cast metal fixed partial denture (titanium, titanium alloy, high noble metal)	$580.00
D6085	Provisional implant crown	$100.00
D6092	Re-cement implant/abutment supported crown	$40.00
D6093	Re-cement implant/abutment supported fixed partial denture	$40.00
D6094	Abutment supported crown (titanium)	$580.00
D6110	Implant /abutment supported removable denture for edentulous arch – Maxillary	$635.00
D6111	Implant /abutment supported removable denture for edentulous arch – Mandibular	$635.00
D6112	Implant /abutment supported removable denture for partially edentulous arch – Maxillary	$640.00
D6113	Implant /abutment supported removable denture for partially edentulous arch – Mandibular	$640.00
D6114	Implant /abutment supported fixed denture for edentulous arch – Maxillary	$635.00
D6115	Implant /abutment supported fixed denture for edentulous arch – Mandibular	$635.00
D6116	Implant /abutment supported fixed denture for partially edentulous arch – Maxillary	$640.00
D6117	Implant /abutment supported fixed denture for partially edentulous arch – Mandibular	$640.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6194	Abutment supported retainer crown for fixed partial denture (titanium)	$580.00
Oral surgery (includes routine postoperative treatment) - Surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (disease) exists.		
D7111	Extraction of coronal remnants – Deciduous tooth	$3.00
D7140	Extraction, erupted tooth or exposed root – Elevation and/or forceps removal	$3.00
D7210	Extraction, erupted tooth – Removal of bone and/or section of tooth	$25.00
D7220	Removal of impacted tooth – Soft tissue	$40.00
D7230	Removal of impacted tooth – Partially bony	$60.00
D7240	Removal of impacted tooth – Completely bony	$80.00
D7241	Removal of impacted tooth – Completely bony, unusual complications (narrative required)	$100.00
D7250	Removal of residual tooth roots – Cutting procedure	$30.00
D7251	Coronectomy - Intentional partial tooth removal	$60.00
D7260	Oroantral fistula closure	$90.00
D7261	Primary closure of a sinus perforation	$90.00
D7270	Tooth stabilization of accidentally evulsed or displaced tooth	$65.00
D7280	Exposure of an unerupted tooth *(excluding wisdom teeth)*	$65.00
D7283	Placement of device to facilitate eruption of impacted tooth	$60.00
D7285	Incisional biopsy of oral tissue – Hard (bone, tooth) *(tooth related – not allowed when in conjunction with another surgical procedure)*	$0.00
D7286	Incisional biopsy of oral tissue – Soft (all others) *(tooth related – not allowed when in conjunction with another surgical procedure)*	$0.00
D7287	Exfoliative cytological sample collection	$50.00
D7288	Brush biopsy – Transepithelial sample collection	$50.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$35.00
D7311	Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$35.00
D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$50.00
D7321	Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$50.00
D7450	Removal of benign odontogenic cyst or tumor – Up to 1.25 cm	$0.00
D7451	Removal of benign odontogenic cyst or tumor – Greater than 1.25 cm	$0.00
D7471	Removal of lateral exostosis – Maxilla or mandible	$55.00
D7472	Removal of torus palatinus	$40.00
D7473	Removal of torus mandibularis	$40.00
D7485	Reduction of osseous tuberosity	$60.00
D7510	Incision and drainage of abscess – Intraoral soft tissue	$20.00
D7511	Incision and drainage of abscess – Intraoral soft tissue complicated	$25.00
D7520	Incision and drainage of abscess – Extraoral soft tissue	$25.00
D7521	Incision and drainage of abscess – Extraoral soft tissue – Complicated (includes drainage of multiple fascial spaces)	$25.00
D7880	Occlusal orthotic device, by report - *(limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)*	$150.00
D7881	Occlusal orthotic device adjustment	$7.00
D7910	Suture of recent small wounds up to 5cm	$25.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach *(limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$850.00
D7952	Sinus augmentation via a vertical approach *(limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$640.00
D7953	Bone replacement graft for ridge preservation - Per site *(limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$100.00
D7960	Frenulectomy – Also known as frenectomy or frenotomy – Separate procedure not incidental to another procedure	$30.00
D7963	Frenuloplasty	$30.00
Orthodontics (tooth movement) - Orthodontic treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8050	Interceptive orthodontic treatment of the primary dentition – Banding	$390.00
D8060	Interceptive orthodontic treatment of the transitional dentition – Banding	$390.00
D8070	Comprehensive orthodontic treatment of the transitional dentition – Banding	$390.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition – Banding	$390.00
D8090	Comprehensive orthodontic treatment of the adult dentition – Banding	$390.00
D8210	Removable appliance therapy	$0.00
D8220	Fixed appliance therapy	$0.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$85.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D8670	Periodic orthodontic treatment visit Children – Up to 19th birthday:	
	24-month treatment fee	$1,224.00
	Charge per month for 24 months	$51.00
	Adults:	
	24-month treatment fee	$1,728.00
	Charge per month for 24 months	$72.00
D8680	Orthodontic retention – Removal of appliances, construction and placement of retainer(s)	$270.00
D8681	Removable orthodontic retainer adjustment	$0.00
D8693	Re-cement or re-bond fixed retainer	$0.00
D8694	Repair of fixed retainers, includes reattachment	$0.00
D8999	Unspecified orthodontic procedure – By report *(orthodontic treatment plan and records)*	$265.00
General anesthesia/IV sedation – General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or IV sedation when used for the purpose of anxiety control or patient management.		
D9211	Regional block anesthesia	$0.00
D9212	Trigeminal division block anesthesia	$0.00
D9215	Local anesthesia	$0.00
D9223	Deep sedation/general anesthesia – Each 15 minute increment	$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia – Each 15 minute increment	$80.00
D9610	Therapeutic parenteral drug, single administration	$15.00

CIGNA DENTAL CARE
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D9612	Therapeutic parenteral drugs, 2 or more administrations, different medications	$25.00
D9630	Drugs or medicaments dispensed in the office for home use	$15.00
D9910	Application of desensitizing medicament	$15.00
Emergency services		
D9110	Palliative (emergency) treatment of dental pain – Minor procedure	$3.00
D9120	Fixed partial denture sectioning	$0.00
D9440	Office visit – After regularly scheduled hours	$25.00
Miscellaneous services		
D9940	Occlusal guard – By report *(limit 1 per 24 months)*	$95.00
D9941	Fabrication of athletic mouthguard *(limit 1 per 12 months)*	$110.00
D9942	Repair and/or reline of occlusal guard	$40.00
D9943	Occlusal guard adjustment	$0.00
D9951	Occlusal adjustment – Limited	$25.00
D9952	Occlusal adjustment – Complete	$40.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays *(all other methods of bleaching are not covered)*	$125.00

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling Cigna Dental at the toll free number listed on your ID card or plan materials. Multiple ways to locate a (*DHMO) Network General Dentist:

- Online provider directory at **Cigna.com**
- Online provider directory on **myCigna.com**
- Call the number located on your ID card to:
  - Use the Dental Office Locator via Speech Recognition
  - Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

* The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

"Cigna," "Cigna Dental Care" and the "Tree of Life" logo are registered service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company ("CGLIC"), Cigna Health and Life Insurance Company ("CHLIC"), Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. ("CDHI") and its subsidiaries. The Cigna Dental Care plan is provided by Cigna Dental Health Plan of Arizona, Inc.; Cigna Dental Health of California, Inc.; Cigna Dental Health of Colorado, Inc.; Cigna Dental Health of Delaware, Inc.; **Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes**; Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska); Cigna Dental Health of Kentucky, Inc. (Kentucky and Illinois); Cigna Dental Health of Maryland, Inc.; Cigna Dental Health of Missouri, Inc.; Cigna Dental Health of New Jersey, Inc.; Cigna Dental Health of North Carolina, Inc.; Cigna Dental Health of Ohio, Inc.; Cigna Dental Health of Pennsylvania, Inc.; Cigna Dental Health of Texas, Inc.; and Cigna Dental Health of Virginia, Inc. In other states, the Cigna Dental Care plan is underwritten by CGLIC, CHLIC, or Cigna HealthCare of Connecticut, Inc., and administered by CDHI.

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DENTAL INSURANCE THAT FITS

Cigna Dental Care Plan[1]

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND HEALTH SERVICES AGREEMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Regular dental care is important for a healthy smile. And a healthy body. With the Cigna Dental Care® plan, you get comprehensive dental coverage that's easy to use. At a wallet-friendly price. Now that's something to smile about.

This overview shows you a sampling of covered services. And what your plan pays. For a full listing of covered services, please call Customer Service at **800.Cigna24 (800.244.6224)**.

Get the most value from your plan

With your Cigna Dental Care plan, some preventive services are covered at 100%. (See chart below.) Your plan also covers many other dental services that help your mouth stay healthy.

Your Cigna Dental Care plan is a **copayment plan**. Here's how it works. When you get a dental service, Cigna allows your network dentist to charge a certain amount. Then **you pay a fixed portion** of that cost, in addition to any allowable charge for upgraded materials (such as gold, high noble metal or porcelain used in molar restorations), CAD/CAM services, complex rehabilitation or characterizations (for dentures). And your plan pays the rest. There are **no annual maximums** and **no deductibles!**

Review your plan materials for more information about how your plan works. If you have questions before enrollment, call **800.Cigna24 (800.244.6224)** and select the "Enrollment Information" prompt.

	WHAT YOU'LL PAY[2]	
Sampling of covered procedures	**With Cigna Dental Care**	**Without dental coverage**
Adult cleaning (two per calendar year – each at $0) (additional cleanings available at $45.00 each)	$0	$68–$155 each
Child cleaning (two per calendar year – each at $0) (additional cleanings available at $35.00 each)	$0	$53–$121 each
Periodic oral evaluation	$0	$40–$90
Comprehensive oral evaluation	$0	$63–$143
Topical fluoride (two per calendar year – each at $0) (additional topic fluoride available at $15.00 each)	$0	$28–$63 each
X-rays – (bitewings) 2 films	$0	$33–$75
X-rays – panoramic film	$0	$83–$189
Sealant – per tooth	$7.00	$41–$94
Amalgam filling (silver colored) – 2 surfaces	$0	$117–$266
Composite filling (tooth – colored) – 1 surface, Anterior	$0	$118–$270
Molar root canal (excluding final restoration)	$195.00	$840–$1,914
Comprehensive orthodontic treatment of the adolescent dentition – Banding	$390.00	$967–$2,203
Periodontal (gum) scaling & root planning – 1 quadrant	$35.00	$182–$414
Periodontal (gum) maintenance	$25.00	$107–$243
Removal/extraction of erupted tooth	$3.00	$124–$282
Removal/extraction of impacted tooth – completely bony	$80.00	$362–$825
Crown – porcelain fused to high noble metal*	$130.00	$839–$1,911
Implant supported retainer for porcelain fused to metal fixed partial denture*	$610.00	$1,079–$2,458
Surgical placement of implant body within jawbone	$1,025.00	$1,487–$3,386
Occlusal appliance, by report (for treatment of TMJ)	$150.00	$730–$1,662

*The co-payments for fixed and removable restorations (crowns, bridges, implant/abutment supported prosthetics, complete and partial dentures) do not include additional charges for material upgrades (such as gold/high noble metal or porcelain used in molar restorations), CAD/CAM services, complex rehabilitation or characterizations (for dentures). Any additional allowable charge for these upgrades is the patient's responsibility as specifically outlined in your Patient Charge Schedule (PCS). For questions regarding these charges you may contact Customer Service at 800.Cigna24 (800.244.6224). Please refer to your PCS for full details.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company or its affiliates.

Smile. You're covered.

You can save money on a wide range of services, including:

- **Preventive care** – cleanings, fluoride, sealants, bitewing X-rays, full mouth X-rays and more
- **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam)
- **Major services** – crowns, bridges, dentures (including those placed over implants), root canals, oral surgery, extractions, treatment for periodontal (gum) disease, and more
- **Orthodontic care** – braces for children and adults
- **General anesthesia** – when medically necessary
- **Teeth whitening** – using take-home bleaching trays and gel
- **Temporomandibular joint (TMJ)** – diagnosis and treatment, including cone beam x-ray and appliance
- **Athletic mouth guard** – including creation and adjustments
- **Dental implant surgery** or services associated with placement, repair, removal or restoration of a dental implant

More about your coverage

- **No deductibles or waiting periods.** You don't have to reach an out-of-pocket cost before your insurance starts.
- **No dollar maximums.** Your coverage isn't limited by a dollar amount.
- **Network dentists file claims for you.** No paperwork for you.
- **No age limit on sealants.** Helps prevent tooth decay.
- **Cancer detection.** Your plan covers procedures such as biopsy and light detection to help find oral cancer in its early stages.
- **24/7 access to dental information line.** Trained professionals can help answer your questions about dental treatment and clinical symptoms.
- **Cigna Identity Theft Program.**[3] Help resolving critical identity theft issues.
- **Cigna Dental Oral Health Integration Program®.** Enhanced dental coverage for customers with certain medical conditions who enroll in this program.

Choosing a Dentist

- You must choose a network general dentist to manage your overall care. You won't be covered if you go to a dentist who's not in our network.[4]
- Each family member can choose their own dentist
- Referrals are required for specialty care services, except for pediatric dentists for children under 13 and orthodontics.*

Finding a network dentist is easy.

Visit **Cigna.com** to find a network general dentist.

Call 800.Cigna24 (800.244.6224) to speak with a customer service representative. You can ask for a customized dental directory to be sent to you via email

* Coverage for treatment by a pediatric dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services generally must be obtained from a network general dentist.

Limitations

PROCEDURE	LIMIT
Oral evaluations	Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145)
X-rays (non-routine)	Full mouth: 1 every 3 calendar years Panorex: 1 every 3 calendar years
Periodontal root planing and scaling	Limit 4 quadrants per consecutive 12 months
Periodontal maintenance	Limited to 4 per year and (Only covered after active periodontal therapy)
Crowns and inlays	Replacement 1 every 5 years
Bridges	Replacement 1 every 5 years
Dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient
Relines, rebases	One every 36 months
Denture adjustments	Four within the first 6 months after installation
Prosthesis over implant	Replacement 1 every 5 years if unserviceable and cannot be repaired

Limitations

PROCEDURE	LIMIT
Surgical placement of implant	Surgical Placement of Implants (D6010, D6012, D6040, and D6050) have a limit of 1 implant per calendar year with a replacement of 1 per 10 years
TMJ treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months
General anesthesia/IV sedation	General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the PCS. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the PCS. Plan limitation for this benefit is 1 hour per appointment.

Listed below are the services or expenses which are NOT covered under your Dental plan. You will be responsible for these services at the dentist's usual fees. There's no coverage for:

- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- 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 received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- Services for the charges which the person is not legally required to pay
- Charges which would not have been made if the person had no insurance
- Services received due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)[4]
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war[5]
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- Consultations and/or evaluations associated with services that are not covered
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- General anesthesia or IV sedation when used for the purpose of anxiety control or patient management
- Prescription medications
- Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- Any services related to surgical implants, including placement, repair, maintenance, removal, and implant abutment(s) unless specifically listed on your PCS
- Services considered unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- Services to the extent you or your enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.[6]
- The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage[7]
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[7]
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement

- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics
- As to orthodontic treatment: incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment.

If any law requires coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) does not apply.

This document outlines the highlights of your plan. For a complete list of both covered and non-covered services, including benefits required by your state, see your official plan documents (the Group Contract and Plan Booklet/Combined Evidence of Coverage and Disclosure Form/ Certificate of Coverage). If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.

1. "Cigna Dental Care" is the brand name used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care (including Dental HMO) plans, and plans with open access features. Cigna Dental Care plans are not available in the following states: AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.
2. Costs listed for the Cigna Dental Care plan do not vary. Estimated costs without dental coverage may vary based on location and dentists' actual charges. These estimated costs are based on charges submitted to Cigna in 2015/2016 and are intended to reflect national average charges as of July 2018 assuming an annual cost increase of three percent. Estimates have been adjusted to reflect the 2016 Cigna Dental Care geographical membership distribution. Office visit fee may also apply.
3. **This is NOT insurance and does not provide for reimbursement of financial losses.** The Cigna Identity Theft Program is provided under a contract with Generali Global Assistance. Full terms,conditions and exclusions are contained in the client program description.
4. **Minnesota residents:** You must visit your selected network dentist in order for the charges on the PCS to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the PCS will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. Of course, you'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Services for more information.
   Oklahoma residents: Cigna Dental Care is an Employer Group Pre-Paid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the PCS will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. Of course, you'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Services for more information.
5. **Oklahoma residents:** This exclusion is replaced by the following: War or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
6. **Arizona and Pennsylvania residents:** This exclusion does not apply. **Kentucky and North Carolina residents:** Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. **Maryland residents:** Services compensated under group medical plans are not excluded.
7. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under your PCS.

Dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided to their patients. They are not agents of Cigna.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. Cigna Dental Care plans are insured by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., **a Prepaid Limited Health Services Organization licensed under Chapter 636,** Florida Statutes, Cigna Dental Health of Kansas, Inc. (KS & NE), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, Cigna Dental Care plans are insured by Cigna Health and Life Insurance Company or Cigna HealthCare of Connecticut, Inc., and administered by Cigna Dental Health, Inc. Policy forms: OK - HP-POL115; TN - HP-POL134/HC-CER17V1 et al. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Cigna Healthcare Financial Exhibit for:

City of Fort Lauderdale (Firefighters)

Effective Date: January 01, 2018

This is a summary of benefits for your dental plan.

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Cigna DPPO Advantage	Out-of-Network
Calendar Year Maximum		
(Class I, II, III Expenses)	$1500, Class I Applies	$1500, Class I Applies
Calendar Year Deductible		
Per Individual	$100	$100
Per Family	No Limit	No Limit
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Non-Routine X-rays	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Space Maintainers (limited to non-orthodontic treatment) Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Stainless Steel/Resin Crowns Brush Biopsy	80%, After Deductible	80%, After Deductible
Class III Expenses - Major Restorative Care		
Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Crowns/Inlays/Onlays Dentures Bridges	50%, After Deductible	50%, After Deductible
Class IV Expenses - Orthodontia		
Coverage for Eligible Children and Adults	50%, No Ortho Deductible	50%, No Ortho Deductible
Lifetime Maximum	$1500	$1500
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on Maximum Allowable Charge (for location of service rendered).
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

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Cigna Healthcare Financial Exhibit for:

City of Fort Lauderdale (Firefighters)

Effective Date: January 01, 2018

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns	Replacement every 5 years
Prosthesis over Implants	1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Orthodontia	Not covered
Missing Tooth Provision	Teeth missing prior to coverage under the Cigna Dental plan are not covered
Late Entrant Limit	50% coverage on Class III and IV for a specified time period
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons;
* Replacement of a lost or stolen appliance;
* Replacement of a bridge or denture within five years following the date of its original installation;
* Replacement of a bridge or denture which can be made useable according to accepted dental standards;
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion;
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
* Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type;
* Instruction for plaque control, oral hygiene and diet;
* Dental services that do not meet common dental standards;
* Services that are deemed to be medical services;
* Services and supplies received from a hospital;
* Charges which the person is not legally required to pay;
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
* Experimental or investigational procedures and treatments;
* Any injury resulting from, or in the course of, any employment for wage or profit;
* Any sickness covered under any workers' compensation or similar law;
* Charges in excess of the reasonable and customary allowances;
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

City of Fort Lauderdale City Employee (Non-Firefighter/IAFF) PPO Dental Plan

CIGNA DENTAL CHOICE
City Plan
Retiree Only
For Texas Residence

EFFECTIVE DATE: January 1, 2022

CN025
3335139

This document printed in December, 2021 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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: City of Fort Lauderdale

GROUP POLICY(S) — COVERAGE
3335139 - DNTC, DNTCC, DNTCF, DNTCS CIGNA DENTAL CHOICE

EFFECTIVE DATE: January 1, 2022

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.

Jill Stadelman
Jill Stadelman, Corporate Secretary

HC-CER2 04-10
V1

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.

Cigna.

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 شمارهگیری کنید).

HC-NOT97 07-17

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Cigna Health and Life Insurance Company's toll-free telephone number for information or to make a complaint at:

1-800-244-6224

You may also write to Cigna Health and Life Insurance Company at:

Cigna Dental
P.O. Box 188047
Chattanooga, TN 37422

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presenter una queja:

Usted puede llamar al número de teléfono gratuito de Cigna Health and Life Insurance Company's para obtener información o para presentar una queja al:

PARA PREGUNTAS ACERCA DEL SEGURO DENTAL

1-800-244-6224

Usted también puede escribir a Cigna Health and Life Insurance Company:

Cigna Dental
P.O. Box 188047
Chattanooga, TN 37422

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 490-1007
Sitio Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamoación, usted debe comunicarse con el agente o la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es sólamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

HC-IMP195 09-16
V1

How To File Your Claim

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 or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

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

TIMELY FILING

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied.

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.

HC-CLM24 04-10
V1

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as a retired Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the date you retire if you are in a Class of Eligible Employees.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Classes of Eligible Employees

Each retired Employee as reported to the insurance company by your former Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form (as applicable), but no earlier than the date you become eligible.

To be insured for these benefits, you must elect the insurance for yourself no later than 60 days from your retirement.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or

you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 60 days from the date of your retirement.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

HC-ELG1 04-10
V6 M

Late Entrant Limit

Coverage for late entrants:

- Class I and Class II services are paid at the amounts set forth in The Schedule.
- All other classes of service are paid at 50% of the amounts set forth in The Schedule.
- After a person has been continuously insured for 12 months, this limit no longer applies.

HC-LEL1 04-10
V3

Cigna.

Cigna Dental Choice

The Schedule

For You and Your Dependents

If you or your Dependent receive services from a Contracted Dentist, payment for a covered procedure will be based on a percentage of the Contracted Fee agreed upon by the Insurance Company and the Contracted Dentist. The insured must pay the balance up to the Contracted Fee amount.
If you or your Dependent receive services from a non-Contracted Dentist, payment for a covered procedure will be based on a percentage of the Maximum Reimbursable Charge. The insured must pay the balance up to the provider's actual charge.

Benefit Payment

Services of a Contracted Dentist are paid based on the Contracted Fee agreed upon by the provider and the Insurance Company.
Services of a non-Contracted Dentist are based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

BENEFIT HIGHLIGHTS	
Classes I, II, III, IX Calendar Year Maximum	$1,500
Class IV Lifetime Maximum	$2,500
Class I	
Preventive Care	100%
Class II	
Basic Restorative	100%
Class III	
Major Restorative	60%
Class IV	
Orthodontia	60%
Class IX	
Implants	60%

Missing Teeth Limitation

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

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

HC-MTL7 04-10
V1

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule 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;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

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, 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, Cigna recommends 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 Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

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

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

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

HC-DEN1 04-10
V1

Texas Statutory Provision

General Anesthesia and I.V. Sedation Services for Certain Persons

Covered Dental Expenses include: Coverage for Medically or Dentally Necessary General Anesthesia and I.V. Sedation Services when performed in a dental office in conjunction with any covered dental procedure, if the individual is unable to undergo dental treatment in a normal office setting or under local anesthesia, and to the extent that the claim is also submitted for payment to any applicable medical carrier for Coordination of Benefits.

HC-DEN310 08-20

Cigna Dental Choice

Plan payment for a covered service delivered by a Contracted 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-Contracted Provider is the Maximum Reimbursable 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-Contracted Provider's actual charge.

HC-DEN288 01-21

Cigna.

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any 3 calendar years.

HC-DEN3 04-10
V5

Class II Services – Basic Restorations, Periodontics, Endodontics, Oral Surgery

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

- Removal of Impacted Tooth, Soft Tissue
- Removal of Impacted Tooth, Partially Bony
- Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I.V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN163 04-10
V1

Class III Services - Major Restorations, Dentures and Bridgework, Prosthodontic Maintenance

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

- Porcelain Fused to High Noble Metal
- Full Cast, High Noble Metal
- Three-Fourths Cast, Metallic

Removable Appliances

- Complete (Full) Dentures, Upper or Lower
- Partial Dentures
- Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
- Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

- Bridge Pontics - Cast High Noble Metal
- Bridge Pontics - Porcelain Fused to High Noble Metal
- Bridge Pontics - Resin with High Noble Metal
- Retainer Crowns - Resin with High Noble Metal
- Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

HC-DEN172 07-14
V1

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the Schedule.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

HC-DEN6 04-10
V3

Class IX Services – Implants

Covered Dental Expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.

Implant coverage may have a separate deductible amount, yearly maximum and/or lifetime maximum as shown in The Schedule.

HC-DEN8 04-10
V1

Expenses Not Covered

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

- services performed solely for cosmetic reasons, except for the treatment of congenital defects in a newborn child.
- replacement of a lost or stolen appliance.
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion.
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
- bite registrations; precision or semiprecision attachments; or splinting.
- instruction for plaque control, oral hygiene and diet.
- dental services that do not meet common dental standards.
- services that are deemed to be medical services.
- services and supplies received from a hospital.
- services for which benefits are not payable according to the "General Limitations" section.

HC-DEX96 10-19
V1

Cigna.

General Limitations

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a 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;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

HC-DEX1 04-10
V3

Coordination Of This Contract's Benefits With Other Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

(a) A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply

only to one of the two, each of the parts is treated as a separate plan.

(b) "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including deductibles, Coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or Coinsurance amounts for which the insured is responsible.

(e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order Of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is

always primary unless the provisions of both plans state that the complying plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a Dependent, for example as an Employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent and primary to the plan covering the person as other than a Dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired Employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a Dependent child must determine the order of benefits using the following rules that apply.

(A) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(B) For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the spouse of the noncustodial parent.

(C) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a Dependent child who has coverage under either or both parents' plans and has his or her own coverage as a Dependent under a spouse's plan, (h)(5) applies.

(E) In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the Dependent child's parent(s) and the Dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off Employee is the secondary plan. The same would hold true if a person is a Dependent of an active Employee and that same person is a Dependent of a retired or laid-off Employee. If the plan that covers the same person as a retired or laid-off Employee or as a Dependent of a retired or laid-off Employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an Employee, member, subscriber, or retiree or covering the person as a Dependent of an Employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an Employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of 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

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance With Federal And State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans Cigna will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give Cigna any facts it needs to apply those rules and determine benefits.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does Cigna may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Cigna will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right Of Recovery

If the amount of the payments made by Cigna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for

whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

HC-COB121 09-14
V1

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent; (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Right Of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

Lien Of The Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. 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 the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical 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 Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not

limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

HC-SUB2 04-10
V1

Payment of Benefits

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 Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, in certain limited circumstances, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. You may assign the right of payment or reimbursement to the Dentist who provides the dental care services. We may pay benefits to you directly in certain rare circumstances. Such circumstances may include if the provider is deceased, if the provider is located in a foreign country or if you have already paid the provider. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna 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, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna 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 to the Dentist who provided the service.

HC-POB160 10-19

Miscellaneous

Clinical research has established an association between dental disease and complication of some medical conditions, such as the conditions noted below.

If you are a Cigna Dental plan member and you have one or more of the conditions listed below, you may apply for 100% reimbursement of your copayment or coinsurance for certain periodontal or caries-protection procedures (up to the applicable plan maximum reimbursement levels and annual plan maximums.)

For members with diabetes, cerebrovascular or cardiovascular disease:

- periodontal scaling and root planing (sometimes referred to as "deep cleaning")
- periodontal maintenance

For members who are pregnant:

- periodic, limited and comprehensive oral evaluation.
- periodontal evaluation
- periodontal maintenance
- periodontal scaling and root planing (sometimes referred to as "deep cleaning")
- treatment of inflamed gums around wisdom teeth.
- an additional cleaning during pregnancy.
- palliative (emergency) treatment – minor procedure

For members with chronic kidney disease or going to or having undergone an organ transplant or undergoing head and neck Cancer Radiation:

- topical application of fluoride
- topical fluoride varnish
- application of sealant
- periodontal scaling and root planing (sometimes referred to as "deep cleaning")
- periodontal maintenance

Please refer to the plan enrollment materials for further details.

HC-POB8 04-10
V1

Termination of Insurance

Employees

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.

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

Dependents

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

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM3 04-10
V1 M

Dental Benefits Extension

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

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

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

HC-BEX3 04-10
V1

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.

HC-SPP4 04-10
V1

The Following Will Apply To Residents Of Texas

When You Have A Complaint Or An Adverse Determination Appeal

For the purposes of this section, any reference to "you," "your" or "Member" 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.

When You Have a Complaint

We are here to listen and help. If you have a complaint regarding a person, a service, the quality of care, or contractual benefits not related to Medical Necessity, you can call our toll-free number and explain your concern to one of our Customer Service representatives. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by Cigna by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an adverse determination. You can also express that complaint in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your complaint, we will send you a letter acknowledging the date on which we received your complaint no later than the fifth working day after we receive your complaint. We will respond in writing with a decision 30 calendar days after we receive a complaint for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

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

Complaint Appeals Procedure

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Your complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. 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 within five working days after the date we receive your request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

When You have an Adverse Determination Appeal

An Adverse Determination is a decision made by Cigna that the health care service(s) furnished or proposed to be furnished to you is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by Cigna of a request to cover a specific prescription drug prescribed by your Dentist. If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. We will acknowledge the appeal in writing within five working days after we receive the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination Appeal request.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the dental plan will respond orally with a decision within 72 hours, but will not exceed one working day from the date all information necessary to complete the appeal is received followed up in writing.

In addition, your treating Dentist may request in writing a specialty review within 10 working days of our written decision. The specialty review will be conducted by a Dentist in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization.

Retrospective Review Requirements

Notice of adverse determinations (denials only) of retrospective reviews must be made in writing to the patient within a reasonable period, not to exceed 30 days from the date of receipt.

The term retrospective review is a system in which review of the medical necessity and appropriateness of health care services provided to an enrollee is performed for the first time subsequent to the completion of such health care services. Retrospective review does not include subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Dentist may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter. Cigna must complete the specialist review and send a written response within 15 days

of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

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

Appeal to the State of Texas

You have the right to contact the Texas Department of Insurance for assistance at any time for either a complaint or an Adverse Determination appeal. The Texas Department of Insurance may be contacted at the following address and telephone number:

Texas Department of Insurance
333 Guadalupe Street
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

Notice of Benefit Determination on Appeal

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

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

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 under Federal Law

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 Cigna until you have completed the Complaint or Adverse Determination Appeal process. If your Complaint is expedited, there is no need to complete the Complaint Appeal process prior to bringing legal action.

HC-APL366 10-19

Definitions

Charges

The term Charges means actual billed charges; except when the Contracted Dentist has contracted directly or indirectly with Cigna for a different amount. If the Contracted Dentist has contracted to receive payment on a basis other than fee-for-service amount then "charges" will be calculated based on a Cigna determined fee schedule or on a Cigna determined percentage of actual billed charges.

HC-DFS225 04-10
V1

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

HC-DFS122 04-10
V1

Contracted Dentist

The term Contracted Dentist means:

- a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services at predetermined fees.

The Dentists qualifying as Contracted Dentists may change from time to time. A list of the current Contracted Dentists will be provided by your Employer.

HC-DFS227 04-10
V1

Contracted Fee

The term Contracted Fee refers to:

- the total compensation level that a Contracted Dentist has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

HC-DFS226 04-10
V1

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.

HC-DFS125 04-10
V3

Dependent

Dependents are:

- 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 mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. During the next two years Cigna may, from time to time, require proof of the continuation of such condition and dependence. After that, Cigna may require proof no more than once a year.

The term child includes your natural child, stepchild, foster child, or legally adopted child, or the child for whom you are the legal guardian, or the child who is the subject of a lawsuit for adoption by you, or the child who is supported pursuant to a court order imposed on you (including a qualified medical child support order) or your grandchild who is your Dependent for federal income tax purposes at the time of application. 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 year 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.

HC-DFS224 04-10
V1

Domestic Partner

A Domestic Partner is defined as 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 Cigna 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 Cigna 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.

HC-DFS47 04-10
V1

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge (MRC) for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna and updated annually. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national data may be used. If sufficient data is unavailable in the database, then data in the database for similar services may be used.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS1421 01-21

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.

HC-DFS16 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

Federal Requirements

The following Federal Requirement section is not part of your group insurance certificate. 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 your group insurance certificate, the provision which provides the better benefit will apply.

HC-FED1 10-10
V1

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

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.

The provisions in the "Exception for Newborns" section of this document 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.

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

Claim Determination Procedures

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.

HC-FED83 03-13

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 qualifying event if the event would result in a loss of coverage under the Plan: termination-for any reason, other than gross misconduct prior to 18 months from the date you retire.

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.

Termination of COBRA Continuation

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

- The balance of 18 months from the date you retire;
- upon cancellation of the retiree plan, the balance of 18 months from the date you retire if your former Employer provides coverage for active Employees;
- the end of the COBRA continuation period of 29 or 36 months from the date you retire, 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 former 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 retiree alone elects COBRA continuation coverage, the retiree 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.

HC-FED66 M 07-14

City of Fort Lauderdale Firefighter (IAFF) PPO Dental Plan

CIGNA DENTAL CHOICE
Firefighters
Retiree Only
For Texas Residents

EFFECTIVE DATE: January 1, 2022

CN026
3335139

This document printed in March, 2022 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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: City of Fort Lauderdale

GROUP POLICY(S) — COVERAGE
3335139 - DNTF, DNTFC, DNTFF, DNTFS CIGNA DENTAL CHOICE

EFFECTIVE DATE: January 1, 2022

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.

Jill Stadelman

Jill Stadelman, Corporate Secretary

HC-CER2 04-10
V1

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.

Cigna.

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 شمارهگیری کنید).

HC-NOT97 07-17

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Cigna Health and Life Insurance Company's toll-free telephone number for information or to make a complaint at:

1-800-244-6224

You may also write to Cigna Health and Life Insurance Company at:

Cigna Dental
P.O. Box 188047
Chattanooga, TN 37422

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presenter una queja:

Usted puede llamar al número de teléfono gratuito de Cigna Health and Life Insurance Company's para obtener información o para presentar una queja al:

PARA PREGUNTAS ACERCA DEL SEGURO DENTAL

1-800-244-6224

Usted también puede escribir a Cigna Health and Life Insurance Company:

Cigna Dental
P.O. Box 188047
Chattanooga, TN 37422

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 490-1007
Sitio Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamoación, usted debe comunicarse con el agente o la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es sólamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

HC-IMP195 09-16
V1

How To File Your Claim

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 or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

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

TIMELY FILING

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied.

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.

HC-CLM24 04-10
V1

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as a retired Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the date you retire if you are in a Class of Eligible Employees.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Classes of Eligible Employees

Each retired Employee as reported to the insurance company by your former Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form (as applicable), but no earlier than the date you become eligible.

To be insured for these benefits, you must elect the insurance for yourself no later than 60 days from your retirement.

Late Entrant - Employee

You are a Late Entrant if:

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

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 60 days from the date of your retirement.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

HC-ELG1 04-10
V6 M

Late Entrant Limit

Coverage for late entrants:

- Class I and Class II services are paid at the amounts set forth in The Schedule.
- All other classes of service are paid at 50% of the amounts set forth in The Schedule.
- After a person has been continuously insured for 12 months, this limit no longer applies.

HC-LEL1 04-10
V3

Cigna.

Cigna Dental Choice

The Schedule

For You and Your Dependents

If you or your Dependent receive services from a Contracted Dentist, payment for a covered procedure will be based on a percentage of the Contracted Fee agreed upon by the Insurance Company and the Contracted Dentist. The insured must pay the balance up to the Contracted Fee amount.
If you or your Dependent receive services from a non-Contracted Dentist, payment for a covered procedure will be based on a percentage of the Maximum Reimbursable Charge. The insured must pay the balance up to the provider's actual charge.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

Benefit Payment

Services of a Contracted Dentist are paid based on the Contracted Fee agreed upon by the provider and the Insurance Company.
Services of a non-Contracted Dentist are based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

BENEFIT HIGHLIGHTS	
Classes I, II, III Calendar Year Maximum	$1,500
Class IV Lifetime Maximum	$1,500
Calendar Year Deductible	
Individual	$100 per person Not Applicable to Class I
Family Maximum	Not Applicable
Class I	
Preventive Care	100%
Class II	
Basic Restorative	80% after plan deductible
Class III	
Major Restorative	50% after plan deductible
Class IV	
Orthodontia	50%

Missing Teeth Limitation

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

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

HC-MTL7 04-10
V1

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule 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;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

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, 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, Cigna recommends 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 Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

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

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

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

HC-DEN1 04-10
V1

Texas Statutory Provision

General Anesthesia and I.V. Sedation Services for Certain Persons

Covered Dental Expenses include: Coverage for Medically or Dentally Necessary General Anesthesia and I.V. Sedation Services when performed in a dental office in conjunction with any covered dental procedure, if the individual is unable to undergo dental treatment in a normal office setting or under local anesthesia, and to the extent that the claim is also submitted for payment to any applicable medical carrier for Coordination of Benefits.

HC-DEN310 08-20

Cigna Dental Choice

Plan payment for a covered service delivered by a Contracted 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-Contracted Provider is the Maximum Reimbursable 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-Contracted Provider's actual charge.

HC-DEN288 01-21

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any 3 calendar years.

HC-DEN3 04-10
V5

Class II Services – Basic Restorations, Periodontics, Endodontics, Oral Surgery

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

- Removal of Impacted Tooth, Soft Tissue
- Removal of Impacted Tooth, Partially Bony
- Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I.V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN163 04-10
V1

Class III Services - Major Restorations, Dentures and Bridgework, Prosthodontic Maintenance

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

- Porcelain Fused to High Noble Metal
- Full Cast, High Noble Metal
- Three-Fourths Cast, Metallic

Removable Appliances

- Complete (Full) Dentures, Upper or Lower
- Partial Dentures
- Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
- Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

- Bridge Pontics - Cast High Noble Metal
- Bridge Pontics - Porcelain Fused to High Noble Metal
- Bridge Pontics - Resin with High Noble Metal
- Retainer Crowns - Resin with High Noble Metal
- Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

HC-DEN172 07-14
V1

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the Schedule.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

HC-DEN6 04-10
V3

Expenses Not Covered

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

- services performed solely for cosmetic reasons, except for the treatment of congenital defects in a newborn child.
- replacement of a lost or stolen appliance.
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion.
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
- bite registrations; precision or semiprecision attachments; or splinting.
- instruction for plaque control, oral hygiene and diet.
- dental services that do not meet common dental standards.
- services that are deemed to be medical services.
- services and supplies received from a hospital.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- services for which benefits are not payable according to the "General Limitations" section.

HC-DEX96 10-19
V1

Cigna.

General Limitations

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a 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;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

HC-DEX1 04-10
V3

Coordination Of This Contract's Benefits With Other Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

(a) A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply

only to one of the two, each of the parts is treated as a separate plan.

(b) "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including deductibles, Coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or Coinsurance amounts for which the insured is responsible.

(e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order Of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is

always primary unless the provisions of both plans state that the complying plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a Dependent, for example as an Employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent and primary to the plan covering the person as other than a Dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired Employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a Dependent child must determine the order of benefits using the following rules that apply.

(A) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(B) For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the spouse of the noncustodial parent.

(C) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a Dependent child who has coverage under either or both parents' plans and has his or her own coverage as a Dependent under a spouse's plan, (h)(5) applies.

(E) In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the Dependent child's parent(s) and the Dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off Employee is the secondary plan. The same would hold true if a person is a Dependent of an active Employee and that same person is a Dependent of a retired or laid-off Employee. If the plan that covers the same person as a retired or laid-off Employee or as a Dependent of a retired or laid-off Employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an Employee, member, subscriber, or retiree or covering the person as a Dependent of an Employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an Employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of 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

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance With Federal And State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans Cigna will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give Cigna any facts it needs to apply those rules and determine benefits.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does Cigna may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Cigna will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right Of Recovery

If the amount of the payments made by Cigna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for

whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

HC-COB121 09-14
V1

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent; (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Right Of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

Lien Of The Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. 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 the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical 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 Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not

limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

HC-SUB2 04-10
V1

Payment of Benefits

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 Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, in certain limited circumstances, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. You may assign the right of payment or reimbursement to the Dentist who provides the dental care services. We may pay benefits to you directly in certain rare circumstances. Such circumstances may include if the provider is deceased, if the provider is located in a foreign country or if you have already paid the provider. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna 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, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna 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 to the Dentist who provided the service.

HC-POB160 10-19

Miscellaneous

Clinical research has established an association between dental disease and complication of some medical conditions, such as the conditions noted below.

If you are a Cigna Dental plan member and you have one or more of the conditions listed below, you may apply for 100% reimbursement of your copayment or coinsurance for certain periodontal or caries-protection procedures (up to the applicable plan maximum reimbursement levels and annual plan maximums.)

For members with diabetes, cerebrovascular or cardiovascular disease:

- periodontal scaling and root planing (sometimes referred to as "deep cleaning")
- periodontal maintenance

For members who are pregnant:

- periodic, limited and comprehensive oral evaluation.
- periodontal evaluation
- periodontal maintenance
- periodontal scaling and root planing (sometimes referred to as "deep cleaning")
- treatment of inflamed gums around wisdom teeth.
- an additional cleaning during pregnancy.
- palliative (emergency) treatment – minor procedure

For members with chronic kidney disease or going to or having undergone an organ transplant or undergoing head and neck Cancer Radiation:

- topical application of fluoride
- topical fluoride varnish
- application of sealant
- periodontal scaling and root planing (sometimes referred to as "deep cleaning")
- periodontal maintenance

Please refer to the plan enrollment materials for further details.

HC-POB8 04-10
V1

Termination of Insurance

Employees

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.

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

Dependents

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

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM3 04-10
V1 M

Dental Benefits Extension

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

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

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

HC-BEX3 04-10
V1

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.

HC-SPP4 04-10
V1

The Following Will Apply To Residents Of Texas

When You Have A Complaint Or An Adverse Determination Appeal

For the purposes of this section, any reference to "you," "your" or "Member" 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.

When You Have a Complaint

We are here to listen and help. If you have a complaint regarding a person, a service, the quality of care, or contractual benefits not related to Medical Necessity, you can call our toll-free number and explain your concern to one of our Customer Service representatives. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by Cigna by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an adverse determination. You can also express that complaint in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your complaint, we will send you a letter acknowledging the date on which we received your complaint no later than the fifth working day after we receive your complaint. We will respond in writing with a decision 30 calendar days after we receive a complaint for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

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

Complaint Appeals Procedure

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Your complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. 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 within five working days after the date we receive your request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

When You have an Adverse Determination Appeal

An Adverse Determination is a decision made by Cigna that the health care service(s) furnished or proposed to be furnished to you is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by Cigna of a request to cover a specific prescription drug prescribed by your Dentist. If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. We will acknowledge the appeal in writing within five working days after we receive the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination Appeal request.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the dental plan will respond orally with a decision within 72 hours, but will not exceed one working day from the date all information necessary to complete the appeal is received followed up in writing.

In addition, your treating Dentist may request in writing a specialty review within 10 working days of our written decision. The specialty review will be conducted by a Dentist in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization.

Retrospective Review Requirements

Notice of adverse determinations (denials only) of retrospective reviews must be made in writing to the patient within a reasonable period, not to exceed 30 days from the date of receipt.

The term retrospective review is a system in which review of the medical necessity and appropriateness of health care services provided to an enrollee is performed for the first time subsequent to the completion of such health care services. Retrospective review does not include subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Dentist may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter. Cigna must complete the specialist review and send a written response within 15 days

of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

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

Appeal to the State of Texas

You have the right to contact the Texas Department of Insurance for assistance at any time for either a complaint or an Adverse Determination appeal. The Texas Department of Insurance may be contacted at the following address and telephone number:

Texas Department of Insurance
333 Guadalupe Street
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

Notice of Benefit Determination on Appeal

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

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

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 under Federal Law

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 Cigna until you have completed the Complaint or Adverse Determination Appeal process. If your Complaint is expedited, there is no need to complete the Complaint Appeal process prior to bringing legal action.

HC-APL366 10-19

Definitions

Charges

The term Charges means actual billed charges; except when the Contracted Dentist has contracted directly or indirectly with Cigna for a different amount. If the Contracted Dentist has contracted to receive payment on a basis other than fee-for-service amount then "charges" will be calculated based on a Cigna determined fee schedule or on a Cigna determined percentage of actual billed charges.

HC-DFS225 04-10
V1

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

HC-DFS122 04-10
V1

Contracted Dentist

The term Contracted Dentist means:

- a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services at predetermined fees.

The Dentists qualifying as Contracted Dentists may change from time to time. A list of the current Contracted Dentists will be provided by your Employer.

HC-DFS227 04-10
V1

Contracted Fee

The term Contracted Fee refers to:

- the total compensation level that a Contracted Dentist has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

HC-DFS226 04-10
V1

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.

HC-DFS125 04-10
V3

Dependent

Dependents are:

- 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 mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. During the next two years Cigna may, from time to time, require proof of the continuation of such condition and dependence. After that, Cigna may require proof no more than once a year.

The term child includes your natural child, stepchild, foster child, or legally adopted child, or the child for whom you are the legal guardian, or the child who is the subject of a lawsuit for adoption by you, or the child who is supported pursuant to a court order imposed on you (including a qualified medical child support order) or your grandchild who is your Dependent for federal income tax purposes at the time of application. 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 year 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.

HC-DFS224 04-10
V1

Domestic Partner

A Domestic Partner is defined as 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 Cigna 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 Cigna 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.

HC-DFS47 04-10
V1

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge (MRC) for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna and updated annually. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national data may be used. If sufficient data is unavailable in the database, then data in the database for similar services may be used.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS1421 01-21

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.

HC-DFS16 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

Federal Requirements

The following Federal Requirement section is not part of your group insurance certificate. 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 your group insurance certificate, the provision which provides the better benefit will apply.

HC-FED1 10-10
V1

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

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.

The provisions in the "Exception for Newborns" section of this document 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.

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

Claim Determination Procedures

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.

HC-FED83 03-13

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 qualifying event if the event would result in a loss of coverage under the Plan: termination-for any reason, other than gross misconduct prior to 18 months from the date you retire.

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.

Termination of COBRA Continuation

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

- The balance of 18 months from the date you retire;
- upon cancellation of the retiree plan, the balance of 18 months from the date you retire if your former Employer provides coverage for active Employees;
- the end of the COBRA continuation period of 29 or 36 months from the date you retire, 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 former 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 retiree alone elects COBRA continuation coverage, the retiree 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.

HC-FED66 M 07-14

City of Fort Lauderdale

CIGNA DENTAL CARE INSURANCE
DHMO Plan

EFFECTIVE DATE: January 1, 2022

CN022
3335139

This document printed in March, 2022 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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: City of Fort Lauderdale

GROUP POLICY(S) — COVERAGE
3335139 - DHMO, DHMOC, DHMOF, DHMOS CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2022

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.

Jill Stadelman

Jill Stadelman, Corporate Secretary

HC-CER17 04-10
V1

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.

Cigna.

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 شمارهگیری کنید).

HC-NOT97 07-17

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

The first day of the month following 30 days from date of hire.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible. If you are a Late Entrant, you may elect the insurance only during an Open Enrollment Period. Your insurance will become effective on the first day of the month after the end of that Open Enrollment Period in which you elect it.

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 – Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or

- you again elect it after you cancel your payroll deduction (if required).

Open Enrollment Period

Open Enrollment Period means a period in each calendar year as designated by your Employer.

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until Cigna agrees to insure that Dependent.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

Choice of Dental Office for Cigna Dental Care

When you elect Employee Insurance, you may select a Dental Office from the list provided by CDH. If your first choice of a Dental Office is not available, you will be notified by CDH of your designated Dental Office, based on your alternate selection. You and each of your insured Dependents may select your own designated Dental Office. No Dental Benefits are covered unless the Dental Service is received from your designated Dental Office, referred by a Network General Dentist at that facility to a specialist approved by CDH, or otherwise authorized by CDH, except for Emergency Dental Treatment. A transfer from one Dental Office to another Dental Office may be requested by you through CDH. Any such transfer will take effect on the first day of the month after it is authorized by CDH. A transfer will not be authorized if you or your Dependent has an outstanding balance at the Dental Office.

HC-ELG4 04-10
V1

Important Information about Your Dental Plan

When you elected Dental Insurance for yourself and your Dependents, you elected one of the two options offered:

- **Cigna Dental Care; or**
- **Cigna Dental Preferred Provider**

Details of the benefits under each of the options are described in separate certificates/booklets.

When electing an option initially or when changing options as described below, the following rules apply:

- **You and your Dependents may enroll for only one of the options, not for both options.**
- **Your Dependents will be insured only if you are insured and only for the same option.**

Change in Option Elected

If your plan is subject to Section 125 (an IRS regulation), you are allowed to change options only at Open Enrollment or when you experience a "Life Status Change."

If your plan is not subject to Section 125 you are allowed to change options at any time.

Consult your plan administrator for the rules that govern your plan.

Effective Date of Change

If you change options during open enrollment, you (and your Dependents) will become insured on the effective date of the plan. If you change options other than at open enrollment (as allowed by your plan), you will become insured on the first day of the month after the transfer is processed.

HC-IMP2 04-10
HC-IMP74 V1

Dental Benefits – Cigna Dental Care

Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you.

Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards,

location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

Other Charges – Patient Charges

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1-800-Cigna24 for a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. Your Network General Dentist will provide care for children 13 years and older. If your child continues to visit the Pediatric Dentist after his/her 13th birthday, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

Your Payment Responsibility (General Care)

For Covered Services provided by your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-network Dentist. You will pay the non-network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See the *Specialty Referrals* section regarding payment responsibility for specialty care.

All contracts between Cigna Dental and network Dentists state that you will not be liable to the network Dentist for any sums owed to the network Dentist by Cigna Dental.

Emergency Dental Care – Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

- **Emergency Care Away From Home**

  If you have an emergency while you are out of your Service Area or unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

- **Emergency Care After Hours**

  There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** – Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** – The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

  Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

General Limitations - Dental Benefits

No payment will be made for expenses incurred or services received:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for 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;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-network Dentist without Cigna Dental's prior approval (except in emergencies).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless the service is specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.

- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for network Dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period when this limitation is noted on your Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered in your Patient Charge Schedule.

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

Appointments

To make an appointment with your network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

Broken Appointments

The time your network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent break an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new

Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1-800-Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

Specialty Care

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental network includes the following types of specialty dentists:

- Pediatric Dentists – children's dentistry.
- Endodontists – root canal treatment.
- Periodontists – treatment of gums and bone.
- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

Specialty Referrals

In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in the Orthodontics section. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90-day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

Orthodontics - (This section is only applicable if Orthodontia is listed on your Patient Charge Schedule.)

Definitions –

- **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.
- **Interceptive Orthodontic Treatment** – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- **Retention (Post Treatment Stabilization)** – the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

Patient Charges

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if banding/appliance insertion does not occur within 90 days of such visit; your treatment plan changes; or there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a prorated basis.

Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

- incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;

- orthognathic surgery and associated incremental costs;
- appliances to guide minor tooth movement;
- appliances to correct harmful habits; and
- services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, and/or bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), and/or fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, and bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, and/or bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

HC-DEN238 01-19

Coordination of Benefits

Under this dental plan Coordination of Benefits rules apply to specialty care only.

This section applies if you or any one of your Dependents is 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.

Definitions

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

Plan

Any of the following that provides benefits or services for medical or dental care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

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.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

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.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a 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.

- 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.
- 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.
- 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 preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

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.

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.

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:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, 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;
  - 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 parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's 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.
- 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 active employee or retiree (or as that employee's 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.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

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. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

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

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

Cigna 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

Cigna, 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.

HC-COB58 04-10
V1

Expenses for Which a Third Party May Be Responsible

Cigna shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for dental expenses and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid for such expenses under the Policy. Cigna's right of subrogation is second to your right to be fully compensated for damages. You or your representative shall execute such documents as may be required to secure Cigna's subrogation rights.

To the extent that benefits are provided or paid under this Policy, you agree that if you fully recover damages from a third party, you will refund to Cigna the amount actually paid for such Covered Expenses by Cigna less any amount required to cover damages in full, from the amount you actually received from the third party for such Covered Expenses at the time that the third party's liability is determined and satisfied, whether by settlement, judgment arbitration or award or otherwise.

HC-SUB32 04-10
V1

Payment of Benefits

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 Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna 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, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right: 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. Recovery of overpayment is limited to 18 months from the date the claim was paid. However, this 18 month time limit will not apply if the insured does not provide complete information, was not

eligible for coverage or if material misstatements or fraud have occurred.

HC-POB41 04-10
V1

Miscellaneous

Certain Dental Offices may provide discounts on services not listed on the Patient Charge Schedule, including a 10% discount on bleaching services. You should contact your participating Dental Office to determine if such discounts are offered.

If you are a Cigna Dental plan member you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

HC-POB27 04-10
V1

Termination of Insurance

Employees

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.
- the last day of the calendar month in which your Active Service ends except as described below.

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, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

Note:

When a person's Dental Insurance ceases, Cigna does not offer any Converted Policy either on an individual or group basis. However, upon termination of insurance due to termination of employment in an eligible class or ceasing to qualify as a Dependent, you or any of your Dependents may apply to Cigna Dental Health, Inc. for coverage under an individual dental plan.

Upon request, Cigna Dental Health Inc. or your Employer will provide you with further details of the Converted Policy.

Dependents

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

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM72 04-10
V1

Dental Benefits Extension

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

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

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

This extension of benefits does not apply if insurance ceases due to nonpayment of premiums.

HC-BEX38 04-10
V1

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.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA 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.

HC-FED18 10-10

Claim Determination Procedures

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.

HC-FED83 03-13

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.

HC-FED66 07-14

Dental Conversion Privilege

Dental Conversion Privilege for Cigna Dental Care, Cigna Dental Preferred Provider and Cigna Traditional Dental

Any Employee or Dependent whose Dental Insurance ceases for a reason other than failure to pay any required contribution or cancelation of the policy may be eligible for coverage under another Group Dental Insurance Policy underwritten by Cigna; provided that: he applies in writing and pays the first premium to Cigna within 31 days after his insurance ceases; and he is not considered to be overinsured.

CDH or Cigna, as the case may be, or the Policyholder will give the Employee, on request, further details of the Converted Policy.

HC-CNV2 04-10
V1

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.

HC-SPP4 04-10
V1

The Following Will Apply To Residents of Tennessee

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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

Start with Member Services

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

> Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

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

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

Level-Two Appeal

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

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

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

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

> Tennessee Department of Commerce and Insurance
> 500 James Robertson Parkway
> Nashville, TN 37423
> 800-342-4029

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; 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); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

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 Cigna until you have completed the Level-One and Level-Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

HC-APL41 04-10
V1

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.

HC-DFS1 04-10
V1

Adverse Determination

An Adverse Determination is a decision made by Cigna Dental that it will not authorize payment for certain limited specialty care procedures. Any such decision will be based on the necessity or appropriateness of the care in question. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and must meet the following requirements. It must:

- be consistent with the symptoms, diagnosis or treatment of the condition present;
- conform to commonly accepted standards of treatment;
- not be used primarily for the convenience of the member or provider of care; and
- not exceed the scope, duration or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the member at the dentist’s Usual Fees.

HC-DFS350 04-10
V1

Cigna Dental Health
(herein referred to as CDH)

CDH is a wholly-owned subsidiary of Cigna Corporation that, on behalf of Cigna, contracts with Participating General Dentists for the provision of dental care. CDH also provides management and information services to Policyholders and Participating Dental Facilities.

HC-DFS352 04-10
V1

Contract Fees

Contract Fees are the fees contained in the Network Specialty Dentist agreement with Cigna Dental which represent a discount from the provider’s Usual Fees.

HC-DFS353 04-10
V1

Covered Services

Covered Services are the dental procedures listed in your Patient Charge Schedule.

HC-DFS354 04-10
V1

Dental Office

Dental Office means the office of the Network General Dentist(s) that you select as your provider.

HC-DFS355 04-10
V1

Dental Plan

The term Dental Plan means the managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

HC-DFS356 04-10
V2

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.

HC-DFS125 04-10
V3

Dependent

Dependents are:

- 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 mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you, including that child from the first day of placement in your home regardless of whether the adoption has become final. It also includes a stepchild, a grandchild who lives with you, a foster child, or a child for whom you are the legal guardian. 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 year in which the limiting age is reached.

HC-DFS201 04-10
V2

Domestic Partner

A Domestic Partner is defined as 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 Cigna 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 Cigna 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.

HC-DFS47 04-10
V1

Cigna.

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7 04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Group

The term Group means the Employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

HC-DFS357 04-10
V1

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.

HC-DFS16 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

Network General Dentist

A Network General Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide general dental care services to plan members.

HC-DFS358 04-10
V1

Network Specialty Dentist

A Network Specialty Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide specialized dental care services to plan members.

HC-DFS359 04-10
V1

Patient Charge Schedule

The Patient Charge Schedule is a separate list of covered services and amounts payable by you.

HC-DFS360 04-10
V1

Service Area

The Service Area is the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

HC-DFS361 04-10
V1

Specialist

The term Specialist means any person or organization licensed as necessary: who delivers or furnishes specialized dental care services; and who provides such services upon approved referral to persons insured for these benefits.

HC-DFS362 04-10
V1

Subscriber

The subscriber is the enrolled employee or member of the Group.

HC-DFS363 04-10
V1

Usual Fee

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

HC-DFS138 04-10
V1

Cigna Dental Care – Cigna Dental Health Plan

The certificate and the state specific riders listed in the next section apply if you are a resident of one of the following states: AZ, CO, DE, KS/NE, MD, OH, VA

CDO32

Cigna Dental Companies

Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Delaware, Inc.
Cigna Dental Health of Florida, Inc. **(a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)**
Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska)
Cigna Dental Health of Kentucky, Inc.
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of Missouri, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of North Carolina, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Virginia, Inc.
P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of dentists dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled "Disenrollment from the Dental Plan–Termination of Benefits."

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.

Cigna.

I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

A. be consistent with the symptoms, diagnosis or treatment of the condition present;

B. conform to commonly accepted standards throughout the dental field;

C. not be used primarily for the convenience of the customer or dentist of care; and

D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

Contract Fees - the fees contained in the Network Dentist agreement with Cigna Dental.

Covered Services - the dental procedures listed on your Patient Charge Schedule.

Dental Office - your selected office of Network General Dentist(s).

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, or your Domestic Partner;

your child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

(a) less than 26 years old; or

(b) 26 years or older, unmarried and if he or she is both:

i. incapable of self-sustaining employment due to mental or physical disability, and

ii. reliant upon you for maintenance and support.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist – a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Patient Charge Schedule - list of services covered under your Dental Plan and how much they cost you.

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

Service Area - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

Subscriber/You - the enrolled employee or customer of the Group.

Usual Fee - the customary fee that an individual dentist most frequently charges for a given dental service.

II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility/When Coverage Begins

To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of

your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

C. Other Charges – Patient Charges

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. Emergency Dental Care - Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. Emergency Care After Hours

There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry -** Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery -** The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services –** Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

  Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations –** When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services –** When covered on the Patient Charge Schedule, surgical

placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

- **Prosthesis Over Implant -** When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

General Limitations Dental Benefits

No payment will be made for expenses incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for 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;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-

fault auto insurance policy, or uninsured motorist policy. (Arizona residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)

- the completion of crowns, bridges, dentures, or root canal treatment, already in progress on the effective date of your Cigna Dental coverage?
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

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

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. Specialty Care

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists – children's dentistry.
- Endodontists – root canal treatment.
- Periodontists – treatment of gums and bone.
- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. Orthodontics (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. Definitions – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:

a. **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.

b. **Interceptive Orthodontic Treatment –** treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.

c. **Comprehensive Orthodontic Treatment –** treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.

d. **Retention (Post Treatment Stabilization) –** the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient Charges

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or

treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

3. Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;

b. orthognathic surgery and associated incremental costs;

c. appliances to guide minor tooth movement;

d. appliances to correct harmful habits; and

e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. What To Do If There Is A Problem

For the purposes of this section, any reference to "you" or "your" also refers to a representative or dentist designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. Start with Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

3. Independent Review Procedure

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas. Consult your State Rider for more details if applicable.

4. Appeals to the State

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

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

XII. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group

Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to Cigna Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. after voluntary disenrollment.

B. Effect on Dependents

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

XIV. Extension of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group, or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at 1-800-Cigna24 to obtain current rates and make arrangements for continuing coverage.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at myCigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at myCigna.com for details.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

SEE YOUR STATE RIDER FOR ADDITIONAL DETAILS.

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State Rider
Cigna Dental Health of Ohio, Inc.

Ohio Residents:

The following is in addition to the information on the first page of your Plan Booklet:

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

The following is in addition to the process described in Section III. Eligibility/When Coverage Begins:

III. Eligibility/When Coverage Begins

You and your Dependents must live or work in the service area to be eligible for coverage.

Under Ohio law, if you divorce, you cannot terminate coverage for enrolled Dependents until the court determines that you are no longer responsible for providing coverage.

Cigna Dental does not require, make inquiries into, or rely upon genetic screening or testing in processing applications for enrollment or in determining insurability under the Dental Plan.

Section IV is renamed:

IV. Your Cigna Dental Plan

The Choice of Dentist provision under Section IV. D. is deleted and is replaced with the following:

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

The following is in addition to the process described in Section IV. E. of your Plan Booklet:

E. Your Payment Responsibility (General Care)

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. There is no additional cost to you.

Cigna Dental is not a member of any Guaranty Fund. In the event of Cigna Dental's insolvency, you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental. However, you may be financially responsible for services rendered by a non-network dentist whether or not Cigna Dental authorizes payment for a referral.

If you are undergoing treatment and the Dental Plan becomes insolvent, Cigna Dental will arrange for the continuation of services until the expiration of your Group Contract.

Provision 1 of Emergency Dental Care – Reimbursement under Section IV. F. is deleted and is replaced with the following:

F. Emergency Dental Care – Reimbursement

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

The Pediatric Dentistry provision under Section IV. G. is deleted and replaced with the following:

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.

The Office Transfers provision under Section VII. is deleted and replaced with the following:

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1.800.Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

The Specialty Referrals provision under Section IX. A is deleted and replaced with the following:

IX. Specialty Referrals

A. In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care,

it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

The following is in addition to the process described in Section XI of your Plan Booklet:

XI. What To Do If There Is A Problem

A. Start With Customer Service

You can reach Customer Service by calling 1.800.Cigna24 or by writing to Cigna Dental Health of Ohio, Inc., P.O. Box 453099, Sunrise, Florida 33345-3099, Attention: Customer Service. You may also submit a complaint in person at any Cigna Dental Office.

B. APPEALS PROCEDURE

1. Level One Appeals

Cigna Dental will provide a written response to your written complaint.

Within 30 days of receiving a response from Cigna Dental, you may appeal a complaint resolution regarding cancellation, termination or non-renewal of coverage by Cigna Dental to the Ohio Superintendent of Insurance.

The Ohio Department of Insurance is located at 50 W. Town Street, Suite 300, Columbus, Ohio 43215, Attention Consumer Services Division. The Department's toll-free number is 1-800-686-1526 or (614) 644-2673.

XII. Dual Coverage

(This section is not applicable when Cigna Dental does not make payments toward specialty care as indicated by your Patient Charge Schedule. For those plans, Cigna Dental is always the primary plan.)

The following supersedes Section XII of your Plan Booklet.

A. COORDINATION OF BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its Policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

Definitions

A. Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental Plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is 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.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan.

However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's Plan is always primary), we will follow the rules of that Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent;

The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared

equally between the Plans meeting the definition of 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

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel Plan, COB shall not apply between that Plan and other Closed panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us at the toll-free number or address that appears on your Benefit Identification card, explanation of benefits, or claim form. If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

The following is in addition to the process described in Section XIII. of your Plan Booklet:

XIII. Disenrollment From The Dental Plan/Termination Of Benefits

A. Causes For Disenrollment/Termination

3. Under Ohio law, you will not be terminated from the dental plan due to a permanent breakdown of the dentist-patient relationship. However, your Network Dentist has the right to decline services to a patient because of rude or abusive behavior.

You or your Dependent may appeal any termination action by Cigna Dental by submitting a written complaint as set out in Section XI.

XVI. Conversion Coverage

You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

A. Nonpayment of Premiums/Prepayment Fees by the Subscriber;

B. Fraud or misuse of dental services and/or Dental Offices;

C. Selection of alternate dental coverage by your Group.

XVIII. Miscellaneous

A. Governing Law

The Group Contract shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with pertinent laws and regulations of the State of Ohio. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

B. Availability of Financial Statement

Cigna Dental Health of Ohio, Inc. will make available to you, upon request, its most recent financial statement.

Cigna Dental Care – Cigna Dental Health Plan

The certificate(s) listed in the next section apply if you are a resident of one of the following states: CA, CT, FL, IL, KY, MO, NJ, NC, PA, TX

CDO33

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Cigna Dental Companies

PLAN BOOKLET
COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM/CERTIFICATE OF COVERAGE

Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Delaware, Inc.
Cigna Dental Health of Florida, Inc. (a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)
Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska)
Cigna Dental Health of Kentucky, Inc.
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of Missouri, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of North Carolina, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Pennsylvania, Inc.
Cigna Dental Health of Virginia, Inc.
P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of dentists dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled "Disenrollment from the Dental Plan–Termination of Benefits."

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at 1.800.Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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Table of Contents

In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.

Cigna.

I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

A. Be consistent with the symptoms, diagnosis or treatment of the condition present;

B. Conform to commonly accepted standards throughout the dental field;

C. Not be used primarily for the convenience of the customer or provider of care; and

D. Not exceed the scope, duration or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - The Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

Contract Fees - The fees contained in the Network Dentist agreement with Cigna Dental.

Covered Services - The dental procedures listed on your Patient Charge Schedule.

Dental Office - Your selected office of Network General Dentist(s).

Dental Plan - Managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - Your lawful spouse, or your Domestic Partner; your child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

A. Less than 26 years old; or

B. Any age if he or she is both:

   1. Incapable of self-sustaining employment due to mental or physical disability, and

   2. Reliant upon you for maintenance and support.

For a child who falls into category (B) above, you will need to furnish Cigna Dental evidence of the child's reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 26 and once a year thereafter for as long as the child is claimed as a Dependent under the Plan.

A **Newly Acquired Dependent** is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

The following definition of Domestic partner applies:

A. A person of the same or opposite sex who:

   1. Shares your permanent residence;

   2. Has resided with you for no less than one year;

   3. Is no less than eighteen years of age;

   4. 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, common 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 durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;

   5. Is not your blood relative any closer than would be prohibited for a legal marriage; and

   6. Has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental Health which shall be made available to Cigna Dental Health upon request; or

B. A person of the same or opposite sex who has registered jointly with you as Domestic Partners with a governmental entity pursuant to a state or local law authorizing such registration and signed jointly with you a notarized affidavit of such registration which can be made available to Cigna Dental Health upon request.

The above definition applies so long as neither you nor your Domestic Partner hereunder:

A. Has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;

B. Is currently legally married to another person; or

C. Has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.

Group - Employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist - A licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - A licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - A licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to You.

Patient Charge - The amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Patient Charge Schedule - List of services covered under your Dental Plan and how much they cost you.

Premiums - Fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

Service Area - The geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

Subscriber/You - The enrolled employee or customer of the Group.

Usual Fee - The customary fee that an individual dentist most frequently charges for a given dental service.

II. Introduction to Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility/When Coverage Begins

To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1.800.Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for

information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

C. Other Charges – Patient Charges

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at **myCigna.com**, or call the Dental Office Locator at 1.800.Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-covered services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-network dentist. You will pay the non-network dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-network dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX., *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. Emergency Dental Care - Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. **Emergency Care Away from Home**

   If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to

your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. **Emergency Care After Hours**

   There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry -** Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist however; exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery -** The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services –** Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

  Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations –** When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of four evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services –** When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant -** When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

General Limitations Dental Benefits

No payment will be made for expenses incurred or services received:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- For 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.
- To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received.
- For the charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- Due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.

- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- Prescription medications.
- Procedures, appliances or restorations if the main purpose is to:
  a. Change vertical dimension (degree of separation of the jaw when teeth are in contact).
  b. Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- Services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)
- The completion of crowns, bridges, dentures, or root canal treatment, already in progress on the effective date of your Cigna Dental coverage.
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- Consultations and/or evaluations associated with services that are not covered.
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- Services performed by a prosthodontist.
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- Any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- Infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- Services to correct congenital malformations, including the replacement of congenitally missing teeth.
- The replacement of an occlusal guard (night guard) beyond one per any 24-consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- Crowns, bridges and/or implant supported prosthesis used solely for splinting.
- Resin bonded retainers and associated pontics.

Preexisting conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

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

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at **myCigna.com**, or call the Dental Office Locator at 1.800.Cigna24. Your transfer request will take about five days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. Specialty Care

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists - Children's dentistry.
- Endodontists - Root canal treatment.
- Periodontists - Treatment of gums and bone.
- Oral Surgeons - Complex extractions and other surgical procedures.
- Orthodontists - Tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

See Section IV.D., *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-covered services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If

you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-network specialty dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-network dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-covered services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. Orthodontics (This section is applicable only when orthodontics is listed on your Patient Charge Schedule.)

1. **Definitions** - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
   - **a. Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the orthodontist.
   - **b. Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
   - **c. Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
   - **d. Retention (Post Treatment Stabilization)** - the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.
2. **Patient Charges**

   The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

   The Patient Charge for orthodontic treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a prorated basis.
3. **Additional Charges**

   You will be responsible for the Orthodontist's Usual Fees for the following non-covered services:
   - a. Incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
   - b. Orthognathic surgery and associated incremental costs;
   - c. Appliances to guide minor tooth movement;
   - d. Appliances to correct harmful habits; and
   - e. Services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.
4. **Orthodontics in Progress**

   If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1.800.Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving six or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you

about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when six or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. What to Do if There Is a Problem

For the purposes of this section, any reference to "you" or "your" also refers to a representative or dentist designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. Start with Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1.800.Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within one year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1.800.Cigna24.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied preauthorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your

current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

3. **Independent Review Procedure**

   The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas. Consult your State Rider for more details if applicable.

4. **Appeals to the State**

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

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

XII. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefits Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, applicable coordination of benefits rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

Coordination of benefits rules are attached to the Group Contract and may be reviewed by contacting your Benefits Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. Disenrollment from the Dental Plan - Termination of Benefits

A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. In which Premiums are not remitted to Cigna Dental.
2. In which eligibility requirements are no longer met.
3. After 30 days' notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. After 30 days' notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. After 60 days' notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. After voluntary disenrollment.

B. Effect on Dependents

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

XIV. Extension of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental

conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship.
- Fraud or misuse of dental services and/or Dental Offices.
- Nonpayment of Premiums by the Subscriber.
- Selection of alternate dental coverage by your Group.
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at 1.800.Cigna24 to obtain current rates and make arrangements for continuing coverage.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1.800.Cigna24, or via the Internet at **myCigna.com**.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at **myCigna.com** for details.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

See Your State Rider for Additional Details.

Cigna Dental Health of Florida, Inc. STATE RIDER

Florida residents: This State Rider is attached to and made part of your Plan Booklet and contains information that either replaces, or is in addition to, information contained in your Plan Booklet.

I. Definitions

Dependent - A child born to or adopted by your covered family member may also be considered a Dependent if the child is pre-enrolled at the time of birth or adoption.

Domestic Partner definition is replaced as follows:

The following definition of Domestic Partner applies:

A. A person of the same or opposite sex who:
   1. Shares your permanent residence;
   2. Is no less than eighteen years of age;
   3. 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, common 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 durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;
   4. Is not your blood relative any closer than would be prohibited for a legal marriage; and
   5. Has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental Health which shall be made available to Cigna Dental Health upon request; or

The above definition applies so long as neither you nor your Domestic Partner hereunder:

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

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.

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III. Eligibility/when coverage begins

There will be at least one open enrollment period of not less than 30 days every 18 months unless Cigna Dental Health and your Group mutually agree to a shorter period of time than 18 months.

If you have family coverage, your newly-born child, or a newly-born child of a covered family member, is automatically covered during the first 31 days of life if the child is pre-enrolled in the Dental Plan at the time of birth. If you wish to continue coverage beyond the first 31 days, you need to begin to pay Premiums, if any additional are due, during that period.

IV. Your Cigna Dental coverage

B. Premiums/prepayment fees

Your Group Contract has a 31-day grace period. This provision means that if any required premium is not paid on or before the date is due, it may be paid subsequently during the grace period. During the grace period, the Group Contract will remain in force.

D. CHOICE OF DENTIST

You may receive a description of the process used to analyze the qualifications and credentials of Network Dentists upon request.

XI. What to do if there is a problem

The following is in addition to the Section XI of your Plan Booklet:

B. Appeals procedure

The Appeals Coordinator can be reached at 1.800.Cigna24 (244.6224) or by writing to P.O. Box 188047, Chattanooga, TN 37422.

1. Level-one appeals

Your written complaint will be processed within 60 days of receipt unless the complaint involves the collection of information outside the service area, in which case Cigna Dental Health will have an additional 30 days to process the complaint. You may file a complaint up to one year from the date of occurrence.

If a meeting with you is necessary, the location of the meeting shall be at Cigna Dental Health's administrative office at a location within the service area that is convenient for you.

4. Appeals to the State

You always have the right to file a complaint with or seek assistance from the Department of Insurance, 200 East Gaines Street, Tallahassee, Florida 32399, 1.800.342.2672.

XIII. Disenrollment from the dental plan/termination

A. Causes for disenrollment/termination

3. Permanent breakdown of the dentist-patient relationship, as determined by Cigna Dental Health, is defined as disruptive, unruly, abusive, unlawful, or uncooperative behavior which seriously impairs Cigna Dental Health's ability to provide services to members, after reasonable efforts to resolve the problem and consideration of extenuating circumstances.

   Forty-five days notice will be provided to you if Cigna Dental Health terminates enrollment in the dental plan.

XIV. Extension of benefits

Coverage for all dental procedures in progress, including Orthodontics, is extended for 90 days after disenrollment.

XVI. Converting from your group coverage

You and your enrolled Dependent(s) are eligible for conversion coverage unless benefits are discontinued because you or your Dependent no longer resides in a Cigna Dental Health Service Area, or because of fraud or material misrepresentation in applying for benefits.

Unless benefits were terminated as previously listed, conversion coverage is available to your Dependents, only, as follows:

A. A surviving spouse and children at Subscriber's death;

B. A former spouse whose coverage would otherwise end because of annulment or dissolution of marriage; or

C. A spouse or child whose group coverage ended by reason of ceasing to be an eligible family member under the Subscriber's coverage.

Coverage and Benefits for conversion coverage will be similar to those of your Group's Dental Plan. Rates will be at prevailing conversion levels.

In addition the following provisions apply to your plan:

Expenses for which a third party may be responsible

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Right of reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

Cigna Dental Health of Florida, Inc.

BY: Matthew G. Manders

TITLE: President

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Benefit Rider

Cigna Dental Companies

Cigna Dental Health of Florida, Inc. **(a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)**

P.O. Box 453099

Sunrise, Florida 33345-3099

This State Rider is attached to and made part of your Plan Booklet/Evidence of Coverage and replaces the following provisions:

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.Cigna.com, or call the Dental Office Locator at 1.800.Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

F. Emergency Dental Care – Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. Emergency Care Away from Home

If you have an emergency while you are out of your Service Area or you are unable to contact your

Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures.

For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. Emergency Care After Hours

There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.
- Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of four evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

General Limitations – Dental Benefits

No payment will be made for expenses incurred or services received:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- For 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.
- To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received.
- For the charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- Due to injuries which are intentionally self-inflicted.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24 To obtain a list of Dental Offices near you, visit our website at my.Cigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the

processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1.800.Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

IX Specialty Referrals

A. In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-covered services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-network specialty dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-network dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-covered services or services not approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

Cigna Dental Health of Florida, Inc.

BY: Frederick E. Landretti

TITLE: President

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Cigna Dental Companies

Cigna Dental Health of North Carolina, Inc.

P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of providers dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled "Disenrollment from the Dental Plan–Termination of Benefits."

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.

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I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

A. be consistent with the symptoms, diagnosis or treatment of the condition present;

B. conform to commonly accepted standards throughout the dental field;

C. not be used primarily for the convenience of the customer or provider of care; and

D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

Contract Fees - the fees contained in the Network Dentist agreement with Cigna Dental.

Covered Services - the dental procedures listed on your Patient Charge Schedule.

Dental Office - your selected office of Network General Dentist(s).

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, or your domestic partner;

Your unmarried child (including newborns, adopted children, foster children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

(a) less than 26 years old; or

(b) any age if he or she is both:

i. incapable of self-sustaining employment due to mental or physical disability, and

ii. reliant upon you for maintenance and support.

For a child who falls into category (b) above, you will need to furnish Cigna Dental evidence of the child's reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter for as long as the child is claimed as a Dependent under the Plan.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist – a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Patient Charge Schedule - list of services covered under your Dental Plan and how much they cost you.

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

Service Area - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

Subscriber/You - the enrolled employee or customer of the Group.

Usual Fee - the customary fee that an individual dentist most frequently charges for a given dental service.

II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

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III. Eligibility/When Coverage Begins

To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 30 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement. Dependent children for whom you are required by a court or administrative order to provide dental coverage may be enrolled at any time. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. If your child is enrolled in the Dental Plan because of a court or administrative order, the child may not be disenrolled unless the order is no longer valid or the child is enrolled in another dental plan with comparable coverage.

If you have family coverage and have a new baby or if you are appointed as guardian or custodian of a foster child who is placed in your home, or an adopted child, the newborn, foster or adopted child will be automatically covered for the first 30 days following birth or placement. Waiting periods do not apply to these categories of Dependents. If you wish to continue coverage beyond the first 30 days, you should enroll the child in the Dental Plan and you need to begin to pay Premiums/Prepayment Fees during the period, if any additional are due, during that period. If additional premium is required you must submit an enrollment form within 30 days of acquiring the new Dependent child. If no additional premium is required, the child will be covered even if not formally enrolled in the plan. However, for ease of administration, you are encouraged to enroll the new Dependent child when coverage begins.

When a child, covered from the moment of birth or placement in the adoptive or foster home, requires dental care associated with congenital defects and anomalies, the dental only plan shall cover such defects to the same extent an otherwise covered dental service is provided by the plan.

A life status change may also include placement for adoption.

Evidence of good dental health is not required for late enrollees.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

No schedule of premiums, or any amendment to the schedule, shall be used until it has been filed with and approved by the Commissioner. Premiums are guaranteed for the group for a period of twelve (12) months. However, Premiums may be adjusted by Cigna Dental upon approval by the North Carolina Department of Insurance but no more often than once every 6 months based on at least 12 months of experience and 45 days' notice to the Group if, in Cigna Dental's sole opinion, its liability is altered by any state or federal law.

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL,

MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

C. Other Charges – Patient Charges

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-

Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

If you are unable to locate, or you do not have timely access to, an In-Network General Dentist in your area who can provide you with a service or supply that is covered under this plan, you should call customer service at 1-800-Cigna24 to obtain authorization of Out-of-Network Provider coverage. If authorization is obtained for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. Emergency Dental Care - Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. Emergency Care After Hours

There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry -** Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery -** The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services –** Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

  Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations –** When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

General Limitations Dental Benefits

No payment will be made for expenses incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for 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;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

Exclusions and limitations do not apply to services performed to correct congenital defects, including cosmetic surgery.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan when Coordination of Benefits rules are applied.
- the completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental

coverage, unless specifically listed on your Patient Charge Schedule.

- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Exclusions and limitations do not apply to services performed to correct congenital defects, including cosmetic surgery.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

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

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1-800-Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. Specialty Care

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists – children's dentistry.
- Endodontists – root canal treatment.
- Periodontists – treatment of gums and bone.

- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., *Orthodontics*. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. Orthodontics (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. Definitions – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:

a. **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.

b. **Interceptive Orthodontic Treatment –** treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.

c. **Comprehensive Orthodontic Treatment –** treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.

d. **Retention (Post Treatment Stabilization) –** the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient Charges

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

3. Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;

b. orthognathic surgery and associated incremental costs;

c. appliances to guide minor tooth movement;

d. appliances to correct harmful habits; and

e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex Rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. What To Do If There Is A Problem

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. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. Start with Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal resolution be expedited if the time frames under the above process

would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You will be notified in writing of the decision no later than 30 days after the date the appeal is made. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

3. Appeals to the State

You have the right to contact your State's Department of Insurance and/or Department of Health for assistance at any time.

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

XII. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to Cigna Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after voluntary disenrollment.

B. Effect on Dependents

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

XIV. Extension of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group, or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at 1-800-Cigna24 to obtain current rates and make arrangements for continuing coverage.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at myCigna.com.

XVIII. Miscellaneous

A. Healthy Rewards

From time to time, Cigna Dental Health may offer or provide certain persons who enroll in the Cigna Dental plan access to certain discounts, benefits or other consideration for the purpose of promoting general health and well being. Discounts arranged by our Cigna HealthCare affiliates may be offered in areas such as acupuncture, cosmetic dentistry, fitness club memberships, hearing care and hearing instruments, laser vision correction, vitamins and herbal supplements, and non-prescription health and wellness products. In addition, our Cigna HealthCare affiliates may arrange for third party service providers, such as chiropractors, massage therapists and optometrists, to provide discounted goods and services to those persons who enroll in the Cigna Dental plan. While Cigna HealthCare has arranged these goods, services and/or third party provider discounts, the third party service providers are liable to enrollees for the provision of such goods and/or services. Cigna HealthCare and Cigna Dental Health are not responsible for the provision of such goods and/or services, nor are we liable for the failure of the provision of the same. Further, Cigna HealthCare and Cigna Dental Health are not liable to enrollees for the negligent provision of such goods and/or services by third party service providers.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

B. Incontestability

Under North Carolina law, no misstatements made by a Subscriber in the application for benefits can be used to void coverage after a period of two years from the date of issue.

C. Willful Failure To Pay Group Insurance Premiums

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY

ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

D. NC Life & Health Guaranty Association Notice

Notice Concerning Coverage

Limitations And Exclusions Under The North Carolina

Life And Health Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina, 27605

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Coverage

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions From Coverage

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

Limits On Amount Of Coverage

The benefits for which the Association is liable do not, in any event, exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not a delinquent insurer; or

(2) With respect to any one individual, regardless of the number of policies, three hundred thousand dollars ($300,000) for all benefits, including cash values; or

(2a) With respect to health insurance benefits for any one individual, regardless of the number of policies:

a. Three hundred thousand dollars ($300,000) for coverages not defined as basic hospital, medical, and surgical insurance or major medical insurance as defined in this Chapter and regulations adopted pursuant to this Chapter, including disability insurance and long-term care insurance; or

b. Five hundred thousand dollars ($500,000) for basic hospital, medical, and surgical insurance or major medical insurance as defined in this Chapter and regulations adopted pursuant to this Chapter;

(3) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code covered by an unallocated annuity contract, or the beneficiaries of each individual if deceased, in the aggregate, three hundred thousand dollars ($300,000) in present value annuity benefits, including net cash surrender and net cash withdrawal values; or

(4) With respect to any one contract holder covered by any unallocated annuity contract not included in subdivision (3) of this subsection, five million dollars ($5,000,000) in benefits, regardless of the number of such contracts held by that contract holder; or

(5) With respect to any one payee (or beneficiaries of one payee if the payee is deceased) of a structured settlement annuity, one million dollars ($1,000,000) for all benefits, including cash values.

(6) However, in no event shall the Association be obligated to cover more than an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one individual under subdivisions (2) and (3) and sub subdivision (2a)a. except with respect to benefits for basic hospital, medical, and surgical and major medical insurance under sub subdivision (2a)b. of this subsection, in which case the aggregate liability of the Association shall not exceed five hundred thousand dollars ($500,000) with respect to any one individual.

PB09NC.2 01.01.19

Cigna Dental Health of New Jersey, Inc.

P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. Please read the following information so you will know from whom or what group of dentists dental care may be obtained. This certificate is subject to the laws of the state of New Jersey.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information - Please Read the Provision Entitled "Disenrollment from the Dental Plan - Termination of Benefits."

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

A. be consistent with the symptoms, diagnosis or treatment of the condition present;

B. conform to commonly accepted standards throughout the dental field;

C. not be used primarily for the convenience of the customer or dentist of care; and

D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

Contract Fees - the fees contained in the Network Dentist agreement with Cigna Dental.

Covered Services - the dental procedures listed on your Patient Charge Schedule.

Dental Office - your selected office of Network General Dentist(s).

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, civil union or your domestic partner (if established in New Jersey prior to February 19, 2007 or if established outside the state of New Jersey prior to or after February 19, 2007); your child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a Dependent child who resides in your home as a result of court order or administrative placement; or a Dependent child acquired through a civil union) who is:

A. less than 26 years old; or

B. any age if he or she is both:

   1. incapable of self-sustaining employment due to mental or physical disability, and

   2. reliant upon you for maintenance and support.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for Dependents living outside a Cigna Dental Service Area is subject to the availability of an approved network where the Dependent resides.

This definition of "Dependent" applies unless modified by your Group Contract.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist - a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Patient Charge Schedule - list of services covered under your Dental Plan and how much they cost you.

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

Service Area - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

Subscriber/You - the enrolled employee or customer of the Group.

Usual Fee - the customary fee that an individual dentist most frequently charges for a given dental service.

II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility When Coverage Begins

To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a Cigna

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Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

C. Other Charges – Patient Charges

Network General Dentists are reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the

network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. Emergency Dental Care – Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

Emergency Care Away From Home - If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed on the front of this booklet.

Emergency Care After Hours - There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

General Limitations Dental Benefits

No payment will be made for expenses incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for 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;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV. F.).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.

- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

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

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer, however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. Specialty Care

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists - children's dentistry.
- Endodontists - root canal treatment.
- Periodontists - treatment of gums and bone.
- Oral Surgeons - complex extractions and other surgical procedures.
- Orthodontists - tooth movement.

There is no coverage for referrals to Prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

See Section IV.D., *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees for no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX. B. *Orthodontics*. Treatment by the Network Specialist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90-day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee.

If you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

B. Orthodontics (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

Definitions - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:

- **Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the Orthodontist.
- **Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- **Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- **Retention (Post Treatment Stabilization)** - the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

Patient Charges

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

- incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- orthognathic surgery and associated incremental costs;
- appliances to guide minor tooth movement;
- appliances to correct harmful habits; and
- services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. What To Do If There Is A Problem

For the purposes of this section, any reference to "you" or "your" also refers to a representative or dentist designated by you to act on your behalf.

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. Start With Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 15 working days.

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

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

We will respond with a decision within 15 working days after we receive your appeal. If we need more time or information to make the decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level- two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 15 working days. If we need more time or information to complete the review, we will notify you in writing to request an extension of up

to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

Appeals to the State

You have the right to contact the New Jersey Department of Insurance and/or Department of Health for assistance at any time.

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

XII. Dual Coverage

A. In General

"Coordination of benefits" is the procedure used to pay health care expenses when a person is covered by more than one plan. Cigna Dental follows rules established by New Jersey law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow New Jersey coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Cigna Dental pays for dental care when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

B. How Cigna Dental Pays As Primary Plan

When you receive care from a Network Specialty Dentist, Cigna Dental pays the Network Specialty Dentist a contracted fee amount less your copayment for the Covered Service. When we are primary, we will pay the full benefit allowed as if you had no other coverage.

C. How Cigna Dental Pays As Secondary Plan

- If your primary plan pays on the basis of UCR, Cigna Dental will pay the difference between the provider's billed charges and the benefits paid by the primary plan up to the amount Cigna Dental would have paid if primary. Cigna Dental's payment will first be applied toward satisfaction of your copayment of your primary plan. You will not be liable for any billed charges in excess of the sum of the benefits paid by your primary plan, Cigna Dental as your secondary plan and the copayment you paid under either the primary or secondary plan. When Cigna Dental pays as secondary, you will never be responsible for paying more than your copayment for the Covered Service.
- When both your primary plan and Cigna Dental pay network providers on the basis of a contractual fee schedule and the provider is a network provider of both plans, the allowable expense will be considered to be the contractual fee of your primary plan. Your primary plan will pay the benefit it would have paid regardless of any other coverage you may have. Cigna Dental will pay the copayment for the Covered Service for which you are liable up to the amount Cigna Dental would have paid if primary and provided that the total amount received by the provider from the primary plan, Cigna Dental and you does not exceed the contractual fee of the primary plan. You will not be responsible for an amount more than your copayment.
- When your primary plan pays network providers on a basis of capitation or a contractual fee schedule or pays a benefit on the basis of UCR, and Cigna Dental pays network providers on the basis of capitation and a service or supply is provided by a network provider of Cigna Dental, we will not be obligated to pay to the network provider any amount other than the capitation payment required under the contract between Cigna Dental and the network provider and we shall not be liable for any deductible, coinsurance or copayment imposed by your primary plan. You will not be responsible for the payment of any amount for eligible services.
- We will pay only for health care expenses that are covered by Cigna Dental.
- We will pay only if you have followed all of our procedural requirements, including: care is obtained

from or arranged by your primary care dentist; coverage in effect when procedures begin; procedures begin within 90 days of referral.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames For Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

- in which Premiums are not remitted to Cigna Dental;
- in which eligibility requirements are no longer met;
- after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office;
- after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices;
- after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area;
- after voluntary disenrollment.

B. Effect on Dependents

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

XIV. Extension of Benefits

Coverage for completion of a dental procedure which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- permanent breakdown of the dentist-patient relationship;
- fraud or misuse of dental services and/or Dental Offices;
- nonpayment of Premiums by the Subscriber;
- selection of alternate dental coverage by your Group; or
- lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at 1-800-Cigna24 to obtain current rates and make arrangements for continuing coverage.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at myCigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at myCigna.com for details.

If you are a Cigna Dental Care customer you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

Cigna Dental Care – Cigna Dental Health Plan

The following rider applies if you are a resident of: AZ, CO, DE, KS/NE, KY/IL, NJ.

CDO34

Benefit Rider

Cigna Dental Companies

Cigna Dental Health Plan of Arizona, Inc.

Cigna Dental Health of Colorado, Inc.

Cigna Dental Health of Delaware, Inc.

Cigna Dental Health of Florida, Inc. (**a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)**

Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska)

Cigna Dental Health of Kentucky, Inc. (Kentucky and Illinois)

Cigna Dental Health of New Jersey, Inc.

Cigna Dental Health of Ohio, Inc.

Cigna Dental Health of Virginia, Inc.

P.O. Box 453099
Sunrise, Florida 33345-3099

This State Rider is attached to and made part of your Plan Booklet/Evidence of Coverage and replaces the following provisions:

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

F. Emergency Dental Care - Reimbursement

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

G. Limitations On Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency,

you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1.800.Cigna24.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

IX. SPECIALTY REFERRALS

A. IN GENERAL

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

When Cigna Dental approves payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

Cigna Dental Care – Cigna Dental Health Plan

The rider(s) listed in the next section are general provisions that apply to residents of:

AZ, CA, CO, CT, DE, IL, KS/NE, KY, MD, MO, NJ, NC, OH, TX, VA

CDO35

Cigna.

Domestic Partner Rider

This definition of Domestic Partner applies to residents of: AZ, CA, CO, CT, DE, IL, KS/NE, KY, MD, NC, OH, TX, VA.

A. A person of the same or opposite sex who:
   1. shares your permanent residence;
   2. has resided with you for no less than one year;
   3. is no less than eighteen years of age;
   4. 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, common 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 durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;
   5. is not your blood relative any closer than would be prohibited for a legal marriage; and
   6. has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental Health which shall be made available to Cigna Dental Health upon request; or

B. A person of the same or opposite sex who has registered jointly with you as Domestic Partners with a governmental entity pursuant to a state or local law authorizing such registration and signed jointly with you a notarized affidavit of such registration which can be made available to Cigna Dental Health upon request.

The above definition applies so long as neither you nor your Domestic Partner hereunder:

A. has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;

B. is currently legally married to another person; or

C. has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.

This insert contains Cigna Dental's standard Domestic Partner definition. Your Group may have purchased one or both coverages (same/opposite sex partners). Consult your Group Contract for additional information.

Kentucky Residents: Coverage terminates (for the domestic partner and any dependents, if included) when the domestic partnership ends. Domestic Partners are entitled to Conversion rights upon termination of coverage.

DPRIDER02 V11

Cigna.

Domestic Partner Rider

This definition of Domestic Partner applies to residents of: NJ.

A domestic partnership shall be established when all of the following requirements are met:

(1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following:
   (a) a joint deed, mortgage agreement or lease;
   (b) a joint bank account;
   (c) designation of one of the persons as a primary beneficiary in the other person's will;
   (d) designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
   (e) joint ownership of a motor vehicle;

(2) Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;

(3) Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;

(4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;

(5) Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older and not of the same sex may establish a domestic partnership if they meet the requirements set forth in this section;

(6) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;

(7) Both persons are at least 18 years of age;

(8) Both persons file jointly an Affidavit of Domestic Partnership; and

(9) Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and, in all cases in which a person registered a prior domestic partnership, the domestic partnership shall have been terminated in accordance with the provisions of section 10 of P.L. 2003, c. 246 (C. 26:8A-10).

DPRIDER02 V5

Cigna.

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.

FDRL1 V2

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with Cigna HealthCare or Cigna Dental Health.

FDRL79

Qualified Medical Child Support Order (QMCSO)

A. 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.

B. 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:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. 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;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. 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.

C. 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.

FDRL2 V1

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 enroll for or change coverage within 30 days of the date you meet the criteria shown in the following Sections B through F.

B. Change of Status

A change in status is defined as:

1. change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
2. change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
3. 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;
4. changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
5. change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
6. 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: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

FDRL70

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance 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.

The provisions in the "Exception for Newborns" section of this document 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.

FDRL6

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.

FDRL75

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

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) 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:

A. 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.

B. 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 or the requirements of any Pre-existing Condition limitation 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.

FDRL74

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.

A. 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.

B. 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 (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) 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 Pre-Existing Condition Limitation (PCL) or 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.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

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.

FDRL58

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 Basic Benefits 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, same sex spouses, 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.

FDRL85

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:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. 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.

FDRL21

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: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

FDRL22 V1

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:
  (a) 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;
  (b) 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
  (c) 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.

FDRL23

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.

FDRL24 V2

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;
- Your child ceases to qualify as a Dependent under the Plan; or
- 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.

FDRL25 V1

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

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.

FDRL87

City of Fort Lauderdale City Employee (Non-Firefighter/IAFF) PPO Dental Plan

CIGNA DENTAL PREFERRED PROVIDER INSURANCE

City Plan

EFFECTIVE DATE: January 1, 2022

CN023

3335139

This document printed in March, 2022 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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: City of Fort Lauderdale

GROUP POLICY(S) — COVERAGE
3335139 - DPPOC, DPPCC, DPPCF, DPPCS CIGNA DENTAL PREFERRED PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2022

THE BENEFITS IN THIS CERTIFICATE CONTAIN A DEDUCTIBLE PROVISION

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.

Jill Stadelman

Jill Stadelman, Corporate Secretary

HC-CER8 04-10
V1

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.

Cigna.

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 شمارهگیری کنید).

HC-NOT97 07-17

How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network 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 or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

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

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied if it was not reasonably possible to give proof in the time required. Cigna will not reduce or deny the claim for this reason if the proof is submitted as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

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.

HC-CLM13 04-10
V1

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

The first day of the month following 30 days from date of hire.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form (if required), 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 - Employee

You are a Late Entrant if:

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

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), 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.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

Newborn Children

Coverage for newborn children of an insured employee or the employee's covered family member begins from the moment of birth.

Coverage for a newborn child of a covered family member terminates when the child is 18 months old.

If notice of birth is given to the company within 30 days there is no premium charge for the initial 30 day period. If timely notice is not given, the insurer may charge additional premium from the time of birth.

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

This policy covers newborn children for the necessary dental care or dental treatment of congenital defects or birth abnormalities of the teeth or gums.

Foster Children, Adoptive Children and Children in Custodial Care

Benefits applicable to children of the insured employee also apply to adoptive children, foster children and children in custodial care. Coverage begins from birth or from the moment of placement in the home. Except in the case of foster children, coverage may not exclude any preexisting condition of the child.

In the case of a newborn adoptive child, coverage begins from the moment of birth if there is a written agreement to adopt the child, whether or not the agreement is enforceable.

Coverage does not extend to an adoptive child who is not ultimately placed in the home of the insured employee.

If notice of the birth or placement of an adopted child is given to the company within 30 days there is no premium charge for the initial 30 day period. If timely notice is not given, the insurer may charge additional premium from the time of birth or placement.

If notice is given within 60 days of the birth or placement of an adopted child, the insurer may not deny coverage for the child due to the failure of the insured to timely notify the insurer of the birth or placement of the child.

If any family member of the insured employee is covered as a dependent, then benefits applicable to children are covered with respect to foster child or other child in court-ordered temporary custody or other custody of the insured employee.

HC-ELG16 04-10
V1

Late Entrant Limit

Coverage for late entrants:

- Class I and Class II services are paid at the amounts set forth in The Schedule.
- All other classes of service are paid at 50% of the amounts set forth in The Schedule.
- After a person has been continuously insured for 12 months, this limit no longer applies.

HC-LEL1 04-10
V2

Important Information about Your Dental Plan

When you elected Dental Insurance for yourself and your Dependents, you elected one of the two options offered:

- **Cigna Dental Care; or**
- **Cigna Dental Preferred Provider**

Details of the benefits under each of the options are described in separate certificates/booklets.

When electing an option initially or when changing options as described below, the following rules apply:

- **You and your Dependents may enroll for only one of the options, not for both options.**
- **Your Dependents will be insured only if you are insured and only for the same option.**

Change in Option Elected

If your plan is subject to Section 125 (an IRS regulation), you are allowed to change options only at Open Enrollment or when you experience a "Life Status Change."

If your plan is not subject to Section 125 you are allowed to change options at any time.

Consult your plan administrator for the rules that govern your plan.

Effective Date of Change

If you change options during open enrollment, you (and your Dependents) will become insured on the effective date of the plan. If you change options other than at open enrollment (as allowed by your plan), you will become insured on the first day of the month after the transfer is processed.

HC-IMP2 04-10
HC-IMP74 V1

Cigna.

Cigna Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes two options. When you select a Participating Provider, this plan pays a greater share of the cost than if you were to select a non-Participating Provider.

Emergency Services

The Benefit Percentage for Emergency Services incurred for 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.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Cigna. 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

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

Simultaneous Accumulation of Amounts

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.

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.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III, IX Combined Calendar Year Maximum	$1,500	
Class IV Lifetime Maximum	$2,500	$2,500

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BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Calendar Year Deductible		
Individual	Not Applicable	$100 per person Not Applicable to Class I
Family Maximum	Not Applicable	$300 per family Not Applicable to Class I
Class I		
Preventive Care	100%	100%
Class II		
Basic Restorative	100%	60% after plan deductible
Class III		
Major Restorative	60%	60% after plan deductible
Class IV		
Orthodontia	60%	60%
Class IX		
Implants	60%	60% after plan deductible

Missing Teeth Limitation

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

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

HC-MTL7 04-10
V2

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule 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;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

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, 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, Cigna recommends 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 Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

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

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

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

HC-DEN1 04-10
V1

Dental PPO – Participating and Non-Participating Providers

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 Reimbursable 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.

HC-DEN179 07-14
V1

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any 3 calendar years.

HC-DEN3 04-10
V5

Class II Services – Basic Restorations, Periodontics, Endodontics, Oral Surgery

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

- Removal of Impacted Tooth, Soft Tissue
- Removal of Impacted Tooth, Partially Bony
- Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I.V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN163 04-10
V1

Class III Services - Major Restorations, Dentures and Bridgework, Prosthodontic Maintenance

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

- Porcelain Fused to High Noble Metal
- Full Cast, High Noble Metal
- Three-Fourths Cast, Metallic

Removable Appliances

- Complete (Full) Dentures, Upper or Lower
- Partial Dentures
- Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
- Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

- Bridge Pontics - Cast High Noble Metal
- Bridge Pontics - Porcelain Fused to High Noble Metal
- Bridge Pontics - Resin with High Noble Metal
- Retainer Crowns - Resin with High Noble Metal
- Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

HC-DEN172 07-14
V1

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the Schedule.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

HC-DEN6 04-10
V3

Class IX Services – Implants

Covered Dental Expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.

Implant coverage may have a separate deductible amount, yearly maximum and/or lifetime maximum as shown in The Schedule.

HC-DEN8 04-10
V1

Expenses Not Covered

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

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- services for which benefits are not payable according to the "General Limitations" section.

HC-DEX5 04-10
V1

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General Limitations

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for services related to an Injury or Sickness paid and/or received under workers' compensation, occupational disease or similar laws;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

HC-DEX5 04-10
V2

Coordination of Benefits

This section applies if you or any one of your Dependents is 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.

Definitions

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

Plan

Any of the following that provides benefits or services for medical or dental care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

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.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

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.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a 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.
- 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.
- 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.
- 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 preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

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.

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.

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:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan.
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee.
- If you are the Dependent of divorced or separated parents, 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;
  - 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 parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's 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.
- 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 active employee or retiree (or as that employee's 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.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

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. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

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

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

Cigna 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

Cigna, 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.

HC-COB6 04-10
V1

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent; (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Right Of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

Lien Of The Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. 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 the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof

including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical 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 Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

HC-SUB2 04-10
V1

Payment of Benefits

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 Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna 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, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna 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.

HC-POB4 04-10
V1

Miscellaneous

As a Cigna Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at www.cigna.com for details.

If you are a Cigna Dental plan member you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

HC-POB5 04-10
V1

Termination of Insurance

Employees

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.
- the last day of the calendar month in which your Active Service ends except as described below.

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.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels your insurance.

Dependents

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

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM3 04-10
V1

Continuation

Special Continuation of Dental Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: the Florida National Guard; or the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance. In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare;
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

Reinstatement of Dental Insurance Employees and Dependents

Upon completion of your active military duty in: the Florida National Guard; or the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: any new waiting periods; or the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and
- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

HC-TRM29 04-10
V1

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease, for any reason other than the person’s failure to pay premiums, will be deemed to be incurred while he is insured if:

- the course of treatment was recommended in writing by the physician and began while the person was insured for dental benefits; and
- the Dental Service is other than a routine examination, prophylaxis, x-ray, sealants or orthodontic services;
- for Orthodontic Services, the treatment commenced while the person was insured and the expenses are incurred within 60 days after his insurance ceases;
- and the Dental Service is performed within 90 days after his insurance ceases.

The terms of this Dental Benefits Extension will not apply to a person who becomes insured under another group policy for similar dental benefits.

HC-BEX23 04-10
V1

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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.

The provisions in the "Newborn Children" section of this document 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.

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.

HC-FED18 10-10

Claim Determination Procedures

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.

HC-FED83 03-13

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.

HC-FED66 07-14

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.

HC-SPP4 04-10
V1

The Following Will Apply To Residents Of Florida

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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

Start with Member Services

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

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level One Appeal

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

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

Level Two Appeal

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

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

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

working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Florida

You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

The Statewide Provider and Subscriber Assistance Panel
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456 or 850-921-5458

The Agency for Health Care Administration
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456

The Department of Insurance
State Treasurer's Office
State Capitol, Plaza Level Eleven
Tallahassee, FL 32308
1-800-342-2762

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; 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); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

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 Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

HC-APL48 4-10
V1

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.

HC-DFS1 04-10
V1

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

HC-DFS122 04-10
V1

Contracted Fee

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

HC-DFS123 04-10
V1

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.

HC-DFS125 04-10
V3

Dependent

Dependents are:

- 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 mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

- a stepchild or a child for whom you are the legal guardian;
- a child born to an insured Dependent child of yours until such child is 18 months old.

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 year 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.

HC-DFS218 04-10
V2

Domestic Partner

A Domestic Partner is defined as 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 Cigna 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 Cigna 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.

HC-DFS47 04-10
V1

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7 04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge (MRC) for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- the policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna and updated annually. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national data may be used. If sufficient data is unavailable in the database, then data in the database for similar services may be used.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS1421 01-21

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.

HC-DFS16 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

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 Cigna 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.

HC-DFS136 04-10
V1

City of Fort Lauderdale Firefighter (IAFF) PPO Dental Plan

CIGNA DENTAL PREFERRED
PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2022

CN024
3335139

This document printed in March, 2022 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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: City of Fort Lauderdale

GROUP POLICY(S) — COVERAGE
3335139 - DPPOF, DPPFC, DPPFF, DPPFS CIGNA DENTAL PREFERRED PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2022

THE BENEFITS IN THIS CERTIFICATE CONTAIN A DEDUCTIBLE PROVISION

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.

Jill Stadelman

Jill Stadelman, Corporate Secretary

HC-CER8 04-10
V1

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.

Cigna.

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 شمارهگیری کنید).

HC-NOT97 07-17

How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network 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 or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

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

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied if it was not reasonably possible to give proof in the time required. Cigna will not reduce or deny the claim for this reason if the proof is submitted as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

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.

HC-CLM13 04-10
V1

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

The first day of the month following 30 days from date of hire.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form (if required), 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 - Employee

You are a Late Entrant if:

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

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), 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.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

Newborn Children

Coverage for newborn children of an insured employee or the employee's covered family member begins from the moment of birth.

Coverage for a newborn child of a covered family member terminates when the child is 18 months old.

If notice of birth is given to the company within 30 days there is no premium charge for the initial 30 day period. If timely notice is not given, the insurer may charge additional premium from the time of birth.

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

This policy covers newborn children for the necessary dental care or dental treatment of congenital defects or birth abnormalities of the teeth or gums.

Foster Children, Adoptive Children and Children in Custodial Care

Benefits applicable to children of the insured employee also apply to adoptive children, foster children and children in custodial care. Coverage begins from birth or from the moment of placement in the home. Except in the case of foster children, coverage may not exclude any preexisting condition of the child.

In the case of a newborn adoptive child, coverage begins from the moment of birth if there is a written agreement to adopt the child, whether or not the agreement is enforceable.

Coverage does not extend to an adoptive child who is not ultimately placed in the home of the insured employee.

If notice of the birth or placement of an adopted child is given to the company within 30 days there is no premium charge for the initial 30 day period. If timely notice is not given, the insurer may charge additional premium from the time of birth or placement.

If notice is given within 60 days of the birth or placement of an adopted child, the insurer may not deny coverage for the child due to the failure of the insured to timely notify the insurer of the birth or placement of the child.

If any family member of the insured employee is covered as a dependent, then benefits applicable to children are covered with respect to foster child or other child in court-ordered temporary custody or other custody of the insured employee.

HC-ELG16 04-10
V1

Late Entrant Limit

Coverage for late entrants:

- Class I and Class II services are paid at the amounts set forth in The Schedule.
- All other classes of service are paid at 50% of the amounts set forth in The Schedule.
- After a person has been continuously insured for 12 months, this limit no longer applies.

HC-LEL1 04-10
V2

Important Information about Your Dental Plan

When you elected Dental Insurance for yourself and your Dependents, you elected one of the two options offered:

- **Cigna Dental Care; or**
- **Cigna Dental Preferred Provider**

Details of the benefits under each of the options are described in separate certificates/booklets.

When electing an option initially or when changing options as described below, the following rules apply:

- **You and your Dependents may enroll for only one of the options, not for both options.**
- **Your Dependents will be insured only if you are insured and only for the same option.**

Change in Option Elected

If your plan is subject to Section 125 (an IRS regulation), you are allowed to change options only at Open Enrollment or when you experience a "Life Status Change."

If your plan is not subject to Section 125 you are allowed to change options at any time.

Consult your plan administrator for the rules that govern your plan.

Effective Date of Change

If you change options during open enrollment, you (and your Dependents) will become insured on the effective date of the plan. If you change options other than at open enrollment (as allowed by your plan), you will become insured on the first day of the month after the transfer is processed.

HC-IMP2 04-10
HC-IMP74 V1

Cigna.

Cigna Dental Preferred Provider Insurance

The Schedule

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.

Emergency Services

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.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Cigna. 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

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

Simultaneous Accumulation of Amounts

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.

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.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III Combined Calendar Year Maximum	$1,500	
Class IV Lifetime Maximum	$1,500	$1,500

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Calendar Year Deductible		
Individual	$100 per person Not Applicable to Class I	
Family Maximum	Not Applicable	
Class I		
Preventive Care	100%	100%
Class II		
Basic Restorative	80% after plan deductible	80% after plan deductible
Class III		
Major Restorative	50% after plan deductible	50% after plan deductible
Class IV		
Orthodontia	50%	50%

Missing Teeth Limitation

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

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

HC-MTL7 04-10
V2

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule 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;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

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, 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, Cigna recommends 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 Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

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

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

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

HC-DEN1 04-10
V1

Dental PPO – Participating and Non-Participating Providers

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 Reimbursable 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.

HC-DEN179 07-14
V1

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any 3 calendar years.

HC-DEN3 04-10
V5

Class II Services – Basic Restorations, Periodontics, Endodontics, Oral Surgery

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

- Removal of Impacted Tooth, Soft Tissue
- Removal of Impacted Tooth, Partially Bony
- Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I.V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN163 04-10
V1

Class III Services - Major Restorations, Dentures and Bridgework, Prosthodontic Maintenance

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

- Porcelain Fused to High Noble Metal
- Full Cast, High Noble Metal
- Three-Fourths Cast, Metallic

Removable Appliances

- Complete (Full) Dentures, Upper or Lower
- Partial Dentures
- Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
- Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

- Bridge Pontics - Cast High Noble Metal
- Bridge Pontics - Porcelain Fused to High Noble Metal
- Bridge Pontics - Resin with High Noble Metal
- Retainer Crowns - Resin with High Noble Metal
- Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

HC-DEN172 07-14
V1

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the Schedule.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

HC-DEN6 04-10
V3

Expenses Not Covered

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

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- services for which benefits are not payable according to the "General Limitations" section.

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Cigna.

General Limitations

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for services related to an Injury or Sickness paid and/or received under workers' compensation, occupational disease or similar laws;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

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Coordination of Benefits

This section applies if you or any one of your Dependents is 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.

Definitions

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

Plan

Any of the following that provides benefits or services for medical or dental care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

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.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

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.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a 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.
- 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.
- 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.
- 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 preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

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.

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.

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:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan.
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee.
- If you are the Dependent of divorced or separated parents, 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;
  - 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 parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's 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.
- 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 active employee or retiree (or as that employee's 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.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

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. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

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

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

Cigna 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

Cigna, 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.

HC-COB6 04-10
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Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent; (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Right Of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

Lien Of The Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. 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 the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof

including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical 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 Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

HC-SUB2 04-10
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Payment of Benefits

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 Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna 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, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna 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.

HC-POB4 04-10
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Miscellaneous

As a Cigna Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at www.cigna.com for details.

If you are a Cigna Dental plan member you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

HC-POB5 04-10
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Termination of Insurance

Employees

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.
- the last day of the calendar month in which your Active Service ends except as described below.

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.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels your insurance.

Dependents

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

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM3 04-10
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Continuation

Special Continuation of Dental Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: the Florida National Guard; or the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance. In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare;
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

Reinstatement of Dental Insurance Employees and Dependents

Upon completion of your active military duty in: the Florida National Guard; or the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: any new waiting periods; or the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and
- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

HC-TRM29 04-10
V1

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease, for any reason other than the person’s failure to pay premiums, will be deemed to be incurred while he is insured if:

- the course of treatment was recommended in writing by the physician and began while the person was insured for dental benefits; and
- the Dental Service is other than a routine examination, prophylaxis, x-ray, sealants or orthodontic services;
- for Orthodontic Services, the treatment commenced while the person was insured and the expenses are incurred within 60 days after his insurance ceases;
- and the Dental Service is performed within 90 days after his insurance ceases.

The terms of this Dental Benefits Extension will not apply to a person who becomes insured under another group policy for similar dental benefits.

HC-BEX23 04-10
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Cigna.

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.

The provisions in the "Newborn Children" section of this document 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.

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.

HC-FED18 10-10

Claim Determination Procedures

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.

HC-FED83 03-13

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.

HC-FED66 07-14

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.

HC-SPP4 04-10
V1

The Following Will Apply To Residents Of Florida

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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

Start with Member Services

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

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level One Appeal

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

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

Level Two Appeal

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

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

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

working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Florida

You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

The Statewide Provider and Subscriber Assistance Panel
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456 or 850-921-5458

The Agency for Health Care Administration
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456

The Department of Insurance
State Treasurer's Office
State Capitol, Plaza Level Eleven
Tallahassee, FL 32308
1-800-342-2762

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; 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); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

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 Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

HC-APL48 4-10
V1

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.

HC-DFS1 04-10
V1

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

HC-DFS122 04-10
V1

Contracted Fee

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

HC-DFS123 04-10
V1

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.

HC-DFS125 04-10
V3

Dependent

Dependents are:

- 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 mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

- a stepchild or a child for whom you are the legal guardian;
- a child born to an insured Dependent child of yours until such child is 18 months old.

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 year 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.

HC-DFS218 04-10
V2

Domestic Partner

A Domestic Partner is defined as 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 Cigna 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 Cigna 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.

HC-DFS47 04-10
V1

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7 04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge (MRC) for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- the policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna and updated annually. If sufficient data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national data may be used. If sufficient data is unavailable in the database, then data in the database for similar services may be used.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS1421 01-21

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.

HC-DFS16 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

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 Cigna 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.

HC-DFS136 04-10
V1

Proposal Questionnaire

Responses to the following questions are to be included in your proposal and also in an electronic format (CD) as a Word document.

General

1. Where are your company's claims and customer service offices located that will be servicing this account? Are there any plans to locate those member call centers out of the country? If so, please elaborate.
2. Is your company willing to provide a dedicated toll free number (and dedicated staff) for servicing this account?
3. Is your company capable of providing the following reports on a monthly basis? If not, please provide a description of reports the company is capable of providing and their frequency. Please list the reports you are not able to provide in the deviation section of your proposal.

   DPPO Plans

   Monthly paid claims separated by plan option, by network, non-network, byemployee, by dependent
   Quarterly Utilization reports by category of services and CDT code
   Monthly Paid Claims and Premium by Plan (by Firefighters & All other groups)
   Quarterly Summary Reports of customer service calls providing the number of calls and categorizing the reasons for the calls such as benefit inquiries, claim issues, provider issues, network assistance.

   DHMO Plans

   Monthly total revenue and expenses including capitation, fee for service and administration.
   Number of encounters by CDT code and description, by month Denied claim report indicating the reasons for denial
   Quarterly Utilization reports by category of services
   Quarterly Summary Reports of customer service calls for the City providing the number of calls and categorizing the reasons for the calls such as benefit inquiries, claim issues, provider issues, network assistance.
4. Please provide your website address and a description of the services and capabilities for employers and members available at that site.
5. How often is your online directory of providers updated for terminations and additions?
6. Does your company have the ability to take automatic weekly eligibility updates from the City's payroll system, Cyborg, and/or Cigna Guided Solutions?
7. Are the DPPO and DHMO plans both serviced through the same toll-free numberand website?
8. Is your organization currently in compliance with Florida Department of FinancialServices statutes and requirements? If no, describe why not.
9. Is member satisfaction information linked to provider compensation? If so, how?
10. How many verbal and written complaints were received per 1,000 members during 2021 and 2022?
11. Are claim forms ever required for patients? If so, under what circumstances?
12. What percentage of your primary care providers are capitated? Specialty providers?

13. What percentage of orthodontists, maxillofacial surgeons, endodontists, and periodontists have certification in their specialty from an accredited program?
14. What process is in place for members to nominate dentists to the DHMO and/or DPPO network? Include the estimated timeframe in which the process will be completed.

DHMO

1. What is the current average waiting time for setting appointments for

	Broward	Miami-Dade	Palm Beach	Monroe
General Dentists	_____	_____	_____	_____
Specialists	_____	_____	_____	_____

2. Does your proposed DHMO plan require the member to select a general dentist andwhat are the requirements for changing DHMO dentists?
3. Can each family member select his or her own dentist when using the DHMO?
4. How often are members permitted to change their selection of a dentist?
5. Does your plan require a referral to a specialist dentist? If yes, please explain the process and turn-around time for the referral.
6. Please provide a description of the process and estimated timeline to add DPPO Dentists and DPPO dentists to your network.
7. Does your plan include a copay for each dentist office visit in addition to the copayfor each defined service provided?
8. Please describe any plans for future DHMO network growth in Broward, Miami-Dade, Palm Beach and Martin Counties. Be specific and include number and type of dentists targeted by county. If no growth is planned, please say so.
9. What is the maximum number of members that may be assigned to a specific dentistbefore a practice is closed to new members? Include a description of how often this is measured and if the calculation includes other DHMO plan members.
10. How many participating general dentists in Broward, Miami-Dade, Palm Beach and Martin Counties left your DHMO network in 2021? How many were added in 2021?
11. How many participating specialist dentists in Broward, Miami-Dade, Palm Beach andMartin Counties left your DHMO network in 2021? How many were added in 2021?
12. Please describe your credentialing criteria and process for DHMO providers.
13. How many general dentists are not accepting new patients? Please provide this information separately for Broward, Miami-Dade, Palm Beach Counties and Monroe counties.

    Broward _____ Palm Beach _____ Martin _____

    Miami-Dade _____
14. What is the 2016 turnover percentage for your DHMO network of general dentists?
15. What is the process for a newly-added DHMO member to receive services if he doesnot yet appear in the provider's eligibility file?
16. How are emergency dental services provided and/or reimbursed for

members whomay be out of area at time of service?
17. Provide a description of benefits available for TMJ. Include details regarding anyrequired authorization processes.
18. Does your proposed DHMO plan include coverage for implants? If yes, please explain the coverage.
19. Does your proposed DHMO plan include coverage for resin-based composite fillingson posterior teeth? If so, please specify any price differences in filling materials.
20. What benefits, if any, are included for the detection of oral cancer?
21. For services that are limited to a certain number of occurrences within a plan year, such as prophylaxis, periodontal maintenance, bitewings and periodic exams, pleasespecify how the frequency is monitored (i.e. days, months, etc.). What limitations and guidelines does your company use to determine when a member is eligible for subsequent occurrences?

DPPO

1. Are members required to select a dentist when enrolled in the PPO?
2. What is the average turn around for a clean non-network claim submission?
3. Please describe the credentialing criteria for PPO dentists.
4. Are non-network claims paid subject to usual, customary and reasonable allowancesor a schedule of allowances?
5. Describe your company's method of determining usual, customary and reasonablecharges.
6. What database does your company use for reasonable and customary profiles?How often is it updated?
7. What percentile is typically used for dental R&C? What are the options?
8. Can your system allow certain tolerance ranges to be applied to reasonable andcustomary limits? Describe.
9. Are participating dentist offices required to file claims on behalf of their members aspart of the provider contract?
10. Do your proposed DPPO plans include coverage for resin-based composite fillingson posterior teeth? If so, please specify any price differences in filling materials.
11. What benefits, if any, are included for the detection of oral cancer?
12. For services that are limited to a certain number of occurrences within a plan year, such as prophylaxis, periodontal maintenance, bitewings and periodic exams, pleasespecify how the frequency is monitored (i.e. days, months, etc.). What limitations and guidelines does your company use to determine when a member is eligible forsubsequent occurrences?

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
	Specialist Services					
	Are charges for noble & high noble metal included in listed copays?					
	Are lab charges included in listed copays?					
	Charge for cases involving more than 6 crowns, implants and/or fixed bridge units					
	Office Visit Copay in addition to copay for specific service					
Diagnostic						
Clinical Oral Evaluations						
D0120	Periodic Oral Evaluation					
D0140	Limited Oral Evaluation					
D0145	Oral Evaluation for a Patient Under 3 Years of Age					
D0150	Comprehensive Oral Evaluation					
D0160	Detailed and Extensive Oral Evaluation					
D0170	Re-evaluation - Limited, Problem Focused					
D0180	Comprehensive Periodontal Evaluation					
Pre-diagnostic Services						
D0190	Screening of a patient					
D0191	Assessment of a patient					
Radiographs/Diagnostic Imaging (Including Interpretation)						
D0210	Intraoral - Complete Series (Including Bitewings)					
D0220	Intraoral - Periapical, First Film					
D0230	Intraoral - Periapical, Each Additional Film					
D0240	Intraoral - Occlusal Film					
D0250	Extraoral - First Film					
D0260	Extraoral - Each Additional Film					
D0270	Bitewing - Single Film					
D0272	Bitewings - Two Films					
D0273	Bitewings - Three Films					
D0274	Bitewings - Four Films					
D0277	Vertical Bitewings - 7 to 8 Films					
D0290	Posterior-Anterior or Lateral Skull and Facial Bone Survey Film					
D0310	Sialography					
D0320	Temporomandibular Joint Arthrogram					
D0321	Other Temporomandibular Joint Films, By Report					
D0322	Tomographic Survey					
D0330	Panoramic Film					
D0340	Cephalometric Film					
D0350	Oral/Facial Photographic Images					
D0360	Cone Beam CT					
D0362	Cone Beam - Two-Dimensional Image Reconstruction					
D0363	Cone Beam - Three-Dimensional Image Reconstruction					
D0364	Cone Beam CT capture and interpretation with limited field of view					
D0365	Cone Beam CT capture and interpretation with field of view of one full dental arch-mandible					
D0366	Cone Beam CT capture and interpretation with field of view of one full dental arch-maxilla, with or without cranium					
D0367	Cone Beam CT capture and interpretation with field of view of both jaws with or withour cranium					
D0368	Cone Beam CT capture and interpretation for TMJ series					
D0369	Maxillofacial MRI capture and interpretation					
D0370	Maxillofacial ultrasound capture and interpretation					
D0371	Sialoendoscopy capture and interpretation					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
Image Capture Only						
D0380	Cone Beam CT image capture with limited field of view-less than one whole jaw					
D0381	Cone Beam CT image capture with field of view of one full dental arch-mandible					
D0382	Cone Beam CT image capture with field of view of one full dental arch- maxilla, with or without cranium					
D0384	Cone Beam image capture for TMJ series including two or more exposures					
D0385	Maxillofacial MRI image capture					
D0386	Maxillofacial ultrasound image capture					
Image Capture Only						
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report					
Tests and Examinations						
D0415	Collection of Microorganisms for Culture and Sensitivity					
D0416	Viral Culture					
D0417	Collection and Preparation of Saliva Sample for Laboratory Diagnostic Testing					
D0418	Analysis of Saliva Sample					
D0421	Genetic Test for Susceptibility to Oral Diseases					
D0425	Caries Susceptibility Tests					
D0431	Adjunctive Pre-diagnostic Test, Not to Include Cytology or Biopsy Procedures					
D0460	Pulp Vitality Tests					
D0470	Diagnostic Casts					
Oral Pathology Laboratory						
D0472	Accession of Tissue, Gross Examination, Preparation and Transmission of Written Report					
D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report					
D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical margins for presence of Disease, Preparation and Transmission of Written Report					
D0480	Accession of Exfoliative Cytologic Smears, Microscopic Examination, Preparation and Transmission of Written Report					
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report					
D0475	Decalcification Procedure					
D0476	Special Stains for Microorganisms					
D0477	Special Stains, not for Microorganisms					
D0478	Immunohistochemical Stains					
D0479	Tissue In-Situ Hybridization, Including Interpretation					
D0481	Electron Microscopy - Diagnostic					
D0482	Direct Immunofluorescence					
D0483	Indirect Immunofluorescence					
D0484	Consultation on Slides Prepared Elsewhere					
D0485	Consultation, Including Preparation of Slides From Biopsy Material Supplied By Referring Source					
D0502	Other Oral Pathology Procedures, By Report					
D0999	Unspecified Diagnostic Procedure, By Report					
Preventive						

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
Dental Prophylaxis						
D1110	Prophylaxis - Adult					
	(Additional Cleaning, In Addition to the One Allowed Every 6 Months)					
D1120	Prophylaxis - Child					
	(Additional Cleaning, In Addition to the One Allowed Every 6 Months)					
Topical Fluoride Treatment (Office Procedure)						
D1203	Topical Application of Fluoride - Child					
D1204	Topical Application of Fluoride - Adult					
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients					
D1208	Topical application of fluoride					
Other Preventive Services						
D1310	Nutritional Counseling for Control of Dental Disease					
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease					
D1330	Oral Hygiene Instructions					
D1351	Sealant - Per Tooth					
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth					
Space Maintenance (Passive Appliances)						
D1510	Space Maintainer - Fixed - Unilateral					
D1515	Space Maintainer - Fixed - Bilateral					
D1520	Space Maintainer - Removable - Unilateral					
D1525	Space Maintainer - Removable - Bilateral					
D1550	Re-cementation of Space Maintainer					
D1555	Removal of Fixed Space Maintainer					
Restorative						
Amalgam Restorations (Including Polishing)						
D2140	Amalgam - One Surface, Primary or Permanent					
D2150	Amalgam - Two Surfaces, Primary or Permanent					
D2160	Amalgam - Three Surfaces, Primary or Permanent					
D2161	Amalgam - Four or More Surfaces, Primary or Permanent					
Resin-Based Composite Restorations - Direct						
D2330	Resin-Based Composite - One Surface, Anterior					
D2331	Resin-Based Composite - Two Surfaces, Anterior					
D2332	Resin-Based Composite - Three Surfaces, Anterior					
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)					
D2390	Resin-Based Composite Crown, Anterior					
D2391	Resin-Based Composite - One Surface, Posterior					
D2392	Resin-Based Composite - Two Surfaces, Posterior					
D2393	Resin-Based Composite - Three Surfaces, Posterior					
D2394	Resin-Based Composite - Four or More Surfaces, Posterior					
Gold Foil Restorations						
D2410	Gold Foil - One Surface					
D2420	Gold Foil - Two Surfaces					
D2430	Gold Foil - Three Surfaces					
Inlay/Onlay Restorations						
D2510	*Inlay - Metallic - One Surface*					
D2520	*Inlay - Metallic - Two Surfaces*					
D2530	*Inlay - Metallic - Three or More Surfaces*					
D2542	*Onlay - Metallic - Two Surfaces*					
D2543	*Onlay - Metallic - Three Surfaces*					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D2544	*Onlay - Metallic - Four or More Surfaces*					
D2610	*Inlay - Porcelain/Ceramic - One Surface*					
D2620	*Inlay - Porcelain/Ceramic - Two Surfaces*					
D2630	*Inlay - Porcelain/Ceramic - Three or More Surfaces*					
D2642	*Onlay - Porcelain/Ceramic - Two Surfaces*					
D2643	*Onlay - Porcelain/Ceramic - Three Surfaces*					
D2644	*Onlay - Porcelain/Ceramic - Four or More Surfaces*					
D2650	*Inlay - Resin-Based Composite - One Surface*					
D2651	*Inlay - Resin-Based Composite - Two Surfaces*					
D2652	*Inlay - Resin-Based Composite - Three or More Surfaces*					
D2662	*Onlay - Resin-Based Composite - Two Surfaces*					
D2663	*Onlay - Resin-Based Composite - Three Surfaces*					
D2664	*Onlay - Resin-Based Composite - Four or More Surfaces*					
Crowns - Single Restorations Only						
D2710	*Crown - Resin-Based Composite (Indirect)*					
D2712	*Crown - 3/4 Resin-Based Composite (Indirect)*					
D2720	*Crown - Resin with High Noble Metal*					
D2721	Crown - Resin with Predominantly Base Metal					
D2722	*Crown - Resin with Noble Metal*					
D2740	*Crown - Porcelain/Ceramic Substrate*					
D2750	*Crown - Porcelain Fused to High Noble Metal*					
D2751	Crown - Porcelain Fused to Predominantly Base Metal					
D2752	*Crown - Porcelain Fused to Noble Metal*					
D2780	*Crown - 3/4 Cast High Noble Metal*					
D2781	Crown - 3/4 Cast Predominantly Base Metal					
D2782	*Crown - 3/4 Cast Noble Metal*					
D2783	Crown - 3/4 Porcelain/Ceramic					
D2790	*Crown - Full Cast High Noble Metal*					
D2791	Crown - Full Cast Predominantly Base Metal					
D2792	*Crown - Full Cast Noble Metal*					
D2794	*Crown - Titanium*					
D2799	Provisional Crown					
Other Restorative Services						
D2910	Recement Inlay, Onlay, or Partial Coverage Restoration					
D2915	Recement Cast or Prefabricated Post and Core					
D2920	Recement Crown					
D2929	Prefabricated porcelain/ceramic crown-primary tooth					
D2930	Prefabricated Stainless Steel Crown - Primary Tooth					
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth					
D2932	Prefabricated Resin Crown					
D2933	Prefabricated Stainless Steel Crown with Resin Window					
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth					
D2940	Protective Restoration					
D2950	Core Buildup, Including Any Pins					
D2951	Pin Retention - Per Tooth, In Addition to Restoration					
D2952	*Post and Core In Addition to Crown, Indirectly Fabricated*					
D2953	*Each Additional Indirectly Fabricated Post - Same Tooth*					
D2954	Prefabricated Post and Core In Addition to Crown					
D2955	Post Removal (Not in Conjunction with Endodontic Therapy)					
D2957	Each Add Prefabricated Post - Same Tooth					
D2960	Labial Veneer (Resin Laminate) - Chairside					
D2961	*Labial Veneer (Resin Laminate) - Laboratory*					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D2962	*Labial veneer (Porcelain Laminate) - Laboratory*					
D2970	Temporary Crown (Fractured Tooth)					
D2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework					
D2975	Coping					
D2980	Crown Repair, By Report					
D2981	Inlay repair necessitated by restorative material failure					
D2982	Onlay repair necessitated by restorative material failure					
D2983	Veneer repair necessitated by restorative material failure					
D2990	Resin infiltration of incipient smooth surface lesions					
D2999	Unspecified Restorative Procedure, By Report					
Endodontics						
Pulp Capping						
D3110	Pulp Cap - Direct (Excluding Final Restoration)					
D3120	Pulp Cap - Indirect (Excluding Final Restoration)					
Pulpotomy						
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) - Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament					
D3221	Pulpal Debridement, Primary and Permanent Teeth					
D3222	Partial Pulpotomy for Apexogenesis - Permanent Tooth with Incomplete Root Development					
Endodontic Therapy on Primary Teeth						
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)					
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)					
Endodontic Therapy						
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)					
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)					
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)					
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access					
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth					
D3333	Internal Root Repair or Perforation Defects					
Endodontic Retreatment						
D3346	Retreatment of Previous Root Canal Therapy - Anterior					
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid					
D3348	Retreatment of Previous Root Canal Therapy - Molar					
Apexification/Recalcification Procedures						
D3351	Apexification/Recalcification - Initial Visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)					
D3352	Apexification/Recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root rsorption, pulp space disinfection, etc.)					
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root Canal Therapy - Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)					
D3354	Pulpal Regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration					
Apicoectomy/Periradicular Services						
D3410	Apicoectomy/Periradicular Surgery - Anterior					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)					
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)					
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)					
D3430	Retrograde Filling - Per Root					
D3450	Root Amputation - Per Root					
D3460	Endodontic Endosseous Implant					
D3470	Intentional Reimplantation (Including Necessary Splinting)					
Other Endodontic Procedures						
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam					
D3920	Hemisection (Including any Root Removal), Not Including Root Canal Therapy					
D3950	Canal Preparation and Fitting of Preformed Dowel or Post					
D3999	Unspecified Endodontic Procedure, By Report					
Periodontics						
Surgical Services (Including Usual Postoperative Care)						
D4210	Gingivectomy of Gingivoplasty - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant					
D4211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant					
D4212	Gingivectomy of Gingivoplasty to allow access for restorative procedure, per tooth					
D4230	Anatomical Crown Exposure - Four or More Teeth Per Quadrant					
D4231	Anatomical Crown Exposure - One to Three Teeth Per Quadrant					
D4240	Gingival Flap Procedure, Including Root Planing - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant					
D4241	Gingival Flap Procedure, Including Root Planing - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant					
D4245	Apically Positioned Flap					
D4249	Clinical Crown Lengthening - Hard Tissue					
D4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant					
D4261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant					
D4263	Bone Replacement Graft - First Site in Quadrant					
D4264	Bone Replacement Graft - Each Additional Site in Quadrant					
D4265	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration					
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site					
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)					
D4268	Surgical Revision Procedure, Per Tooth					
D4270	Pedicle Soft Tissue Graft Procedure					
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)					
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth					
D4274	Distal or Proximal Wedge Procedure (When Not performed in Conjunction With Surgical Procedures in the Same Anatomical Area)					
D4275	Soft Tissue Allograft					
D4276	Combined Connective Tissue and Double Pedicle Graft, Per Tooth					
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft					
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site					
Non-Surgical Periodontal Service						

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D4320	Provisional Splinting, Intracoronal					
D4321	Provisional Splinting, Extracoronal					
D4341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant					
D4342	Periodontal Scaling and Root Planing - One to Three Teeth Per Quadrant					
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis					
D4381	Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth, By Report					
Other Periodontal Services						
D4910	Periodontal Maintenance					
	Additional Periodontal Maintenance					
D4920	Unscheduled Dressing Change (by someone other than treating dentist)					
D4999	Unspecified Periodontal Procedure, By Report					
Prosthodontics (Removable)						
Complete Dentures						
D5110	*Complete Denture - Maxillary*					
D5120	*Complete Denture - Mandibular*					
D5130	*Immediate Denture - Maxillary*					
D5140	*Immediate Denture - Mandibular*					
Partial Dentures (Including Routine Post-delivery Care)						
D5211	*Maxillary Partial Denture - Resin Base (Including any Conventional Clasps, Rests and Teeth)*					
D5212	*Mandibular Partial Denture - Resin Base (Including any Conventional Clasps, Rests and Teeth)*					
D5213	*Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)*					
D5214	*Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)*					
D5225	*Maxillary Partial Denture - Flexible Base (Including any Clasps, Rests and Teeth)*					
D5226	*Mandibular Partial Denture - Flexible Base (Including any Clasps, Rests and Teeth)*					
D5281	*Removable Unilateral Partial Denture - One Piece Cast Metal (Including Clasps and Teeth)*					
Adjustments to Dentures						
D5410	Adjust Complete Denture - Maxillary					
D5411	Adjust Complete Denture - Mandibular					
D5421	Adjust Partial Denture - Maxillary					
D5422	Adjust Partial Denture - Mandibular					
Repairs to Complete Dentures						
D5510	*Repair Broken Complete Denture Base*					
D5520	*Replace Missing or Broken Teeth - Complete Denture (Each Tooth)*					
Repairs to Partial Dentures						
D5610	*Repair Resin Denture Base*					
D5620	*Repair Cast Framework*					
D5630	*Repair or Replace Broken Clasp*					
D5640	*Replace Broken Teeth - Per Tooth*					
D5650	*Add Tooth to Existing Partial Denture*					
D5660	*Add Clasp to Existing Partial Denture*					
D5670	*Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)*					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D5671	*Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)*					
Denture Rebase Procedures						
D5710	*Rebase Complete Maxillary Denture*					
D5711	*Rebase Complete Mandibular Denture*					
D5720	*Rebase Maxillary Partial Denture*					
D5721	*Rebase Mandibular Partial Denture*					
Denture Reline Procedures						
D5730	Reline Complete Maxillary Denture (Chairside)					
D5731	Reline Complete Mandibular Denture (Chairside)					
D5740	Reline Maxillary Partial Denture (Chairside)					
D5741	Reline Mandibular Partial Denture (Chairside)					
D5750	*Reline Complete Maxillary Denture (Laboratory)*					
D5751	*Reline Complete Mandibular Denture (Laboratory)*					
D5760	*Reline Maxillary Partial Denture (Laboratory)*					
D5761	*Reline Mandibular Partial Denture (Laboratory)*					
Interim Prosthesis						
D5810	*Interim Complete Denture (Maxillary)*					
D5811	*Interim Complete Denture (Mandibular)*					
D5820	*Interim Partial Denture (Maxillary)*					
D5821	*Interim Partial Denture (Mandibular)*					
Other Removable Prosthetic Services						
D5850	Tissue Conditioning, Maxillary					
D5851	Tissue Conditioning, Mandibular					
D5860	Overdenture - Complete, By Report					
D5861	Overdenture - Partial, By Report					
D5862	Precision Attachment, By report					
D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)					
D5875	Modification of Removable Prosthesis Following Implant Surgery					
D5899	Unspecified Removable Prosthodontic Procedure, By Report					
Maxillofacial Prosthetics						
D5911	Facial Moulage (Sectional)					
D5912	Facial Moulage (Complete)					
D5913	Nasal Prosthesis					
D5914	Auricular Prosthesis					
D5915	Orbital Prosthesis					
D5916	Ocular Prosthesis					
D5919	Facial Prosthesis					
D5922	Nasal Septal Prosthesis					
D5923	Ocular Prosthesis, Interim					
D5924	Cranial Prosthesis					
D5925	Facial Augmentation Implant Prosthesis					
D5926	Nasal Prosthesis, Replacement					
D5927	Auricular Prosthesis, Replacement					
D5928	Orbital Prosthesis, Replacement					
D5929	Facial Prosthesis, Replacement					
D5931	Obturator Prosthesis, Surgical					
D5932	Obturator Prosthesis, Definitive					
D5933	Obturator Prosthesis, Modification					
D5934	Mandibular Resection Prosthesis with Guide Flange					
D5935	Mandibular Resection Prosthesis without Guide Flange					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D5936	Obturator Prosthesis, Interim					
D5937	Trismus Appliance (Not for TMD Treatment)					
D5951	Feeding Aid					
D5952	Speech Aid Prosthesis, Pediatric					
D5953	Speech Aid Prosthesis, Adult					
D5954	Palatal Augmentation Prosthesis					
D5955	Palatal Lift Prosthesis, Definitive					
D5958	Palatal Lift Prosthesis, Interim					
D5959	Palatal Lift Prosthesis, Modification					
D5960	Speech Aid Prosthesis, Modification					
D5982	Surgical Stent					
D5983	Radiation Carrier					
D5984	Radiation Shield					
D5985	Radiation Cone Locator					
D5986	Fluoride Gel Carrier					
D5987	Commissure Splint					
D5988	Surgical Splint					
D5991	Topical Medicament Carrier					
D5992	Adjust maxillofacial prosthetic appliance, by report					
D5993	Maintenance and Cleaning of a Maxillofacial Prosthesis (Extra or Intraoral) Other Than Required Adjustments, By Report					
D5999	Unspecified Maxillofacial Prosthesis, By Report					
Implant Services						
Pre-Surgical Services						
D6190	Radiographic/surgical Implant Index, By Report					
Surgical Services						
D6010	Surgical Placement of Implant Body: Endosteal Implant					
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant					
D6040	Surgical Placement: Eposteal Implant					
D6050	Surgical Placement: Transosteal Implant					
D6100	Implant Removal, By Report					
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure					
D6102	Ddebridement of osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure					
D6103	Bone graft for repair of periimplant defect-not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration					
D6104	Bone graft at time of implant placement					
Implant Supported Prosthetics						
Supporting Structures						
D6051	Interim abutment					
D6055	Connecting Bar - Implant Supported or Abutment Supported					
D6056	Prefabricated Abutment - Includes Placement					
D6057	Custom Abutment - Includes Placement					
Implant/Abutment Supported Removable Dentures						
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch					
D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch					
Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)						

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D6078	Implant/Abutment Supported Fixed Denture for Completely Edentulous Arch					
D6079	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch					
Single Crowns, Abutment Supported						
D6058	*Abutment Supported Porcelain/Ceramic Crown*					
D6059	*Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)*					
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)					
D6061	*Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)*					
D6062	*Abutment Supported Cast Metal Crown (High Noble Metal)*					
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)					
D6064	*Abutment Supported Cast Metal Crown (Noble Metal)*					
D6094	*Abutment Supported Crown - (Titanium)*					
Single Crowns, Implant Supported						
D6065	*Implant Supported Porcelain/Ceramic Crown*					
D6066	*Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, or High Noble Metal)*					
D6067	*Implant Supported Metal Crown (Titanium, Titanium Alloy, or High Noble Metal)*					
Fixed Partial Denture, Abutment Supported						
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD					
D6069	*Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)*					
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)					
D6071	*Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)*					
D6072	*Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)*					
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)					
D6074	*Abutment Supported Retainer for Cast Metal FPD (Noble Metal)*					
D6194	*Abutment Supported Retainer Crown for FPD- (Titanium)*					
Fixed Partial Denture, Implant Supported						
D6075	Implant Supported Retainer for Ceramic FPD					
D6076	*Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)*					
D6077	*Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)*					
Other Implant Services						
D6080	Implant Maintenance Procedures, Including Removal of Prosthesis, Cleansing of Prosthesis and Abutments and Reinsertion of Prosthesis					
D6090	Repair Implant Supported Prosthesis, By Report					
D6095	Repair Implant Abutment, By Report					
D6091	Replacement of Semi-Precision or Precision Attachment (Male or Female Component) of Implant/Abutment Supported Prosthesis, Per Attachment					
D6092	Recement Implant/Abutment Supported Crown					
D6093	Recement Implant/Abutment Supported Fixed Partial Denture					
D6199	Unspecified Implant Procedure, By Report					
Prosthodontics, Fixed						

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
Fixed Partial Denture Pontics						
D6205	Pontic - Indirect Resin Based Composite					
D6210	*Pontic - Cast High Noble Metal*					
D6211	Pontic - Cast Predominantly Base Metal					
D6212	*Pontic - Cast Noble Metal*					
D6214	*Pontic - Titanium*					
D6240	*Pontic - Porcelain Fused to High Noble Metal*					
D6241	Pontic - Porcelain Fused to Predominantly Base Metal					
D6242	*Pontic - Porcelain Fused to Noble Metal*					
D6245	*Pontic - Porcelain/Ceramic*					
D6250	*Pontic - Resin with High Noble Metal*					
D6251	Pontic - Resin with Predominantly Base Metal					
D6252	*Pontic - Resin with Noble Metal*					
D6253	*Provisional Pontic*					
D6254	Interim Pontic					
Fixed Partial Denture Retainers - Inlays/Onlays						
D6545	*Retainer - Cast Metal for Resin Bonded Fixed Prosthesis*					
D6548	Retainer - Porcelain/Ceramic for Resin Bonded Fixed Prosthesis					
D6600	*Inlay - Porcelain/Ceramic - Two Surfaces*					
D6601	*Inlay - Porcelain/Ceramic - Three or More Surfaces*					
D6602	*Inlay - Cast High Noble Metal, Two Surfaces*					
D6603	*Inlay - Cast High Noble Metal, Three or More Surfaces*					
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces					
D6605	Inlay - Cast Predominantly Base Metal, Three or More Surfaces					
D6606	*Inlay - Cast Noble Metal, Two Surfaces*					
D6607	*Inlay - Cast Noble Metal, Three or More Surfaces*					
D6624	Inlay - Titanium					
D6608	*Onlay - Porcelain/Ceramic - Two Surfaces*					
D6609	*Onlay - Porcelain/Ceramic - Three or More Surfaces*					
D6610	*Onlay - Cast High Noble Metal, Two Surfaces*					
D6611	*Onlay - Cast High Noble Metal, Three or More Surfaces*					
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces					
D6613	*Onlay - Cast Predominantly Base Metal, Three or More Surfaces*					
D6614	*Onlay - Cast Noble Metal, Two Surfaces*					
D6615	*Onlay - Cast Noble Metal, Three or More Surfaces*					
D6634	Onlay - Titanium					
Fixed Partial Denture Retainers - Crowns						
D6710	*Crown - Indirect Resin Based Composite*					
D6720	*Crown - Resin with High Noble Metal*					
D6721	Crown - Resin with Predominantly Base Metal					
D6722	*Crown - Resin with Noble Metal*					
D6740	*Crown - Porcelain/Ceramic*					
D6750	*Crown - Porcelain Fused to High Noble Metal*					
D6751	Crown - Porcelain Fused to Predominantly Base Metal					
D6752	*Crown - Porcelain Fused to Noble Metal*					
D6780	*Crown - 3/4 Cast High Noble Metal*					
D6781	Crown - 3/4 Cast Predominantly Base Metal					
D6782	*Crown - 3/4 Cast Noble Metal*					
D6783	*Crown - 3/4 Porcelain/Ceramic*					
D6790	*Crown - Full Cast High Noble Metal*					
D6791	Crown - Full Cast Predominantly Base Metal					
D6792	*Crown - Full Cast Noble Metal*					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D6794	*Crown - Titanium*					
D6793	Provisional Retainer Crown					
D6795	Interim Retainer Crown					
Other Fixed Partial Denture Services						
D6920	Connector Bar					
D6930	Recement Fixed Partial Denture					
D6940	Stress Breaker					
D6950	Precision Attachment					
D6970	*Cast Post and Core In Addition to Fixed Partial Denture Retainer, Indirectly Fabricated*					
D6972	Prefabricated Post and Core In Addition to Fixed Partial Denture Retainer					
D6973	Core Buildup for Retainer, Including Any Pins					
D6975	Coping - Metal					
D6976	Each Additional Indirectly Fabricated Post - Same Tooth					
D6977	Each Additional Prefabricated Post - Same Tooth					
D6980	*Fixed Partial Denture Repair By Report*					
D6985	Pediatric Partial Denture, Fixed					
D6999	Unspecified Fixed Prosthodontic Procedure, By Report					
Oral and Maxillofacial Surgery						
Extractions						
D7111	Extraction of Coronal Remnants - Deciduous Tooth					
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)					
Surgical Extractions						
D7210	Surgical Removal of Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated					
D7220	Removal of Impacted Tooth - Soft Tissue					
D7230	Removal of Impacted Tooth - Partially Bony					
D7240	Removal of Impacted Tooth - Completely Bony					
D7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications					
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)					
D7251	Coronectomy - Intentional Partial Tooth Removal					
Other Surgical Procedures						
D7260	Oroantral Fistula Closure					
D7261	Primary Closure of a Sinus Perforation					
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth					
D7272	Tooth Transplantation (Includes Reimplantation from One Site to Another and Splinting and/or Stabilization)					
D7280	Surgical Access of an Unerupted Tooth					
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption					
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth					
D7285	Biopsy of Oral Tissue - Hard (Bone, Tooth)					
D7286	Biopsy of Oral Tissue - Soft					
D7287	Exfoliative Cytological Sample Collection					
D7288	Brush Biopsy - Transepithelial Sample Collection					
D7290	Surgical Repositioning of Teeth					
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D7292	Surgical Placement; Temporary Anchorage Device (Screw Retained Plate) Requiring Surgical Flap					
D7293	Surgical Placement; Temporary Anchorage Device Requiring Surgical Flap					
D7294	Surgical Placement; Temporary Anchorage Device without Surgical Flap					
D7295	Harvest of Bone Fur Use In Autogenous Grafting Procedure					
Alveoloplasty - Surgical Preparation of Ridge for Dentures						
D7310	Alveoloplasty in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant					
D7311	Alveoloplasty in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant					
D7320	Alveoloplasty not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant					
D7321	Alveoloplasty not in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant					
Vestibuloplasty						
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)					
D7350	Vestibuloplasty - Ridge Extension (Including Soft Tissue Grafts, Muscle Reattachment, etc.)					
Surgical Excision of Soft Tissue Lesions						
D7410	Excision of Benign Lesion Up to 1.25 cm					
D7411	Excision of Benign Lesion Greater than 1.25 cm					
D7412	Excision of Benign Lesion, Complicated					
D7413	Excision of Malignant Lesion Up to 1.25 cm					
D7414	Excision of Malignant Lesion Greater than 1.25 cm					
D7415	Excision of Malignant Lesion, Complicated					
D7465	Destruction of Lesion(s) By Physical or Chemical Method, By Report					
Surgical Excision of Intra-Osseous Lesions						
D7440	Excision of Malignant Tumor - Lesion Diameter Up to 1.25 cm					
D7441	Excision of Malignant Tumor - Lesion Diameter Greater than 1.25 cm					
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm					
D7451	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Greater than 1.25 cm					
D7460	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm					
D7461	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter Greater than 1.25 cm					
Excision of Bone Tissue						
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)					
D7472	Removal of Torus Palatinus					
D7473	Removal of Torus Mandibularis					
D7485	Surgical Reduction of Osseous Tuberosity					
D7490	Radical Resection of Maxilla or Mandible					
Surgical Incision						
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue					
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage of Multiple Fascial Spaces)					
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue					
D7521	Incision and Drainage of Abscess - Extraoral Soft Tissue Complicated (Includes Drainage of Multiple Fascial Spaces)					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D7530	Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue					
D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System					
D7550	Partial Ostectomy/Sequestrectomy for Removal of Non-vital Bone					
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body					
Treatment of Fractures - Simple						
D7610	Maxilla - Open Reduction (Teeth Immobilized, if Present)					
D7620	Maxilla - Closed Reduction (Teeth Immobilized, if Present)					
D7630	Mandible - Open Reduction (Teeth Immobilized, if Present)					
D7640	Mandible - Closed Reduction (Teeth Immobilized, if Present)					
D7650	Malar and/or Zygomatic Arch - Open Reduction					
D7660	Malar and/or Zygomatic Arch - Closed Reduction					
D7670	Alveolus - Closed Reduction, May Include Stabilization of Teeth					
D7671	Alveolus - Open Reduction, May Include Stabilization of Teeth					
D7680	Facial Bones - Complicated Reduction with Fixation and Multiple Surgical Approaches					
Treatment of Fractures - Compound						
D7710	Maxilla - Open Reduction					
D7720	Maxilla - Closed Reduction					
D7730	Mandible - Open Reduction					
D7740	Mandible - Closed Reduction					
D7750	Malar and/or Zygomatic Arch - Open Reduction					
D7760	Malar and/or Zygomatic Arch - Closed Reduction					
D7770	Alveolus - Open Reduction Stabilization of Teeth					
D7771	Alveolus - Closed Reduction Stabilization of Teeth					
D7780	Facial Bones - Complicated Reduction with Fixation and Multiple Surgical Approaches					
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions						
D7810	Open Reduction of Dislocation					
D7820	Closed Reduction of Dislocation					
D7830	Manipulation under Anesthesia					
D7840	Condylectomy					
D7850	Surgical Discectomy, with/without Implant					
D7852	Disc Repair					
D7854	Synovectomy					
D7856	Myotomy					
D7858	Joint Reconstruction					
D7860	Arthrotomy					
D7865	Arthroplasty					
D7870	Arthrocentesis					
D7871	Non-arthroscopic Lysis and Lavage					
D7872	Arthroscopy - Diagnosis, with or without Biopsy					
D7873	Arthroscopy - Surgical: Lavage and Lysis of Adhesions					
D7874	Arthroscopy - Surgical: Disc Repositioning and Stabilization					
D7875	Arthroscopy - Surgical: Synovectomy					
D7876	Arthroscopy - Surgical: Discectomy					
D7877	Arthroscopy - Surgical: Debridement					
D7880	Occlusal Orthotic Device, By Report					
D7899	Unspecified TMD Therapy By Report					
Repair of Traumatic Wounds						
D7910	Suture of Recent Small Wounds up to 5 cm					
Complicated Suturing						

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D7911	Complicated Suture - Up to 5 cm					
D7912	Complicated Suture - Greater than 5 cm					
Other Repair Procedures						
D7920	Skin Graft (Identify Defect Covered, Location and Type of Graft)					
D7921	Collection and application of autologous blood concentrate product					
D7940	Osteoplasty - For Orthognathic Deformities					
D7941	Osteotomy - Mandibular Rami					
D7943	Osteotomy - Mandibular Rami with Bone Graft; Includes Obtaining the Graft					
D7944	Osteotomy - Segmented or Subapical					
D7945	Osteotomy - Body of Mandible					
D7946	LeFort I (Maxilla - Total)					
D7947	LeFort I (Maxilla - Segmented)					
D7948	LeFort II or LeFort III - without Bone Graft					
D7949	LeFort II or LeFort III - with Bone Graft					
D7950	Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Maxilla - Autogenous or Nonautogenous, By Report					
D7951	Sinus Augmentation with Bone or Bone Substitutes					
D7952	Sinus augmentation via a vertical approach					
D7953	Bone Replacement Graft for Ridge Preservation - Per Site					
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect					
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate procedure					
D7963	Frenuloplasty					
D7970	Excision of Hyperplastic Tissue -Per Arch					
D7971	Excision of Pericoronal Gingival					
D7972	Surgical Reduction of Fibrous Tuberosity					
D7980	Sialolithotomy					
D7981	Excision of Salivary Gland, By Report					
D7982	Sialodochoplasty					
D7983	Closure of Salivary Fistula					
D7990	Emergency Tracheotomy					
D7991	Coronoidectomy					
D7995	Synthetic Graft - Mandible or Facial Bones, By Report					
D7996	Implant - Mandible for Augmentation Purposes (Excluding Alveolar Ridge), By Report					
D7997	Appliance Removal (Not by Dentist who Placed Appliance), Includes Removal of Archbar					
D7998	Intraoral Placement of a Fixation Device not in Conjunction with a Fracture					
D7999	Unspecified Oral Surgery Procedure, By Report					
Orthodontics						
Limited Orthodontic Treatment						
D8010	Limited Orthodontic Treatment of the Primary Dentition					
D8020	Limited Orthodontic Treatment of the Transition Dentition					
D8030	Limited Orthodontic Treatment of the Adolescent Dentition					
D8040	Limited Orthodontic Treatment of the Adult Dentition					
Interceptive Orthodontic Treatment						
D8050	Interceptive Orthodontic Treatment of the Primary Dentition					
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition					
Comprehensive Orthodontic						
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition					
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition					
Minor Treatment to Control Harmful Habits						
D8210	Removable Appliance Therapy					
D8220	Fixed Appliance Therapy					
Other Orthodontic Services						
D8660	Pre-Orthodontic Treatment Visit					
D8670	Periodic Orthodontic Treatment Visit (As Part of Contract)					
	Children (Up to 19th Birthday):					
	24 Month Treatment Fee					
	Charge Per Month for 24 Months					
	Adults:					
	24 Month Treatment Fee					
	Charge Per Month for 24 Months					
	Ortho Visits Beyond 24 Months of Active Treatment or Retention					
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer (s))					
D8690	Orthodontic Treatment (Alternative Billing to a Contract Fee)					
D8691	Repair of Orthodontic Appliance					
D8692	Replacement of Lost or Broken Retainer					
D8693	Rebonding or Recementing; and/or Repair, as Required, of Fixed Retainers					
D8999	Unspecified Orthodontic Procedure, By Report					
Adjunctive General Services						
Unclassified Treatment						
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure					
D9120	Fixed Partial Denture Sectioning					
Anesthesia						
D9210	Local Anesthesia Not in Conjunction with Operative or Surgical Procedures					
D9211	Regional Block Anesthesia					
D9212	Trigeminal Division Block Anesthesia					
D9215	Local Anesthesia in Conjunction With Operative or Surgical Proedures					
D9220	Deep Sedation/General Anesthesia - First 30 Minutes					
D9221	Deep Sedation/General Anesthesia - Each Additional 15 Minutes					
D9230	Inhalation of Nitrous Oxide/anxiolysis, analgesia					
D9241	Intravenous Conscious Sedation/Analgesia - First 30 Minutes					
D9242	Intravenous Conscious Sedation/Analgesia - Each Additional 15 Minutes					
D9248	Non-intravenous Conscious Sedation					
Professional Consultation						
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician other than Requesting Dentist or Physician					
Professional Visits						
D9410	House/Extended Care Facility Call					
D9420	Hospital or Ambulatory Surgical Center Call					
D9430	Office Visit for Observation (During Regularly Scheduled Hours) - No other Services Performed					
D9440	Office Visit - After Regularly Scheduled Hours					
D9450	Case Presentation, Detailed and Extensive Treatment Planning					
	Broken Appointment without 24 hour notice - Per 15 Minutes					
Drugs						
D9610	Therapeutic Parenteral Drug, Single Administration					

DHMO Copay Comparison

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	
D9612	Therapeutic Parenteral Drugs, Two or More Administrations, Different Medications					
D9630	Other Drugs and/or Medicaments, By Report					
Miscellaneous Services						
D9910	Application of Desensitizing Medicament					
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, Per Tooth					
D9920	Behavior Management, By Report					
D9930	Treatment of Complications (Post-surgical) - Unusual Circumstances, By Report					
D9940	Occlusal Guard, By Report					
D9941	Fabrication of Athletic Mouthguard					
D9942	Repair and/or Reline of Occlusal Guard					
D9950	Occlusion Analysis - Mounted Case					
D9951	Occlusal Adjustment - Limited					
D9952	Occlusal Adjustment - Complete					
D9970	Enamel Micro abrasion					
D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections					
D9972	External Bleaching, Per Arch					
D9973	External Bleaching, Per Tooth					
D9974	Internal Bleaching, Per Tooth					
D9975	External bleaching for home application, per arch; includes materials and fabricaiton of custom trays					
D9999	Unspecified Adjunctive Procedure, By Report					

Additional lab and metal charges may apply for procedures in italics.

CITY OF FORT LAUDERDALE

2022 BENEFITS HANDBOOK

CITY OF FORT LAUDERDALE OUR VALUES MATTER

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT EXCELLENCE

All-America City

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City of FORT LAUDERDALE

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CITY OF FORT LAUDERDALE OUR VALUES MATTER — INTEGRITY · COMPASSION · ACCOUNTABILITY · RESPECT · EXCELLENCE

All-America City

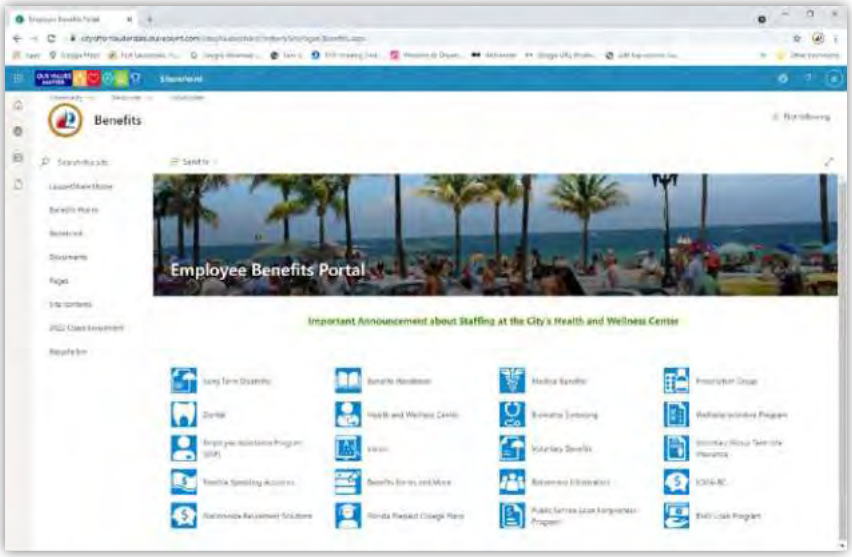
INTRODUCTION

City of FORT LAUDERDALE

The City of Fort Lauderdale offers eligible employees a comprehensive benefits package that includes medical, dental, vision, life insurance, health care and dependent care flex spending accounts, long-term disability, wellness initiatives, retirement plans and a variety of voluntary benefits. The information included in this Handbook is a general summary of available options and also serves to increase your awareness of policies and procedures. If any information in this Handbook conflicts with governing plan documents, certificates of coverage, City resolutions, or state/federal laws, the provisions of the governing plan documents, certificates of coverage, City resolutions and state/federal laws will prevail.

Please also take the time to review the Benefits web page for Frequently Asked Questions, important notices, plan certificates of coverage, available forms, any updates subsequent to printing this book and much more at www.fortlauderdale.gov/benefits or on LauderShare at www.fortlauderdale.gov/laudershare. You may also contact the plan administrators directly to discuss your personal situation.

www.fortlauderdale.gov/benefits



www.fortlauderdale.gov/laudershare

City of **FORT LAUDERDALE**

ONLINE ENROLLMENT AND CHANGES

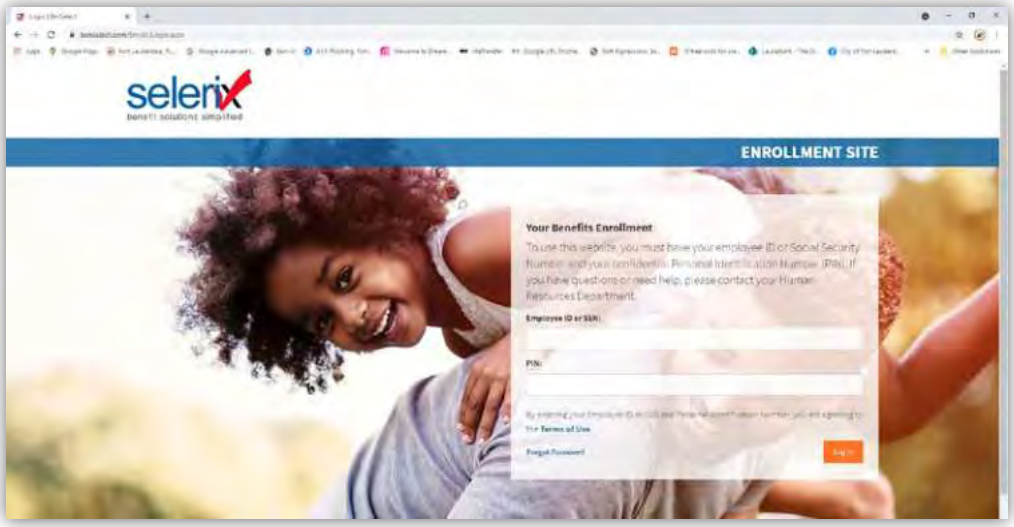
The City of Fort Lauderdale provides employees with an online enrollment platform, BenSelect, through Selerix. Selerix BenSelect provides benefits eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment period, New Hire Orientation, or Qualifying Life Events (QLE).

Accessible 24 hours a day, throughout the year, employees may log-in and review comprehensive information regarding benefit plans and view and print an outline of benefit elections for themselves and their covered dependent(s). Employees can report qualifying life events and review and make changes to Life Insurance beneficiary designations. Employees can login to Selerix BenSelect using a computer, tablet or smart phone.

TO ACCESS SELERIX BENSELECT:

1. Go to **https://www.benselect.com/enroll**.
2. Login:
   - Newly Eligible employees enrolling for the first time need to enter their employee ID and 4-digit PIN. The PIN is a combination of the employee's 2-digit birth month and last 2-digits of their birth year. For example, if you were born May 21, 1973, your PIN would be "0573".
   - Existing employees currently enrolled in one or more benefit who have had a QLE need to enter their employee ID and PIN. The PIN is the password you created when you originally enrolled in your benefit(s).
3. If an employee has forgotten their password, click on the link "Forgot Password" and follow the instructions.
4. Once logged in, navigate the menu to review current elections, learn about benefit options, and make elections, changes or beneficiary designations.

If you experience login issues and need assistance, please contact the Benefits Section, HR at 954-828-5160.



www.benselect.com/enroll

NOTE: You must provide the Social Security number for each eligible dependent you choose to enroll. A copy of the required documentation (Example: birth or marriage certificate) must be provided to Benefits Section, HR if you are enrolling a new dependent. Please have this information readily available to upload into Selerix BenSelect. New dependents will not be covered without the required eligibility documentation.

WELLNESS

City of FORT LAUDERDALE

CITY OF FORT LAUDERDALE HEALTH AND WELLNESS CENTER
(Operated by Marathon Health)

The City of Fort Lauderdale Health and Wellness Center (Center) provides employees, retirees, and their families (children ages 6+) who are enrolled in one of the City's medical plans with high quality primary, preventive, and acute care at no cost for professional services. The City wants you and your family to be healthy. The City is investing in your health because, over the long term, it will help mitigate costs to both you and the City, and improve the quality of your life.

The Center's staff is licensed to diagnose and treat a wide variety of common illnesses and injuries as well as prescribe various medications. The staff will work with you to address your concerns about stress, diet, exercise, smoking, and other forces that impact your health and well-being. The experienced and knowledgeable staff includes:

- A Board-Certified Family Practice Physician
- A Board-Certified Physician Assistant
- A Board-Certified Nurse Practitioner
- A part-time Registered Dietician
- Medical Assistants

The City's Onsite Wellness Coordinator is also available at the Wellness Center. The role of the Coordinator is to educate employees, retirees, and their covered dependents about Cigna benefits, resolve plan-related issues, and facilitate City wellness events. The Coordinator can be contacted at 954-652-1306. Cigna customer service representatives are available 24/7 and may be reached toll-free at 1-800-244-6224.

The Center follows the same rules and privacy regulations that protect your privacy at your personal physician's office, a hospital, or other health provider. In fact, the privacy of your personal health information is protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

CENTER INFORMATION

City of Fort Lauderdale Health and Wellness Center
4750 North Federal Highway, Suite 300
Fort Lauderdale, FL 33308
Telephone: 754-206-2420
Fax: 1-954-867-5583 (must dial 1 in front)

Monday - Wednesday / Friday: 7am – 4 pm
Thursday: 7 am – 6 pm / Saturday: 8 am – Noon
Closed on Sundays and holidays
Closed Daily for lunch 1 pm - 2 pm

To schedule an appointment, call 754-206-2420 or visit the Marathon Health secure website at **my.marathon-health.com or use the Marathon Health app. Get the app from Google Play or the App Store**. The Health and Wellness Center is also offering virtual (video) and telephone visits for many of their regular services, including medical visits, comprehensive health reviews and health coaching.

SERVICES

The Center provides high quality care and wellness services for the entire family including, but not limited to, treatment for:

- Common Illness
- Chronic Conditions
- Women's Health & Men's Health
- Minor Injuries
- Suture Removal
- Allergy Shots
- Sports Physicals
- EKG
- Health Coaching
- Health Assessments
- Nutrition

A complete list of services offered at the Center is available online at **www.fortlauderdale.gov/benefits** or **www.fortlauderdale.gov/laudershare**.

City of FORT LAUDERDALE

WELLNESS

LAB SERVICES

Many lab tests can be processed at the Center, including hemoglobin A1C, lipid panel, stools for occult blood, fasting glucose, random glucose, rapid strep, urinalysis, oxygen saturation levels, influenza A and B, mononucleosis tests, pregnancy tests, and more. All tests processed at the Center are at no charge to employees, retirees, and their family members enrolled in one of the City's medical plans. All other laboratory tests (i.e., urine culture, strep culture, complete blood count, chemistry profile, TSH) can be drawn by Marathon Health providers, but will be sent to an external laboratory for processing. The external laboratory will submit a claim to your medical plan for this service, and you may be responsible for a portion of the bill.

PRESCRIPTION MEDICINE PROVIDED AT TIME OF TREATMENT

The City's Health and Wellness Center stocks a supply of 30 to 40 prescription medications that the medical staff may dispense as part of your medical care. A list of the current medications provided at the is available online at **www.fortlauderdale.gov/benefits** or **www.fortlauderdale.gov/laudershare**. The Health and Wellness Center is not a pharmacy. Prescriptions written by another physician cannot be filled at the Health and Wellness Center, but in many cases, and in the context of care the staff provides, you and your family may be able to get certain medications at the Center at no cost.

WELLNESS INITIATIVES

The City's Health and Wellness Center is not just for when you are sick. The medical staff helps eligible employees, retirees, and their family members stay healthy, achieve health goals, and manage chronic conditions by working with individuals to create a personalized, step-by-step health plan. These plans empower people with chronic conditions to be more active and prevent medical conditions from becoming more serious in the future. Medical staff can also address concerns about stress, diet, exercise, smoking, and other forces that impact health and well-being.

Biometric Screening and Health Risk Assessment (HRA) Questionnaire: Employees, retirees, and covered spouses/domestic partners participating in one of the City's medical plans must complete a biometric screening for each plan year to avoid being charged a post-tax biometric surcharge per person, per paycheck. The post-tax biometric surcharge will continue until the requirements are completed. Newly eligible employees and their covered spouse/domestic partner (if applicable) have 30 days from their medical coverage effective date to complete the biometric screening. It is recommended that Cigna medical plan enrollees complete a HRA questionnaire. Completing the HRA questionnaire is a requirement for eligible employees who wish to participate in the City's Motivate*Me*® Wellness Incentive Program.

The City's Health and Wellness Center or your personal physician may conduct the biometric screening and review the data on a personal and confidential basis directly with you to develop an action plan to improve your health.

Tobacco Use: This initiative only applies to employees and retirees participating in one of the City's medical plans. Newly eligible employees who are tobacco users have 60 days from their medical coverage effective date to complete a City authorized Tobacco Cessation Program (if applicable) to avoid paying a $25 biweekly post-tax surcharge. The City's authorized Tobacco Cessation Programs are:

- One-on-one or group programs through the City's Health and Wellness Center: Call 754-206-2420
- Online/phone program through Cigna: Register online at **www.mycigna.com** or call 866-417-7848
- IQuit program with Area Health Education Center (AHEC) at **www.ahectobacco.com/calendar** or call 1-877-848-6696

WELLNESS INCENTIVE PROGRAM

City of FORT LAUDERDALE

MotivateMe® WELLNESS INCENTIVE PROGRAM (WIP)

The City of Fort Lauderdale is committed to your overall health and well-being. The Benefits Section of the Human Resources Department is excited to continue offering **MotivateMe®**, the City's voluntary **Wellness Incentive Program** to eligible employees.

The purpose of MotivateMe® is to **provide you with information about your current health status** and promote wellness-related activities to **encourage, engage, and help you take charge of and improve your health and happiness** while at work or at home. With MotivateMe®, you have the opportunity to earn a valuable incentives while improving your health.

Who can participate in the MotivateMe® WIP?

All permanent, full-time, active City employees enrolled in one of the City's medical plans can participate, including:

- International Association of Firefighters
- Teamsters Employee Group
- Confidential
- Management and Management Fellowship Program
- All Federation of Public Employees, including Federation employees not enrolled in one of the City's medical plans based on their Collective Bargaining Agreement.

What does MotivateMe® Offer?

The City will provide you with an annual **$500** (taxable) wellness incentive for the healthy actions you take through Cigna's MotivateMe® WIP. The goal is to motivate you to get your annual checkup, know your key health numbers and, ultimately, take control of your health.

How does MotivateMe® Work?

You must complete the three required goals and earn at least 200 additional points through wellness-related activities every calendar year between January 1 and December 31 to receive an annual $500 (taxable) wellness incentive. The incentive is payable after March 31 of the following year (to allow for reporting of claims data into your MotivateMe® Incentive Awards account).

TO EARN THE WELLNESS INCENTIVE:

1. You MUST complete all three of the following Required Program Goals:

- Annual Physical (Preventive Exam) – 100 Points
- Biometric Health Screening (blood pressure check, cholesterol screening, blood glucose/blood sugar screening, and height and weight measurements) – 100 Points
- Cigna's Personalized Health Assessment online at myCigna.com or the Marathon Health Questionnaire from the City's Employee Health and Wellness Center – 100 Points

2. Complete any of the following wellness activities to earn 200 additional points:^

Preventive Screenings or Health Coaching

- Flu Shot – 50 Points
- Annual OB/GYN Exam – 50 Points
- Mammogram* – 50 Points
- Colonoscopy* – 50 Points
- Cervical Cancer Screening – 50 Points
- Prostate Cancer Screening – 50 Points
- Health Coaching Session at the City's Health and Wellness Center – 50 Points

^ WIP Required Program Goals and Preventive Screening/ Coaching activity points will be credited one time per completion of an activity per payout year. Duplicate services will not be credited toward the annual incentive.

Self-Reported Activities (You must enter/report these activities in your myCigna.com account by December 31.)

- Complete a Wellness Activity (e.g., Lunch/Breakfast and Learns, Employee Assistance Program webinars, wellness webinars, Tobacco and Stress Management Programs) – 25 points each (4 per year)
- Complete a Physical Activity (e.g., gym workouts, walking, exercise classes) – 25 points each (4 per year)
- Complete a Weight Management Activity (e.g., appointments with a licensed dietician, Weight Watchers, Jenny Craig, other weight management program) – 25 points each (4 per year)
- COVID-19 Vaccine - 50 Points (1 per year)

City of FORT LAUDERDALE

WELLNESS INCENTIVE PROGRAM

All services performed at the City's Health and Wellness Center are available at no cost, except for those services previously listed with an asterisk (*). Services outside the Center are subject to your medical plan benefits.

All Biometric Screening and Health Assessment information will be confidentially collected and stored by the participant's health plan or Marathon Health and Wellness. The results are provided only to the participant; by law, they cannot be shared with an employer.

Preventive services are available at no cost if the Affordable Care Act (ACA) guidelines are met and services are provided in-network.

Wellness activities will be tracked online through your myCigna.com account in Incentive Awards, eliminating the need for paper forms. Except for self-reported activities and goals, wellness activity completion will be automatically reported.

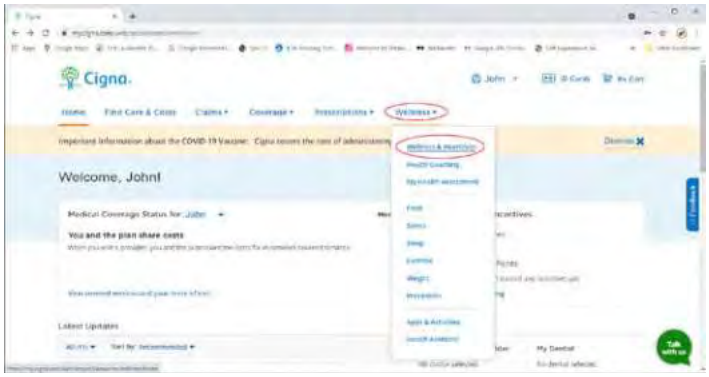
Why participate in WIP?

If you complete the three required goals and earn at least 200 additional non-duplicated wellness activity points between January 1 and December 31, you will engage in beneficial wellness activities and you will also be rewarded with a $500 (taxable) wellness incentive.

How do I receive my WIP payout?

1. Record your self-reported wellness activities in your **myCigna.com** account in Incentive Awards.
2. Complete your wellness activities. Wellness activities that are automatically reported through Cigna claims will be visible in your Incentive Awards account by December 31.
3. You must be an active eligible City employee at the end of the calendar year (as of December 31).
4. After the conclusion of the calendar year, Cigna will provide a list of all employees who completed the three required goals and earned at least 200 non-duplicated additional points. The City will issue the $500 (taxable) WIP payout after March 31 of the following year to allow for reporting of claims data into your Cigna Motivate*Me*® Incentive Awards account.

All submissions must be entered by December 31st (NO EXCEPTIONS).



All eligible employees must track and record their wellness activities through their MyCigna.com account. There are only two (2) exceptions that will require forms:

1. Eligible members of the Federation of Public Employees who are not enrolled in a City Medical Plan.
2. Eligible City employees who are enrolled in one of the City's medical plans as a dependent (spouse or domestic partner) of another City employee.

How can I participate and receive my incentive reward if I qualify as one of these two (2) exceptions?

1. Record your wellness activities on the Wellness Incentive Tracker Form (both Part 1 and Part 2) found on LauderShare at www.fortlauderdale.gov/laudershare or www.fortlauderdale.gov/benefits. This form must be completed with the three required goals and at least 200 non-duplicated additional points.
2. Submit the completed Wellness Incentive Tracker form AND the completed Wellness Incentive Program Physician Verification form(s) to the City's onsite Wellness Coordinator. BOTH forms must be completed and received by December 31 to receive your WIP payout. Please fax the completed forms to 860-847-5126 OR submit/mail to: City of Fort Lauderdale Health and Wellness Center, 4750 N. Federal Highway, Suite 300, Fort Lauderdale, FL 33308, Attention: Wellness Coordinator, Phone: 954-652-1306. Retain your proof of mailing or fax confirmation.
3. You must be an active eligible City employee at the end of the calendar year (as of December 31).
4. After the conclusion of the calendar year, Cigna will provide a list of all employees completed the three required goals and earned at least 200 non-duplicated additional points. The City will issue the $500 (taxable) WIP payout after March 31 of the following year.

WELLNESS INCENTIVE PROGRAM

City of FORT LAUDERDALE

Who do I contact for more information?

For more information, please contact Human Resources-Benefits Section at (954) 828-5160 or **Healthyliving@fortlauderdale.gov**. You may also contact the City's Onsite Wellness Coordinator at (954) 652-1306.

Motivate*Me*® is a voluntary wellness program available to all employees enrolled in the Cigna Medical Plan. The program is administered by Cigna according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood pressure check, cholesterol screening, a blood glucose/blood sugar screening, and a measurement of height and weight. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a $500 (taxable) incentive for completing the three required goals and earning at least 200 non-duplicated additional points. In order to qualify for the incentive, you must complete the biometric screening, an annual physical (preventive exam), and health risk assessment for 300 points. An additional 200 wellness activity points are earned by employees who participate in certain health-related activities (i.e., getting a flu shot, Health Coaching at the City's Health and Wellness Center, attend a Lunch or Breakfast and Learn, complete physical or weight management activities) of their choice within the program guidelines. Although you are not required to complete the HRA or participate in the biometric screening and other wellness activities, only employees who do so will receive the $500 (taxable) incentive.

For all participants: If you think you might be unable to meet a standard for a reward under this wellness program you might qualify for an opportunity to earn the same reward by different means, contact the City of Fort Lauderdale's Wellness Coordinator at (954) 652-1306 or Human Resources, Benefits Section at (954) 828-5160.

For participants who may have an impairment: If you are unable to participate in any of the program events, activities, or goals, because of a disability, you may be entitled to a reasonable accommodation for participation, or an alternative standard for rewards. For worksite accommodations, please contact the City Benefits Office at 954-828-5160. For accommodations with online, phone, or other Cigna programs, contact the City of Fort Lauderdale's Wellness Coordinator at 954-652-1306, Human Resources, Benefits Section at 954-828-5160, or Cigna at 800-244-6224.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as in person, telephonic, or online coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and The City of Fort Lauderdale may use aggregate information it collects to design a program based on identified health risks in the workplace, Cigna, Motivate*Me*®, and Marathon Health, a third party vendor who staffs and manages The Health and Wellness Center, will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Cigna, Motivate*Me*® and Marathon Health, a third party vendor who staffs and manages The Health and Wellness Center (if authorized) in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you as soon as possible within the time frame specified by law.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the City of Fort Lauderdale's Wellness Coordinator at 954-652-1306 or Human Resources, Benefits Section at 954-828-5160.

City of FORT LAUDERDALE

EMPLOYEE ASSISTANCE PROGRAM (EAP)

As an employee of City of Fort Lauderdale, you and your household members have access to the valuable Cigna Employee Assistance Program (EAP) at no cost. This free program is available 24 hours a day / 7 days a week.

FOR A CONFIDENTIAL EAP APPOINTMENT OR QUESTIONS, CONTACT:

Call 1.877.622.4327 or login to myCigna.com. Employer ID: cofl (Needed for initial registration only).
If already registered on myCigna.com, simply login and go to the EAP link under the Coverage tab.

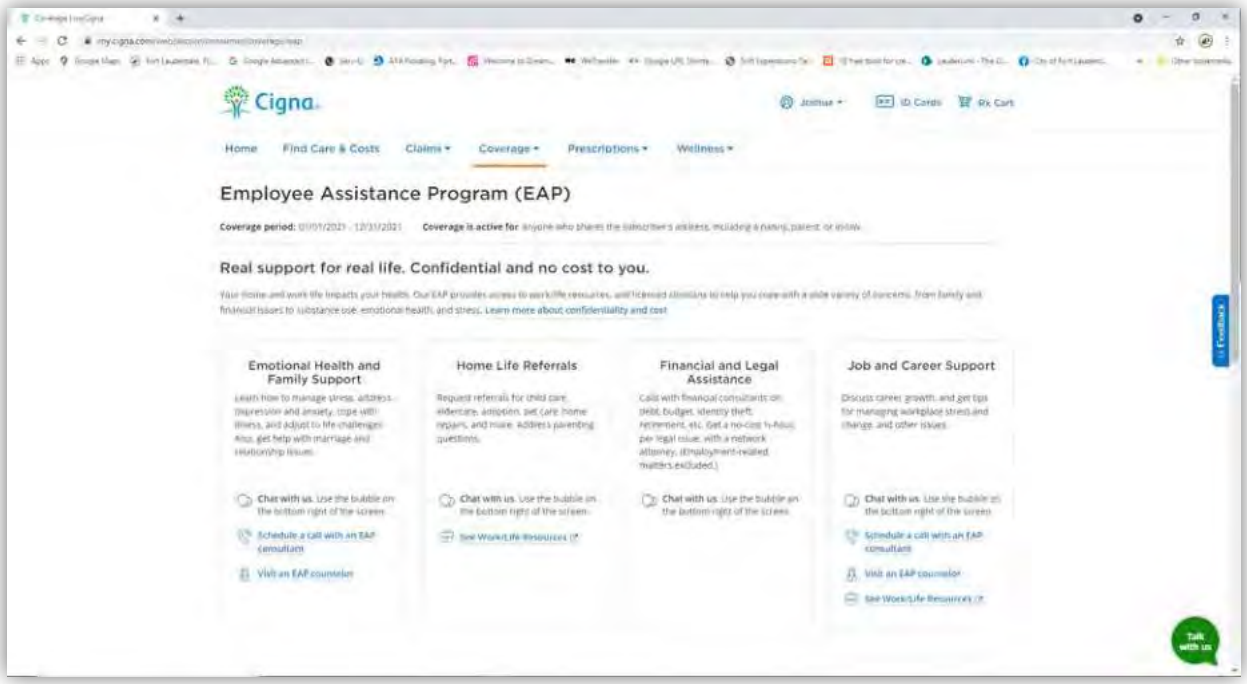
How is confidentiality insured?

To insure confidentiality, only the EAP staff will keep records, which are not available to anyone without your written consent. In addition, NO information is listed in your personnel file, and your participation will NOT affect your job security or opportunities.

Video-based sessions are also available to fit your busy schedule. Call the EAP for information.

EAP services include:

- **Counseling:** Provides up to 10 free face-to-face sessions per issue per year with a mental health or substance abuse professional
- **Legal Assistance:** Free, 30-minute consultation with an attorney face-to-face or by phone.
- **Financial:** Free 30-minute telephonic consultation by phone with a qualified specialist on issues such as debt counseling or planning for retirement
- **Identity Theft:** 60-minute free consultation with a fraud resolution specialist
- **Directory Assistance:** Provides free directory assistance to a variety of helpful resources in your community for services such as pet care, child care, adoption, senior care, and more.



myCigna.com

MEDICAL
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City of FORT LAUDERDALE

OPEN ACCESS PLUS IN-NETWORK PLANS (OAPIN 1 (HMO1), OAPIN2 (HMO2))

With Cigna's Open Access Plus In-Network Plans, you get access to a large network of health care professionals and facilities. Each time you need care, you choose the in-network doctor or facility that works best for you.

Depending on your plan, you may have to pay an annual amount (deductible) before the plan begins to pay for covered medical costs. Once you meet your deductible, you pay a copay or coinsurance (a portion of the charges) for most services from an in-network doctor or facility. Then, the plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the medical plan pays your covered medical care costs at 100%.

In-network: In order for your medical care to be covered by the plan, you must choose a health care professional who is in the Cigna Open Access Plus network.

No-referral specialist care: If you need to see a specialist, you do not need a referral to see an in-network doctor.

Out-of-network: If you choose to see a doctor who is not in the network, you will not have coverage except in emergencies.

Emergency and urgent care: When you need care, you have coverage.

CONSUMER DRIVEN HEALTH PLAN (CDHP) - WITH HEALTH REIMBURSEMENT ACCOUNT (HRA)

The Cigna CDHP provides a medical plan with an HRA funded by the City to help pay for some of the costs of covered expenses, including medical expenses and prescription drugs.

How the HRA Works

- Per IRS Section 125, only tax qualified dependents are eligible to use HRA funds.
- At the start of the year, the City deposits a specific dollar amount in your HRA.
- Your account is used to pay 100% of eligible medical expenses until the money is used up.
- The medical costs that were paid from your HRA account toward your deductible (the amount you pay before your plan starts to pay), reducing your share.
- When you reach your deductible, you share the costs for covered medical expenses (coinsurance).
- You are protected by an annual limit on how much you pay.
- At the end of the year, any unused HRA funds will roll over to the following year.
- If you switch medical plans or leave the City, you forfeit your unused HRA funds.

CONSUMER DRIVEN HEALTH PLAN (CDHP) - WITHOUT HEALTH REIMBURSEMENT ACCOUNT (HRA)

- Per IRS Section 125, non-tax qualified dependents (i.e. adult child dependents (ages 26-30), domestic partners and domestic partner's child(ren)) are not eligible to use HRA funds.
- Non-tax qualified dependents will be enrolled in their own medical plan that is separate from the employee and tax qualified dependents.
- Non-tax qualified dependents will share their own deductible and out-of-pocket maximum that is separate from the employee and tax qualified dependents.
- When non-tax qualified dependents reach their deductible, they share the costs for covered medical expenses with the City (coinsurance).
- Non-tax qualified dependents are protected by an annual limit on how much they pay.

City of FORT LAUDERDALE

MEDICAL
CIGNA | GROUP #3335139

2022 MEDICAL PLAN COMPARISON SUMMARY

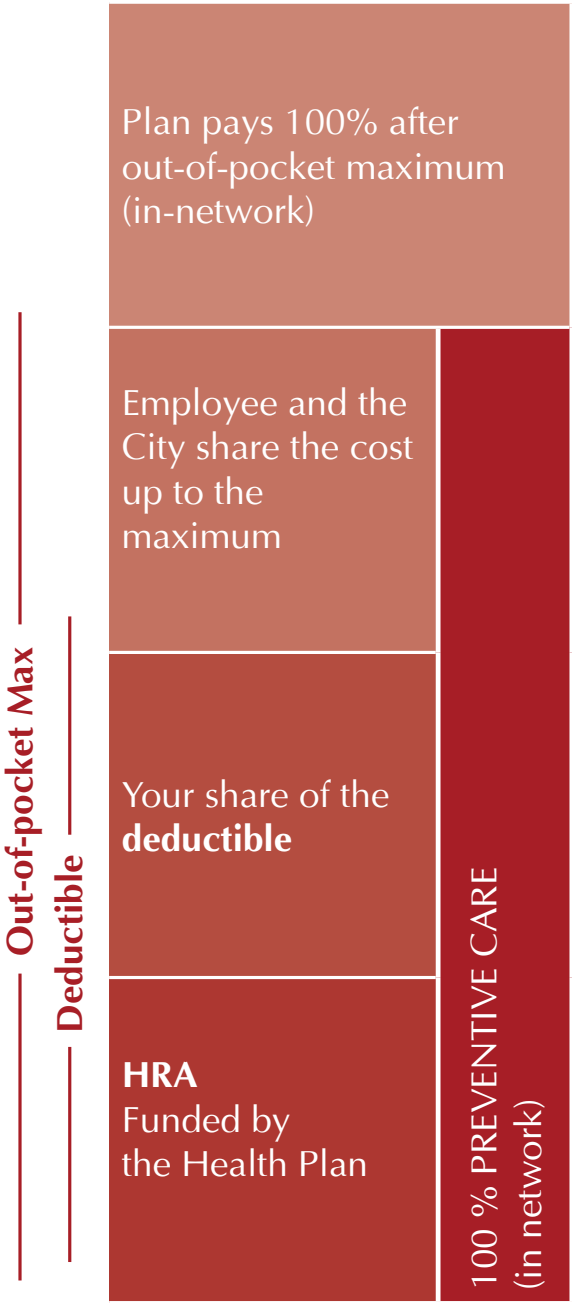
Medical Plan Coverage	OAPIN1 (HMO1)	OAPIN2 (HMO2)	Consumer Driven Health Plan (CDHP)	
Health Reimbursement Account (HRA) * (For Active Employees and their Tax Qualified Dependents ONLY)	n/a	n/a	$1,000-EE, $1,500-EE+1, $2,000=EE + 2 or more	
Medical Plan Coverage	**OAPIN1 (HMO1) You Pay**	**OAPIN2 (HMO2) You Pay**	**Consumer Driven Health Plan (CDHP) You Pay**	
			In-Network	Out-of-Network**
Deductible	No Deductible	$1,000=EE $2,000=EE+1 $3,000=EE+Family	$2,000=EE $3,000=EE+1 $4,000=EE+2 or more	$2,000=EE $3,000=EE+1 $4,000=EE+2 or more
Coinsurance	See Below	See Below	You pay 10%	You pay 30%
Your Out-of-Pocket Maximum	$5,000=EE; $7,000=EE+1 $10,000=EE+2 or more	$6,350=EE $10,000=EE+1 $12,700=EE+2 or more	$5,000=EE, $7,000=EE+1, $10,000=EE+2 or more (Includes calendar year deductible & coinsurance)	$5,000=EE, $7,000=EE+1, $10,000=EE+2 or more (Includes calendar year deductible & coinsurance)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventative Services	No Charge	No Charge	No Charge	See Below***
Primary Care Physician and Telehealth	$40	$40	Subject to calendar year deductible & coinsurance (HRA applies)	Subject to calendar year deductible & coinsurance (HRA applies)
Specialist Physician	$40	$40		
Maternity	$40 Initial Visit****	$40 Initial Visit****		
Hospital	$500/day, $2,500 Annual Maximum	Deductible then 20% Coinsurance		
Outpatient Surgery	$500	Deductible then 20% Coinsurance		
Outpatient Diagnostics (X-rays, Ultrasound, etc.)	10% Coinsurance	10% Coinsurance		
Outpatient Diagnostics (CAT & PET scans, MRI)	$200 per test	$200 per test		
Routine Lab	10% Coinsurance	10% Coinsurance		
Emergency Room	$200	$200		
Urgent Care	$60	$60		
Mental Health (outpatient)	$40	$40		
Mental Health (inpatient)	$500/day, $2,500 Annual Maximum	Deductible then 20% Coinsurance		
Allergy Treatments/Injections	$10	$10		
Ambulance	no charge	$100 copay		
Prescription Drugs Pharmacy, 30-day supply ***	$20 generic $40 preferred $60 non-preferred	$20 generic $40 preferred $60 non-preferred	Subject to calendar year deductible & coinsurance of 30% generic, 40% preferred, 60% non-preferred (HRA applies)	Not Covered
Prescription Maintenance Drugs Retail or Mail Order, *** Mandatory 90-day supply ****	$40 generic $80 preferred $120 non-preferred	$40 generic $80 preferred $120 non-preferred		
Prescription for Chronic Conditions & Preventative ****	Generic prescription provided - waiving copays	Generic prescription provided - waiving copays	Generic prescription provided - waiving copays	Not Covered
Vision	(only medical conditions)	(only medical conditions)	(only medical conditions)	(only medical conditions)

* Health Reimbursement Account (HRA) City annual contributions: The HRA funding is prorated for enrollment after January and only accessible to tax qualified dependents.. ** Cigna's reimbursement is based on Usual Customary and Reasonable (UCR) charges. ***30% coinsurance after deductible, waived for children up to 16 years of age. ****See the applicable plan document for details regarding benefit payments. *****Members Pay the Difference generic program pharmacy benefit rules apply. ****** Cigna 90 Now Program: For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription.

MEDICAL
CIGNA | GROUP #3335139

City of FORT LAUDERDALE

CONSUMER DRIVEN HEALTH PLAN (CDHP) EXAMPLE - WITH HEALTH REIMBURSEMENT ACCOUNT (HRA)



Maximum Out-of-Pocket: This is the limit you will pay on an annual basis (each calendar year) for covered expenses regardless of how high your medical bills get. Participants have an out-of-pocket maximum for their eligible in-network medical expenses depending on their tier of coverage. You may be billed for charges in excess of CIGNA's usual customary and reasonable charges if you use out-of-network providers.

Employee = $5,000
Employee + 1 = $7,000
Family = $10,000

Coinsurance: This is the percentage of costs you pay for covered health care services after you have paid your deductible. **The plan pays the rest.**

Employee pays 10% in-network or 30% out-of-network
City pays 90% in-network or 70% out-of-network

Deductible: A deductible is the portion of your covered medical expenses you are responsible for paying during each plan year until you reach the specified amount. Then, your plan will begin to pay a portion of covered medical costs (coinsurance). After the money in the HRA is spent you pay for covered medical expenses until you reach your individual annual deductible.

Employee = $2,000 ($1,000 after $1,000 HRA)
Employee + 1 = $3,000 ($1,500 after $1,500 HRA)
Family = $4,000 ($2,000 after $2,000 HRA)

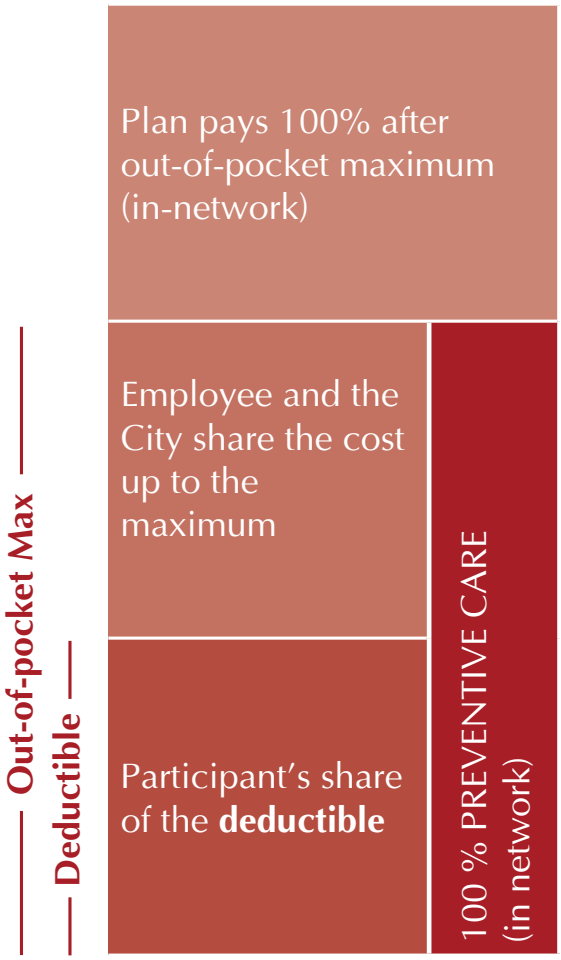
Health Reimbursement Account (HRA): At the start of the year, the City deposits a specific contribution in your HRA. Your account automatically pays eligible medical expenses until the money is used up. The medical costs that were paid from your HRA count toward your deductible, reducing your share. At the end of the year, any unused HRA funds will roll over to the following year. If you switch medical plans or leave the City, you forfeit your unused HRA funds. The HRA fund can only be used for covered medical and prescription drug expenses.

2022 City Annual HRA Contributions:
Employee = $1,000
Employee + 1 = $1,500
Family = $2,000
Note: HRA funding is prorated for enrollment after January.

City of FORT LAUDERDALE

MEDICAL
CIGNA | GROUP #3335139

CONSUMER DRIVEN HEALTH PLAN (CDHP) EXAMPLE - WITHOUT HEALTH REIMBURSEMENT ACCOUNT (HRA)



Maximum Out-of-Pocket: This is the limit the participant will pay on an annual basis (each calendar year) for covered expenses regardless of how high their medical bills get. Participants have an out-of-pocket maximum for their eligible in-network medical expenses depending on their tier of coverage. Participants may be billed for charges in excess of CIGNA's usual customary and reasonable charges if they use out-of-network providers.

Non-tax Qualified Adult Dependent/Domestic Partner = $5,000

Non-tax Qualified Domestic Partner + 1 Child of Domestic Partner = $7,000

Non-tax Qualified Domestic Partner + 2 or more Children of Domestic Partner = $10,000

Coinsurance: This is the percentage of costs you pay for covered health care services after you have paid your deductible. **The plan pays the rest.**

Participant pays 10% in-network or 30% out-of-network

City pays 90% in-network or 70% out-of-network

Deductible: A deductible is the portion of your covered medical expenses you are responsible for paying during each plan year until you reach the specified amount. Then, the plan will begin to pay a portion of covered medical costs (coinsurance).

Non-tax Qualified Adult Dependent/Domestic Partner = $2,000

Non-tax Qualified Domestic Partner + 1 Child of Domestic Partner = $3,000

Non-tax Qualified Domestic Partner + 2 or more Children of Domestic Partner = $4,000

HRA EXAMPLES

Meet the Smiths: A family of five

The Smiths are an active family of five. All family members get their yearly wellness exams. Mrs. Smith has high cholesterol that requires her to take prescription medication daily. She also suffers from severe low back pain and sees her chiropractor regularly. The Smiths are enrolled in family coverage with $2,000 in their HRA.

Service (In-Network)	Discounted Provider Charge	The Smith's HRA Account $2,000	The Smith's Responsibility
5 Annual preventive exams	Plan pays direct	$0	$0
6 Chiropractic visits	$510	-$510	$0
2 Urgent care visits	$260	-$260	$0
2 Primary doctor visits	$124	-$124	$0
Cholesterol prescription	$252	-$252	$0
Year-end balance	$1,146	$854	$0

Meet the Davidsons: Married couple, late 50s

Mr. Davidson was in a severe auto accident. As a result, he was hospitalized and his recovery consisted of rehabilitation and many visits to specialists. The Davidsons are enrolled in the Employee + 1 with $1,500 in their HRA account.

Service (In-Network)	Discounted Provider Charge	The Davidson's HRA Account $1,500	The Davidson's Responsibility
2 Annual preventive exams	Plan pays direct	$0	$0
Hospitalization	$25,000	-$1,500	-$1,500 remaining deductible -$2,200 (10% coinsurance on $22,000 hospital)
2 Radiology visits	$2,500	$0	-$3,700 -$250 (10% coinsurance)
20 Rehabilitation visits	$2,500	$0	-$250 (10% coinsurance)
Year-end balance	$32,500	$0	$4,450

City of FORT LAUDERDALE

MEDICAL
CIGNA | GROUP #3335139

PHARMACY BENEFIT PROGRAM FOR ALL CIGNA MEDICAL PLANS

Cigna continually reviews medicines, products, and prices for the City of Fort Lauderdale. This review includes evaluating costly medications that have clinically effective lower-cost alternatives, which may help you and the City obtain cost savings. Prescription drugs are not covered out-of-network.

Cigna Value 3-Tier Prescription Drug List (PDL)

- Tier 1: Generic, Tier 2: Preferred Brands, Tier 3: Non-Preferred Brands
- A formulary is a comprehensive list of preferred drugs chosen on the basis of quality and efficacy by an independent committee of physicians and pharmacists. The Value 3-Tier Prescription Drug List is updated often so it's important to know that this is not a complete list of the medications your plan covers.
- Cigna's Value 3-Tier Drug List of covered drugs is available for review at www.fortlauderdale.gov/benefits. If you have any questions or need additional information, please call Cigna at 1-800-244-6224.

Mandatory 90-day Supply Required for Maintenance Medications - Cigna 90 Now Maintenance Medication Program

- Maintenance medications are taken regularly, over time, to treat an ongoing health condition, such as diabetes, high blood pressure, cholesterol or asthma.
- Filling your prescriptions in a 90-day supply may help you stay healthy because having a larger supply of your medication on-hand typically means you're less likely to miss a dose. It also means you can make fewer visits to the pharmacy to refill your medication, and when filling a maintenance medication for a 90-day supply, OAPIN1 and OAPIN2 plan enrollees can save money by only paying for a 60-day supply. CDHP plan enrollees are subject to their plan deductible.
- For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription. Cigna will not cover any of the cost.
- Maintenance medication 90-day local pharmacies include such pharmacies as CVS (Target), Walmart, and Navarro. Check MyCigna.com for a complete list of participating pharmacies.

SaveOnSP Prescription Drug Program

- SaveOnSP is an opt-in program that applies to approximately 145 specialty medications dispensed through Accredo, Cigna's Specialty Pharmacy.
- SaveOnSP can help lower your out-of-pocket medication costs to $0 and there's no extra cost to participate.
- If you are eligible, SaveOnSP will notify you by mail starting November 1st.

Member Pay the Difference generic program

- In Florida, pharmacists automatically substitute generics for brand-name prescriptions unless a doctor specifies a brand is necessary. However, some members and practitioners continue to request brand-name prescriptions even though a generic equivalent is available. This can increase costs for both employers and members.
- With the Member Pay the Difference generic program, members can still receive the brand medication, but members will pay the brand-name copay plus the difference in cost between the brand-name medication and the generic, up to the brand name total cost. This additional cost for a brand-name drug when a generic equivalent is available is applicable even if a physician specifically prescribes a brand-name medication that has a generic equivalent. Physicians may appeal this decision to Cigna if there is medical evidence that supports why the member cannot take the specific generic medication.
- **For details and specific information, please go to www.mycigna.com.**

Member Pay the Difference generic program example for OAPIN1 and OAPIN2 Plans:

Here's an example:

Susan is deciding between a $100 brand-name medication and its $30 generic equivalent. According to her plan, she has a copay of:

- $20 for a 30-day supply of generic medications
- $40 for a 30-day supply of brand name medications

Generic	**If she chooses the generic, all she pays is her generic copay**	**$20**
Brand Name	**If she chooses the brand name, she pays** **$40** brand-name copay + **$70** brand-name costs ($100) – generic cost ($30) = **$110 TOTAL brand-name cost**	**$110**

CIGNA RESOURCES

CIGNA | GROUP #3335139

City of FORT LAUDERDALE

USEFUL CIGNA TOOLS

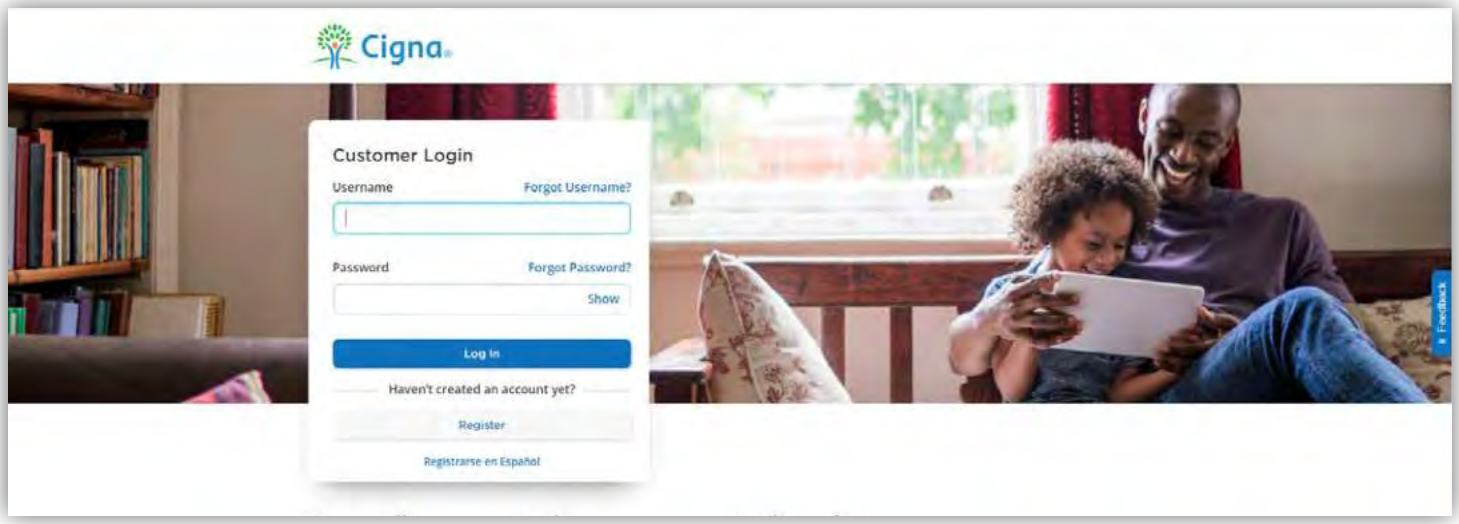
How to register on myCigna.com or myCigna mobile app

Register today. It is this easy:

- Go to myCigna.com and select "Register Now."
- Enter the requested information (i.e., name, address, and date of birth).
- Confirm your identity with secure information, such as your Cigna ID, social security number, or complete a security questionnaire. This will make sure only you can access your information.
- Create a user ID and password.
- Review your information and submit.

Once registered, you will be able to find all your coverage information online.
My Cigna.com provides you with the following tools:

- Access your Motivate*Me*® Wellness Incentive Program Account
- View your ID card information, which can also be faxed or emailed through the mobile app
- Find in network doctors, dentists, hospitals, pharmacies and medical services
- Manage and track claims
- See cost estimates for common medical and dental procedures and compare prescription costs
- Compare quality of care ratings for doctors and hospitals
- Access a variety of health and wellness tools and resources
- Review your coverages
- Fill your prescriptions and view your order history online through Cigna Home Delivery Pharmacy
- Track your account balances and deductibles
- Access Employee Assistance Program (EAP) benefits



City of FORT LAUDERDALE

CIGNA RESOURCES

CIGNA | GROUP #3335139

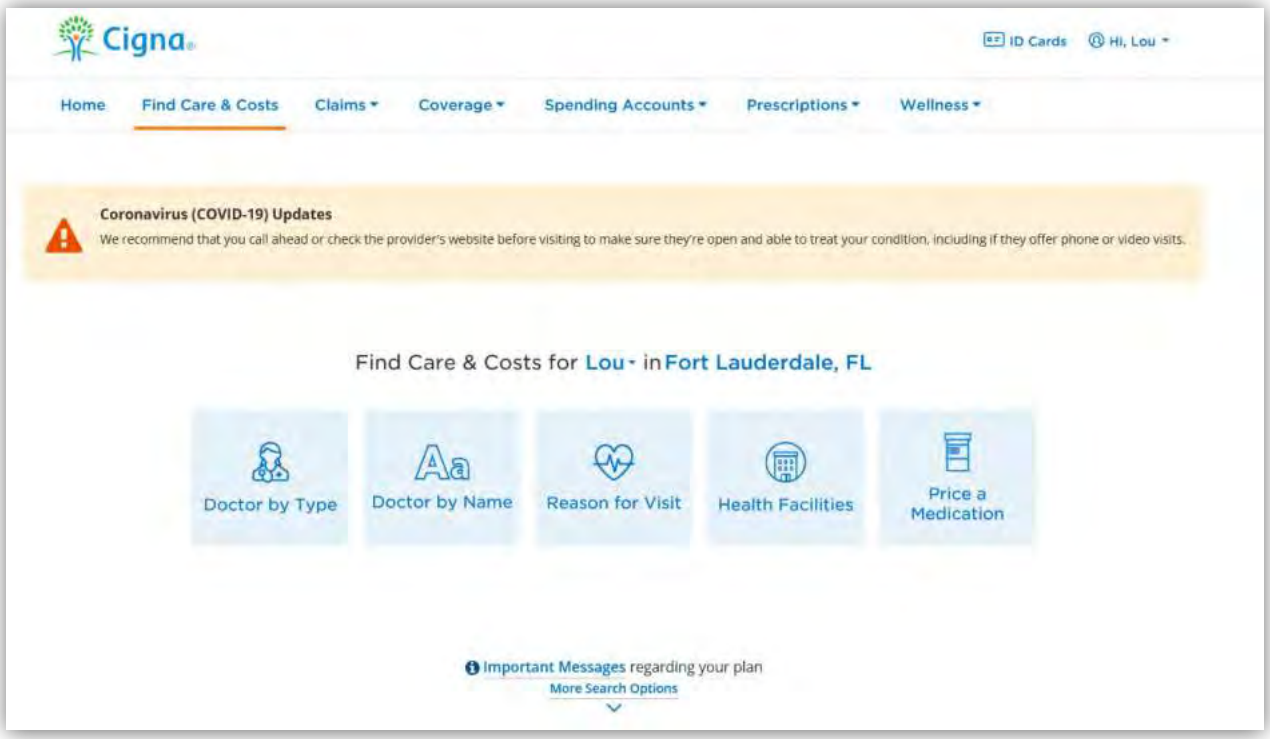
FIND A CIGNA DOCTOR OR FACILITY:

One Cigna network of providers for everyone: OpenAccessPlus

- OpenAccessPlus is the Cigna Network used for all three plans: OAPIN1 (HMO1), OAPIN2 (HMO2) and Consumer Driven Health Plan (CDHP).
- To search for a participating provider in the Cigna network, select "Find a Doctor or Facility" by logging into www.myCIGNA.com or by calling 1-800-244-6224. When choosing a physician, we encourage you to choose a Cigna Care Designated (CCD) Physician. Cigna Care Designated includes doctors who meet specific criteria in the areas of quality, number of patients treated, efficiency, and customer access. Cigna Care Designated Physicians are easily located on mycigna.com by a blue "C" and the title "Cigna Care Designation."

Cigna's Cost Estimator Tool

- The more you know about the cost and quality of doctors and hospitals, the easier it is to make the best choices for you and your family. After all, no one wants to pay too much for health care.
- The myCigna health care professional directory allows you to see integrated cost and quality information throughout the directory, helping you compare doctors and control health care spending.
- To help you make the most confident, cost-effective decisions about your care it is wise to compare costs and to understand how much your plan will pay and how much you will need to cover.



CIGNA RESOURCES

CIGNA | GROUP #3335139

City of FORT LAUDERDALE

ONE GUIDE - Start using Cigna One Guide today – by app, chat, or phone.

App Chat Phone

Download the myCigna app or call 1-800-244-6224 to talk with your personal guide.

Cigna One Guide service can help you make smarter, informed choices and get the most from your plan. It's Cigna's highest level of support that provides enhanced live customer service and includes the use of a powerful app. One Guide personal support, tools, and reminders can help you stay healthy and save money. Your Cigna One Guide representative will be there to guide you through the complexities of the health care system and help you avoid costly missteps. The goal is a simpler health care journey for you and your family.

Call a Cigna One Guide representative to get personalized, useful guidance. Your personal guide will help you:

Understand your plan

- Know your coverage and how it works with your medical, prescription drug, and dental benefits.
- Get answers to all your health care or plan questions.

Get care

- Find the right in-network doctor, dentist, hospital, lab, pharmacy, or urgent or convenience care center to help you avoid unnecessary costs.
- Get dedicated one-on-one support for complex health situations.
- Connect to health coaches, pharmacists, and other resources.
- Stay on track with appointments and preventive care.

Save and earn

- Maximize your benefits and earn incentives for the Motivate*Me*® Wellness Incentive Program.
- Get cost estimates and service comparisons.

Personalized Customer Service

- Understand your Explanation of Benefits and claims.
- Proactive messaging based on individual health needs.
- Get help/personal assistance to resolve health care issues.
- Save time and money.
- Get answers to any other questions you may have about the plans or provider networks available to you.

City of FORT LAUDERDALE

CIGNA RESOURCES

CIGNA | GROUP #3335139

CIGNA VIRTUAL CARE

Virtual Care is the delivery of health-related services and information via telecommunications technologies, including telephones, smartphones, and personal computers, for virtual consultations. Among the most significant benefits are ease of access, convenience, time savings, and competitive cost.

What is Cigna Virtual Care?

Cigna Virtual Care is Cigna's voluntary telemedicine program (provided by MDLIVE) that includes live appointments with board-certified doctors and pediatricians via video or phone who can diagnose and prescribe, when appropriate. Participants can choose the time and day that works best for them, with medical Virtual Care services available 24/7/365.

Does Virtual Care replace my primary care provider?

No. Virtual Care is not intended to replace the City's Health & Wellness Center nor your primary care provider (PCP). For common or chronic conditions, a virtual consultation can sometimes be a convenient and affordable alternative to a provider's office or non-urgent emergency room (ER) visit. Communication with your PCP is important for continuity of care.

Can Virtual Care handle emergency situations?

No. Virtual Care is designed to handle minor, non-emergency medical issues. You should NOT use Virtual Care if you are experiencing a medical emergency. If you have a medical emergency, you should dial 911 immediately or visit the nearest hospital.

USING VIRTUAL CARE

When should I consider using Virtual Care?

- When the City's Health and Wellness Center or your PCP is not available
- If you're considering an ER or an urgent care center for a non-emergency medical issue
- When traveling within the USA and in need of medical care (Virtual Care is not available outside of the USA)
- After normal business hours, nights, weekends, and even holidays

HOW IT WORKS

Who can use Virtual Care services?

Employees and covered dependents enrolled in one of the City's Cigna medical plans are eligible to use the program.

3 Ways to Access Virtual Care

Employees enrolled in one of the Cigna medical plans and covered dependents may access Virtual Care services from MDLIVE.

A. **Through the web at myCigna.com**
   - Log in to myCigna.com
   - Select "Find Care & Cost"
   - Select "Talk to a doctor or nurse 24/7"

B. **Download the MyCigna® App through your smartphone or mobile device**

C. **By telephone at 1-888-726-3171**

CIGNA RESOURCES

CIGNA | GROUP #3335139

City of FORT LAUDERDALE

COSTS AND PAYMENT

Are covered claims for visits with MDLIVE Virtual Care doctors covered at my in-network rate?

Yes. The claims will be processed by Cigna and you will receive an explanation of benefits (EOB), just as you do when other medical claims are processed.

How much will it cost to use the programs?

The cost of the visit depends on your medical plan. The OAPIN1 and OAPIN2 medical plans will have a $40 primary care physician copayment and the CDHP will be the Cigna contracted rate subject to calendar year deductible and coinsurance (HRA applies).

Can I pay for my telehealth visit with a health reimbursement account (HRA) or flexible spending account (FSA)?

Yes. Virtual Care is a qualifying expense for HRA or FSA accounts.

Will all registrations require a debit or credit card to be on file to cover the cost of the copay/coinsurance?

Yes. The payment information is gathered at point of consultation and kept on file; however, you may need to provide your credit card information for future consultations.

How do I pay for a prescription called in by a telehealth doctor?

Virtual Care works the same as a primary care physician for prescribing medications. When you go to your pharmacy of choice to pick up the prescription, you will be responsible for any amount due based on your plan's coverage terms, including deductible, coinsurance, or copay requirements.

If the doctor recommends that I see a specialist or my PCP, do I still pay for the visit?

Yes. Like seeing any doctor, if you are referred to another doctor, the consultation fees still apply.

Am I charged if I miss a scheduled visit?

Appointments need to be canceled at least 12 hours before the time of your scheduled consultation to avoid being charged.

How can I get additional help if I have more questions about MDLIVE?

You may call MDLIVE at 888-726-3171 or visit MDLIVEforCigna.com.
You may also call the Cigna customer service number on the back of your Cigna ID card.

USE CIGNA VIRTUAL CARE TO CONNECT WITH A DOCTOR ABOUT:

General health

- Acne
- Allergies
- Asthma
- Bronchitis
- Colds and flu
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

Pediatric care

- Colds and flu
- Constipation
- Earaches
- Nausea
- Pink eye

City of FORT LAUDERDALE

DENTAL

CIGNA | GROUP #3335139

For benefit-eligible employees other than International Association of Fire Fighters (IAFF)

The City offers two Cigna dental plan choices – DHMO and DPPO. Please go to www.cigna.com to view a list of participating dental providers. For DHMO providers, select Cigna Dental Care Access. For DPPO providers, select Total Cigna DPPO. Cigna will mail dental cards to plan participants.

1. The Cigna Dental Care Access DHMO plan focuses on maintaining oral health, prevention, and cost containment. Members must receive services from the participating primary care dentist (PCD) that they are assigned to for eligible services to be covered. Cigna will automatically assign a default dentist based on your home ZIP code. You can select or request to change your dentist at any time by contacting Cigna directly at 1-800-244-6224. Cigna will process your request as soon as administratively feasible. You may see your assigned dentist as often as necessary. There are no deductibles to meet and no waiting periods. Copayments for listed procedures are applicable at either a participating general dentist or participating specialist.

   A PCD may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

   Specialists services: Should members need a specialist (i.e., endodontist, oral surgeon, periodontist, or pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. For DHMO plans, copayment amounts are applicable when treatment is performed by participating specialists.

2. The Total Cigna Dental PPO plan features a schedule of benefits for Preventive (100%), Basic (100%), Major (60%), and Orthodontic services all subject to exclusions and limitations.

Below is a very brief summary of the dental plan offered by the City of Fort Lauderdale. For further information, please refer to the Cigna plan documents at **www.fortlauderdale.gov/benefits**, LauderShare, or contact Cigna directly at 1-800-244-6224.

PLAN FEATURES	Participant Maximum	Preventive Services Exam, cleaning, fluoride, x-rays, sealants	Basic Services Fillings, periodontics, endodontics	Major Services Crowns, bridges, dentures	Orthodontia Up to 24 month treatment, children or adult braces
DENTAL HMO*	No Maximum	$0 copayments	Refer to Plan	Refer to Plan Copayments	Refer to Plan Copayments
	IMPORTANT: DHMO PARTICIPANTS MUST SELECT A PRIMARY CARE DENTIST • Go to **www.cigna.com**				
DENTAL PPO*	$1,500 Maximum annual benefit per person combined in or out of network	100% (no deductibles)	100% (no deductibles)**	60% (no deductibles)**	60% (no deductibles) $2,500 lifetime maximum

Cigna DPPO Plan offered to IAFF members only:

Visit www.cigna.com for a list of participating dentists. Non-participating dentists may bill you for charges above the amount covered by your Cigna Dental Plan.

Cigna will mail dental cards to plan participants.

PLAN FEATURES	Participant Maximum	Preventive Services Exam, cleaning, fluoride, x-rays, sealants	Basic Services Fillings, periodontics, endodontics	Major Services Crowns, bridges, dentures	Orthodontia Up to 24 month treatment, children or adult braces
DENTAL PPO*	$1,500 Maximum annual benefit per person combined in or out of network	100% (no deductibles)	80% (after $100 deductible)	50% (after $100 deductible)	50% (no deductible) $1,500 lifetime maximum

* Teeth missing prior to coverage under the Cigna Dental plans are not covered.

** Please see the applicable summary plan description on the City benefits website or Laudershare for all limitations and exclusions.** Please note if a non-network PPO dentist is used, there will be a $100 individual/$300 family deductible and 60% coverage for Basic and Major Services. Non-participating dentists may bill you for charges above the amount covered by your Cigna Dental Plan. Visit **www.cigna.com** to check out participating dentists.

VISION
UNITEDHEALTHCARE | GROUP #755936

City of FORT LAUDERDALE

VOLUNTARY VISION PLAN (EYE EXAMS, EYEGLASSES AND CONTACTS)

The Vision Plan is a voluntary stand-alone benefit and is provided by UnitedHealthcare for all eligible employees and their dependents. UnitedHealthcare also offers a network of national and independent vision providers and even provides substantial savings on hearing aids.

In-Network Benefits Summary

(Visit www.fortlauderdale.gov/departments/human-resources/employee-benefits/vision-benefits for more details)

1. Once every calendar year employees can get a comprehensive exam, spectacle lenses, and contact lenses instead of eye glasses. Once every other calendar year employees can get frames.
2. $130 retail frame allowance for private practice or retail chain providers.
3. Standard scratch-resistant coating is available to all participants at no charge. Polycarbonate lenses are covered in full for dependent children up to age 19. Other optional lens upgrades may be offered at a discount (discount varies by provider).
4. Coverage for a second eye exam each plan year for members up to age 13 and members pregnant or breastfeeding at no additional premium cost; standard copays apply.
5. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter (unit to measure the optical power of the lens an eye requires) or greater. The 2nd exam and replacement benefits are the same as the initial exam, frames and lens benefits. Standard copays apply.

	In-Network copays	Out-of-network Reimbursements (copays do not apply)
Exam	$10	$40
Frames and one of the following:	$25	$45
Single vision lenses		$40
Bifocal lenses		$60
Trifocal lenses		$80
Lenticular lenses		$80
Selection contact lenses		$105
* Non-selection contact lenses in lieu of eye glasses	$105 allowance	$105
Medically necessary contact lenses in lieu of eye glasses	$25 (then covered in full)	$210

Contact lens benefit:

- Selection contact lenses refers to UnitedHealthcare's formulary contact list. A copy of the list can be found at www.myuhcvision.com. The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to four boxes are included when obtained from an in-network provider. $25 copay for in-network and reimbursed for up to $105 if out-of-network.
- Non-selection contact lenses are contact lenses not listed on the formulary. A copy of the list can be found at myuhcvision.com. A $105 allowance is applied toward the purchase of contact lenses outside the covered selection (materials copay does not apply).
- Medically necessary contact lenses instead of eyeglasses: $25 copay (then covered in full) for in-network and reimbursed up to $210 if out-of-network.

City of FORT LAUDERDALE

LIFE INSURANCE

STANDARD INSURANCE COMPANY | GROUP #754544

CITY PAID GROUP TERM LIFE INSURANCE

The City provides all active full-time, senior management fellows, and temporary full-time employees with group term life insurance at no cost equivalent to one times their base salary up to a maximum of $300,000. This coverage includes Accidental Death and Dismemberment (AD&D). The amount of coverage will be updated to reflect the employee's base salary as of January 1 of each year. Life Insurance coverage reduces to 65% of coverage beginning at age 70.

Life insurance is a tax-free benefit in amounts up to **$50,000**. The Internal Revenue Service (IRS) requires you to pay income tax on the value of any amount exceeding **$50,000**. The IRS-determined value is called "imputed income" and is calculated from the government's "Uniform Premium Table I." Coverage provided each calendar year will be based on the employee's age as of the last day of the tax year. The monthly imputed income is applied to the second paycheck of each month.

UNIFORM PREMIUM TABLE I

AGE	COST (per $1,000 for 1 month)
Under age 25	.05
25 to 29	.06
30 to 34	.08
35 to 39	.09
40 to 44	.10
45 to 49	.15
50 to 54	.23
55 to 59	.43
60 to 64	.66
65 to 69	1.27
70 and Older	2.06

Example of how life insurance imputed income is calculated:

- **$81,000** Annual salary for a 46-year-old City employee (as of December 31, 2021)
- **$81,000** minus **$50,000** IRS non-taxable salary limitation = **$31,000**
- **$31,000** annual salary over IRS limitation / $1,000 x .15 IRS tax rate from table above = **$4.65 monthly imputed income**
- **$4.65** monthly imputed income **x .28** estimated tax rate = **$1.30** estimated tax per month
- **Annual imputed income** = **$55.80 x .28** estimated tax rate = **$15.60** estimated tax per year

81,000.00	Insurance amount
-50,000.00	IRS non-taxable salary limitation
31,000.00	Annual salary over IRS limitation
/ 1,000	Cost per $1,000 salary for one month per table above
31	
X 0.15	IRS tax rate from table above
4.65	Monthly imputed income
X 0.28	Estimated tax bracket rate
1.30	Estimated tax per month
55.80	Annual imputed income
X 0.28	Estimated tax bracket rate
15.60	Estimated annual tax

LIFE INSURANCE

STANDARD INSURANCE COMPANY | GROUP #754544

City of FORT LAUDERDALE

VOLUNTARY GROUP TERM LIFE INSURANCE

Newly eligible employees (e.g., new hires) may purchase additional life insurance coverage without completing a Medical History Statement (also known as Evidence of Insurability (EOI)), of up to $300,000 at the rates indicated below (for their age bracket). Eligible employees may apply for life insurance coverage in increments of $5,000 within a range of $5,000 (minimum) to $400,000 (maximum). Employees must be actively at work for coverage to become effective. The voluntary group term life insurance includes Accidental Death and Dismemberment (AD&D) for both employees and spouses/domestic partners. Please refer to Standard Insurance Company's certificates of coverage for complete information about your benefits.

A Medical History Statement/EOI is not required for a newly eligible employee nor for a Qualifying Life event (QLE) unless the employee or spouse/domestic partner was previously declined or the amount applied for is more than the Guarantee Issue (GI). Any new enrollment or coverage increase requested during Open Enrollment from $5,000 - $20,000 of additional coverage will be approved up to the guaranteed issue amount without evidence of insurability (EOI). Any new enrollment or coverage increase requested during Open Enrollment over $20,000 will be subject to EOI and requires a completed Medical History Statement. The completed Medical History Statement may be downloaded from the Benefits web page at www.fortlauderdale.gov/benefits and must be submitted or faxed directly to Standard Insurance Company or may be submitted via the online process using Group ID #754544.

All eligible employees must complete a life insurance beneficiary designation via the online enrollment process. You may port or convert your current coverage directly with The Standard when you separate from City employment.

BI-WEEKLY VOLUNTARY TERM LIFE RATES

Voluntary Standard Insurance Company group term life insurance automatically includes AD&D. If you die from natural causes your beneficiary receives the term amount. If you die as a result of an accident your beneficiary will receive term amount plus AD&D (equal to term amount).

Newly eligible employees may secure up to $300,000 guaranteed issue voluntary group term life insurance and up to $400,000 with EOI. **Life Insurance coverage reduces to 65% of coverage beginning at age 70. The premium will be adjusted to reflect the reduced coverage.**

HOW MUCH YOUR COVERAGE COSTS

Because this insurance is offered through the City of Fort Lauderdale, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your age and your spouse's rate.

If you buy Life coverage for your child(ren), your monthly rate is $0.50 for $10,000, no matter how many children you're covering.

City of FORT LAUDERDALE

LIFE INSURANCE

STANDARD INSURANCE COMPANY | GROUP #754544

HOW MUCH YOUR COVERAGE COSTS (continued)

Use this formula to calculate your premium payment:

_____ ÷ 1000 = _____ x _____ = _____ ➡ _____

Enter the amount of coverage you are requesting between $5,000 - $400,000.

Enter your rate from the rate table.

This amount is an estimate of how much you would pay each month.

To get a sense of your biweekly premium, multiply your monthly premium amount by 12 and then divide by 26.

Age (as of January 1)	Your Rate* (Per $1,000 of Total Coverage)	Your Spouse's Rate** (Per $1,000 of Total Coverage)
<30	$0.058	$0.058
30-35	$0.067	$0.067
35–39	$0.067	$0.067
40–44	$0.092	$0.092
45–49	$0.153	$0.153
50–54	$0.230	$0.230
55–59	$0.368	$0.368
60–64	$0.411	$0.411
65–69	$0.746	$0.746
70–74	$1.219	$1.219
75+	$2.075	$2.075

*Includes a monthly AD&D rate of $0.015 per $1,000 of AD&D benefit.

**Includes a monthly AD&D rate of $0.015 per $1,000 of AD&D benefit for your spouse.

SPOUSE/DOMESTIC PARTNER COVERAGE: Spouse/domestic partner coverage is available in increments of $5,000 as long as the employee is enrolled in voluntary group term life insurance. Amounts more than $50,000 are subject to EOI. The maximum coverage amount for a Spouse/DP can be increased up to the coverage amount of the employee. Spouse/domestic partner rates are based on the employee's age. If you elect coverage for your spouse, your monthly rate is shown in the table above. Use the same formula to calculate the premium that you used for yourself, but use your age and your spouse's rate. Employees adding a spouse/domestic partner outside of their initial eligibility period must provide EOI. The employee must be enrolled in voluntary group term life insurance to select spouse/domestic partner coverage. A spouse/domestic partner who is a benefits-eligible employee cannot be covered by another benefits-eligible employee.

CHILDREN COVERAGES: Children may be enrolled for $10,000 of coverage through the end of the calendar year they turn age 26 for a biweekly rate of $0.23 (covers all children at one premium). The employee must be enrolled in voluntary group term life insurance to select coverage for their child(ren).

BENEFICIARY DESIGNATIONS

You are encouraged to update your life insurance beneficiaries when you experience a change in family status such as marriage, death, divorce, etc. You may change your beneficiaries at any time online through Selerix BenSelect at **https://www.benselect.com**.

TAX SAVINGS ACCOUNTS

City of FORT LAUDERDALE

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Effective January 1, 2022, the employer-sponsored Flexible Spending Accounts (FSA) program offered by the City of Fort Lauderdale is administered by P&A Group, which has replaced Benefits Outsource, Inc. (BOI). Employees have the option of participating in the Health Care or Dependent Care account, or both. **You MUST re-enroll annually during open enrollment. 2021 FSA** account owners may continue to use their BOI debit cards for 2022 eligible expenses through the end of the grace period which is **December 31, 2022**. Claims incurred through the grace period must be submitted to BOI no later than **December 31, 2022**.

2022 FSA enrollees will be provided with a new benefits debit card from P&A Group for use for **eligible expenses incurred in 2022**. Claims incurred through the grace period, which ends **March 15, 2023**, must be submitted to P&A Group no later than **April 15, 2023**. Should you enroll in an FSA plan in 2022 but still have a balance from Plan Year 2021, use your Plan Year 2021 funds first.

An FSA allows you to reduce your taxable income by setting aside pre-tax dollars to pay for eligible health care and dependent care expenses approved by the Internal Revenue Code (IRC). Eligible expenses covered are for you and all of your dependents, even if they are not covered under your primary health plan(s). It is important that you only allocate dollars for predictable health and dependent care expenses. Any unused FSA funds at the end of the grace period, March 15, 2023 (for 2022 Plan Year), will be forfeited, also called the use-it-or-lose-it rule. You must file for reimbursement no later than April 15, 2023 (for 2022 Plan Year).

HEALTH CARE FSA (ANNUAL MAXIMUM ELECTION $2,750)

The minimum annual election amount is $260 for the Health Care FSA and the maximum annual election is $2,750. This is an annual benefit that allows participation when an election is made during the open enrollment period. Nonetheless, newly hired employees may also participate and enroll within the initial enrollment eligibility period. A big perk with the Healthcare FSA is that it is pre-funded, meaning that the full annual election amount is accessible at the beginning of the plan year. Eligible out-of-pocket expenses for reimbursement relate to any health plan (i.e., medical, dental and vision). Eligible expenses include copays, deductibles, co-insurance, eyeglasses, dental care, over-the-counter medications, feminine products, and certain medical supplies. (Over-the-counter medications are eligible with a doctor's prescription. View the full list of eligible expenses at www.irs.gov/publications/p502/.) The benefits debit card provided upon enrollment lets you easily access all of your account so there are no out-of-pocket costs.

Please note: Employees enrolled in the Consumer Driven Health Plan (CDHP) medical plan should first exhaust their Health Reimbursement Account (HRA) for any eligible medical expenditures BEFORE using their Health Care FSA funds.

DEPENDENT CARE FSA (ANNUAL MAXIMUM ELECTION $5,000)

A Dependent Care FSA is also a pre-tax account established for employees to benefit tax-wise while paying for eligible daycare expenses in order to work. The IRS limits annual contributions to $5,000 annually if "married filing joint tax returns" or "single head of household" or $2,500 for "married filing separately." Qualified dependents are:

- Children under the age of 13 who share the same residence with you, or
- Your spouse or qualifying child or relative who is physically or mentally unable to care for him/herself who shares the same residence with you whose income is less than the federal exemption amount

2021 Dependent Care FSAs: Temporarily, unused 2021 Dependent Care FSA reimbursement is **extended through December 31, 2022 for children, until age 14**, who "aged out" during the pandemic. Any 2021 unused FSA Account balances will be forfeited, if not utilized and claims must be received by BOI **no later than December 31, 2022.**

2022 Dependent Care FSAs: The maximum age is 12 for eligible reimbursable expenses.

City of FORT LAUDERDALE

TAX SAVINGS ACCOUNTS

Should you enroll in an FSA plan in 2022 but still have a balance from Plan Year 2021, use your Plan Year 2021 funds first. Unlike the Health Care FSA, with the Dependent Care FSA, you can only spend up to the amount that has been deducted from your paycheck. With the swipe of your benefits debit card, you can access your funds; otherwise, you can submit manual claims for reimbursement.

ELIGIBLE EXPENSES INCLUDE:

- Before school or after school care (other than tuition)
- Custodial care for dependent adults
- Licensed day care centers
- Nursery schools or preschools
- Placement fees for a provider, such as au pair
- Day camp, nursery school or a private sitter
- Late pick-up fees
- Summer or holiday day camp (not sleepover)

ANNUAL MINIMUM ELECTION $260 – HEALTH AND DEPENDENT CARE FSA

The minimum employee annual contribution for Health and/or Dependent Care FSA is $260. The minimum election mitigates the employee risk and allows you to experience the pre-tax savings of this worthwhile employer-sponsored benefit.

CLAIM REIMBURSEMENT

Your benefits debit card lets you easily access the Healthcare FSA and Dependent Care FSA funds. Employees who re-enroll in the FSA account will continue to use the same debit card up to the card's expiration date. A new debit card will be issued to new enrollees and to those whose previous debit card expired. Payments are automatically withdrawn from your account(s). One card can access all of your benefit accounts. If manual submission of a claim is required, you may submit itemized receipts to P&A Group, via mobile app, fax, mail and online portal upload. Disbursements of claim reimbursements are done via ACH/direct deposit or manual check.

2020 AND 2021 FSA ADMINISTRATIVE SERVICES INFORMATION
Benefits Outsource, Inc.
5599 South University Drive, Suite 201
Davie, FL 33328

For information about your **2020/2021 FSA account(s)**, please contact Benefits Outsource, Inc. (BOI) at 954-680-7626 or 1-888-877-2780. You may also register at **boi.wealthcareportal.com** to access your account information or file a claim.

2022 FSA ADMINISTRATIVE SERVICES INFORMATION
P&A Group
17 Court Street, Suite 500
Buffalo, NY 14202
PH: (716) 852-2611
www.padmin.com

To contact P&A Group with any questions regarding your **2022 FSA account(s)**, please call their customer service department Monday - Friday from 8:30 a.m. to 10:00 p.m. EST at 1-716-852-2611.

For 24/7 online access to your account, logon to **www.padmin.com** or the mobile app. You may upload documentation online, through the mobile app, by fax (1-877-855-7105) or by mail.

DEFERRED COMPENSATION *City of* FORT LAUDERDALE

457(b) DEFERRED COMPENSATION

The 457(b) Deferred Compensation Plan is tax-deferred and may be used to supplement your defined contribution or defined benefit plan and social security benefits during retirement. The 457(b) Deferred Compensation Plan allows for both pre-tax and after-tax contributions. Employees can select which option best suits their long-term financial needs. The City offers two deferred compensation plan providers, MissionSquare Retirement (formerly ICMA-RC) and Nationwide Retirement Solutions. Contributions to a tax-deferred plan will lower taxable income in the year contributed. After-tax plans do not lower taxable income in the year contributed. All income taxes are deferred until you withdraw or receive a distribution after separation from service. You may contribute to either or both providers. Both MissionSquare Retirement and Nationwide offer a wide selection of investment options ranging from conservative to aggressive. Nationwide and MissionSquare Retirement cannot provide tax advice; however, each company has a professional investment advisory program that you can elect to help manage your accounts.

457(b) Deferred Compensation Features

- If you experience an unforeseeable emergency hardship, you may be able to withdraw funds from your account as permitted by Internal Revenue Code Section.
- The plan also allows participants to apply for loans of up to 50% of their account balance, not to exceed $50,000.
- Does not include a 10% tax penalty for early distributions/withdrawals upon separation of employment prior to age 59½, as is typical in 401(a) plans. However, withdrawing from the Roth-457 may have a 10% penalty if withdrawing under these conditions: not yet 59 1/2, have not severed employment and the Roth 457 has not been established for more than 5 years.
- Upon separation from employment, you may keep the funds invested in the accounts or roll them over to another tax-qualified retirement plan. You are required to begin receiving minimum distributions the latter of April 1 following the calendar year in which you turn 72 or April 1 following the year in which you retire (if 72).

457(b) Maximum tax year contributions (as of posting):

- $20,500 normal limit
- $27,000 if age 50 or older as year-end
- $41,000 if you qualify for pre-retirement catch-up contributions

Benefits that Go Together

A Roth IRA and 457(b) Deferred Compensation Plan go together; use both to reach your savings goals with added tax benefits and flexibility.

- For different savings goals: Additional retirement income, health care, a home purchase, college education, emergencies
- For different tax benefits: You can get a tax benefit now when you contribute to your 457(b) plan and a tax benefit later when you withdraw from your Roth IRA. And, if you retire early you can withdraw from your 457(b) plan without penalties.

MATCH YOUR ROTH IRA WITH YOUR 457(b) PLAN

Tax-free withdrawals/distributions, including earnings, are tax- and penalty-free if you have:

- Owned a Roth IRA for at least five years, as defined by the IRS; and
- A qualifying event, such as age 59½, a “first-time” home purchase, disability or death.

Otherwise, income and penalty taxes may apply to the withdrawal of earnings, but contributions can be withdrawn at any time without taxes or penalties. There are no IRS required minimum distributions, so loved ones can receive money you do not need tax free.

Maximum annual Roth contributions (as of posting):
Up to $6,000, or $7,000 if age 50 or older, as of the current year-end and if your IRS Modified Adjusted Gross Income is less than:

- $125,000 for individual filers ($125,000 - $139,999 to make partial contributions)
- $198,000 for married joint filers ($198,000 - $207,000 to make partial contributions)

LEARN MORE

MISSIONSQUARE RETIREMENT:

IRA: www.icmarc.org/ira
457(b) plan: www.icmarc.org/fortlauderdale.html
Contact your Mission Square Retirement Representative at yflores@icmarc.org.

NATIONWIDE RETIREMENT SOLUTIONS:

www.nrsforu.com
Contact your Nationwide Retirement Solutions Representative at pinzona@nationwide.com or schwara5@nationwide.com.

City of FORT LAUDERDALE

LONG-TERM DISABILITY

CIGNA

CITY PAID LONG-TERM DISABILITY INSURANCE

The City provides Long-Term Disability (LTD) insurance, at no cost, to benefit-eligible employees through Cigna to be replaced. The LTD benefit pays the employee a percentage of monthly earnings if the employee becomes disabled due to an illness, non-work related accident, or injury. Eligible employees are automatically enrolled in this coverage.

LTD Plan Summary

Eligibility	**All active, full-time employees of the City covered under the 401(a) Defined Contribution Retirement Plan, regularly working a minimum of 40 hours per week.**
Eligibility Waiting Period	First of month following 30 days of Active Service
Monthly Benefit	60% to $15,000
Minimum Benefit	Greater of $100 or 10% of benefit
Benefit Waiting Period	180 days
Definition of Disability	24 months own occupation
Definition of Covered Earnings	Employee's annual wage or salary excluding bonuses, commissions, overtime pay, and extra compensation.
Accumulated Sick Leave	Not included in benefit waiting period
Maximum Benefit Duration	Social Security Normal Retirement Age (SSNRA)
Employer Contribution	100%
Survivors Benefits	3 months lump sum
Pre-Existing Condition Limitation	3 months prior/12 months insured

For additional policy information go to **www.fortlauderdale.gov/benefits** or on LauderShare at **www.fortlauderdale.gov/benefits**.

VOLUNTARY BENEFITS

City of FORT LAUDERDALE

VOLUNTARY BENEFITS

The City offers Voluntary Benefits that are administered by FBMC Benefits Management to all eligible active employees. These are optional benefit plans that are paid 100% by employees and typically have the advantage of preferred rates, not available to individuals on their own, and the convenience of paying premiums through payroll deduction.

Employees can only add voluntary benefits during open enrollment. Newly eligible employees have 30 days from their eligibility date to enroll in voluntary benefits. The effective date for all voluntary benefits is the first of the month following 30 days of the voluntary benefits enrollment application being signed through the online enrollment platform. Example: A new hire with a hire date of October 8, 2021 enrolled in and signed the voluntary benefits application on November 2, 2021 making their voluntary benefits effective January 1, 2022.

Aflac Plans:

- **Group Hospital Indemnity Insurance, Aflac** (Post-Tax): Provides financial assistance when you are confined to a hospital.
- **Group Accident Insurance, Aflac** (Pre-Tax): Provides financial benefits for covered accidents.
- **Group Short-Term Disability Insurance, Aflac** (Post-Tax): Provides financial benefits in the event of a qualified disability.
- **Group Critical Illness Insurance, Aflac** (Pre-Tax): Provides benefits when diagnosed with a covered critical illness.

ARAG Legal Insurance Plans:

- **Legal Insurance, ARAG** (Post-Tax): Provides attorney fees for most covered legal matters within the plan limits.

If you are a newly eligible employee who has questions or needs guidance to enroll in any of the voluntary Aflac or ARAG benefits, you may speak with the Senior Employee Benefits Specialist. The Senior Employee Benefits Specialist will be available for telephone appointments. During your appointment, the Senior Employee Benefits Specialist will:

- Provide education on voluntary benefits offered and assist you with making benefits decisions to best meet your needs
- Answer any questions you may have about offered voluntary benefits
- Assist you with making your voluntary benefits elections

To learn more about your benefits or if you need assistance enrolling, please visit **cofl.fbmcbenefits.com** or by calling 1-866-849-COFL (2635).

You may schedule a telephonic appointment at **www.myenrollmentschedule.com/fll** or by calling 1-866-849-COFL (2635).

LOANS AT WORK (Post-Tax): This voluntary loan program will provide City employees with the opportunity to apply for unsecured loans for health care expenses or any other needs up to $5,000 (capped at 20% of net take-home pay) to be repaid through payroll deductions.

City of FORT LAUDERDALE

FREQUENTLY ASKED QUESTIONS (FAQS)

WHO IS ELIGIBLE TO PARTICIPATE IN GROUP COVERAGE?

EMPLOYEES

- Full-time employees (both regular full time and temporary full time) are eligible to participate in all group benefits. Variable hour employees, such as part-timers who satisfy the criteria under the Affordable Care Act, are eligible to participate in any of the City's medical plans for the 2022 plan year.
- Newly eligible employees (i.e. new hires or employees promoted from part time to full time) are eligible for benefits the first day of the month following 30 days from their eligibility date (i.e. date of hire or promotion effective date). The coverage effective date for selected benefits is the same as the eligible date as long as Benefits Section, HR receives the electronic enrollment requirements via Selerix BenSelect no later than 30 days from the eligibility date (must be actively working for life insurance to be effective). Enrollment requests after the 30 day time limit will not be processed and you cannot re-apply until the next open enrollment, unless you experience an Internal Revenue Code (IRC) Section 125 qualifying event or Special Enrollment Rights. You may contact Benefits Section, HR at 954-828-5160 if you do not have access to a computer. **Social Security numbers and documentation to support dependent status must be provided to Benefits Section, HR for all dependents**. Please visit www.fortlauderdale.gov/benefits or Laudershare at www.fortlauderdale.gov/laudershare.
- Police employees represented by the Fraternal Order of Police (FOP) are eligible for medical, dental and vision benefits through the FOP ONLY and may participate in the City's life, Health Care and Dependent Care Flex Spending Accounts and voluntary benefits.

DEPENDENTS

Who are my eligible dependents and what documentation is required as proof of eligibility?

If you enroll for medical, dental, or vision insurance you may also enroll your eligible dependents (identified below). The type of documentation acceptable, as proof of dependent eligibility, is identified in parenthesis. Documentation must be provided at the time you enroll via attachment in Selerix BenSelect or by submitting the document(s) to Benefits Section, HR. If the documentation is not readily available, please complete the online enrollment (active employees) or change request form (retirees) and follow-up with the documentation as soon as it becomes available. **Your enrollment request will not be processed without the supporting documentation.** Please remember to write your employee ID number on each document submitted. If both parents are enrolled for benefits as employees through the City, children may not be enrolled for coverage under both parents.

- Spouse, if she/he is not also a benefits-eligible City of Fort Lauderdale employee **(official marriage certificate)**. A spouse who is a benefits-eligible employee cannot be covered by another benefits-eligible employee. **An Ex-spouse is not eligible for coverage under your insurance**
- Domestic partner (if she/he is not also a City of Fort Lauderdale employee eligible for benefits) as established by the City **(Affidavit of Domestic Partnership)**. A domestic partner who is a benefits-eligible employee cannot be covered by another benefits-eligible employee.
- Your biological child, legally adopted child or a child placed in the home for adoption in accordance with applicable state and federal laws **(official birth certificate, copy of official legal documents proving the status)**
- Child(ren) of your domestic partner, unless covered by a spouse/domestic partner who also works for the City of Fort Lauderdale **(copy of official birth certificate showing the domestic partner as the parent)**
- Your child, if permanently physically and/or mentally disabled **(and not an eligible City employee)**, may be covered indefinitely beyond the limiting age as long as acceptable proof of the disability is provided to the plans.
- Specified dependent child or foster child placed in your home **(copy of the executed court order)**
- A grandchild up to age 18 months if born while your child is covered under the plan (Florida Statute 627.6575) and the parent remains covered under the plan **(copy of birth certificate)**
- The Affordable Care Act permits married or unmarried dependent children to be covered under the medical plans to the last day of the calendar year that they reach the age of 26. An unmarried dependent child may be covered for medical beyond the end of the calendar year in which he/she turns age 26 to age 30, if the criteria established by Florida Statutes are satisfied. Dependent children enrolled for dental, vision and life insurance coverage are eligible to the end of the calendar year in which they turn age 26.
- Your foster child, if placed in your home prior to age 18 **(proof of placement by the Department of Children and Families or the foster care program of a licensed agency)**

What are the criteria for dependent children ages 26-30 (end of calendar year) to be eligible for group medical coverage?

- Florida Statute Chapter 627.6562 stipulates that the child must be (a) unmarried without any dependents, (b) a resident of Florida or a full-time/part-time student and (c) is not provided coverage or is not a covered person under any other group medical insurance policy or individual medical benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act. Certification must be completed upon initial enrollment and annually thereafter.
- Employees enrolling a new dependent child age 26+ must provide supporting documentation that the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

FREQUENTLY ASKED QUESTIONS (FAQS)

City of FORT LAUDERDALE

PRE-TAX PREMIUM/IMPUTED INCOME

What is pre-tax premium?

Pre-tax premium is an insurance contribution deducted from your paycheck before you pay any taxes. Premium contributions for medical, dental, vision, health care and dependent care FSAs are deducted through a Cafeteria Plan established under Internal Revenue Code (IRC) Section 125 and the City's Flexible Benefits Plan document. Due to IRC Section 125 rules, mid-year pre-tax premium changes may only be processed if the employee satisfies a qualifying event as permitted by the IRC Section 125, and the City's Plan document, or exercises a HIPAA Special Enrollment Right and submits a timely request.

Are premiums for adult children ages 26 to 30 and domestic partners/dependent children of domestic partners deducted pre-tax?

Generally, no. Premiums attributable to dependent children ages 26 to 30 are deducted post-tax unless they meet the definition for tax-qualified dependent under the Internal Revenue Code. The City does not subsidize premiums for adult children ages 26 to 30 years old. Premiums attributable to domestic partners, and the children of domestic partners are deducted post-tax unless it is established that they are qualified tax dependents as defined by the Internal Revenue Code. To have premiums payroll deducted pre-tax, the employee must also complete the Domestic Partner Certification of Dependent Status Form and must re-certify annually during open enrollment. The required forms are included under the Forms section on the Employee Benefits web page at www.fortlauderdale.gov/benefits and LauderShare at www.fortlauderdale.gov/laudershare.

What is imputed income for health insurance?

The Internal Revenue Code (IRC) allows employees to pay "tax-free" health insurance subsidies for themselves and their eligible dependents as defined under IRC provisions but generally excludes the amount attributable to dependent children after the end of the year in which they turn age 26, domestic partners and children of domestic partners. This excluded amount is referred to as imputed income. Please see the life insurance section for imputed income related to City paid life insurance. The monthly Imputed income is applied to the second paycheck of each month.

IRC SECTION 125 CHANGE IN STATUS QUALIFYING AND OTHER PERMITTED EVENTS

What mid-year (outside of the annual open enrollment period) qualifying events allow me to add or delete dependents?

The health plans are governed by Internal Revenue Code Section 125 rules and the City's Flexible Benefits Plan document, which permits mid-year plan changes (example to add or delete dependents) only if certain qualifying events are experienced by the employee or dependent. Therefore, a participant may not revoke any elections made, outside of the annual benefits open enrollment period, **except** as illustrated in the following qualifying events or Special Enrollment Rights:

- A change in the participant's legal status, including marriage, divorce, death of the participant's spouse, domestic partnership status (post-tax, unless a qualified tax dependent as defined by the Internal Revenue Code and the employee completes a Domestic Partner Certification of Dependent Status Form)
- A change in the number of dependents that the participant has for federal income tax purposes due to events such as birth, adoption, placement for adoption or death
- Termination or commencement of employment of the participant, spouse, domestic partner (post-tax unless a qualified tax dependent under the Internal Revenue Code), or dependent of the participant
- A reduction or increase in the hours of employment such as a switch between part-time and full-time status, going on an approved unpaid leave of absence (LOA)/Family Medical Leave Act (FMLA) or returning from an approved LOA/FMLA
- An event that causes the participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age
- A court order or judgment, decree, or change in legal custody, including a qualified medical child support order
- Entitlement to/or loss of Medicare eligibility, entitlement to Medicaid
- Entitlement to Premium Assistance under State Medicaid or Children's Health Insurance Program (CHIP), OR loss of eligibility for State Medicaid or CHIP (60 days allowed to exercise special enrollment rights after termination of Medicaid or CHIP coverage)
- Differences in the open enrollment periods between the City and another employer affecting the participant's spouse or dependent
- Significant increases in plan costs
- Significant curtailment in plan benefits
- Special Enrollment Rights: If an employee becomes eligible to exercise any Special Enrollment Rights, he/she may change election for the balance of the plan year and file a new election which corresponds with the exercise of those rights. For more information on Special Enrollment Rights, please click on the Cigna image on the Benefits web page to review the certificates of coverage.

City of FORT LAUDERDALE

FREQUENTLY ASKED QUESTIONS (FAQS)

What is the consistency rule governing change in status requests?

IRC Section 125 requires that any change in status requests processed must be consistent with the qualifying event. For example, if the employee gets a divorce, it would be a qualifying event to delete the ex-spouse, but not to add existing dependent children who were not on the employee's plan. Another example is the event of a deceased spouse. It would be a qualifying event to delete the deceased spouse and add the existing dependents, if they were enrolled under the spouse's health plan, within 30 days from the date of death.

How do I make a Qualified Life Event (QLE) change to my benefits outside of the annual open enrollment and what is the time frame?

To make a change to your benefits outside of the annual open enrollment, ACTIVE employees must login to Selerix BenSelect and complete their benefit enrollment and/or changes no later than 30 days from the event (60 days for newborns/adoptions/placement for adoption/entitlement or loss of Medicaid/CHIP and other events noted in IRC section 125). Retirees must complete a Health Benefits Election Change Form and a Retiree Benefits Election Form and submit them to Benefits Section, HR. These forms may be downloaded from www.fortlauderdale.gov/benefits or obtained from the Benefits Section, HR. Do not delay completing your online request (Active Employees) or submitting the completed change forms (Retirees) while you gather the supporting documentation. Change requests must be completed within the specified time frames. You must then follow up with the supporting documentation by uploading them into Selerix BenSelect or submitting them to Benefits Section, HR as soon as it becomes available, but no later than 30 days after the event. The types of documentation required to support the change in status are provided in Selerix BenSelect. Changes between health plans are generally not allowed.

When do requested changes become effective?

Open enrollment changes become effective January 1 of the following year with the exception of life insurance increases which are effective subject to approval from Standard Insurance Company. Outside of the open enrollment period, changes generally become effective the first day of the month following receipt of the change request if provided within 30 days from the date of the event (60 days for newborns/adoptions/placement for adoption/ entitlement to State Medicaid/CHIP or entitlement to CHIP).

When do changes to add a new dependent become effective?

Changes to add a new dependent become effective the first day of the month following, or coincident to, timely enrollment online through Selerix BenSelect (Active Employees) or receipt of the completed forms (Retirees) by Benefits Section, HR with the exception of birth, adoption or placement for adoption which become effective as of birth or the earlier of (a) adoption or (b) placement for adoption.

Payroll changes to add newborn child(ren) are processed in accordance with Florida Statute 641.31(9). If the change request is completed within 30 days of birth, the premium is waived for the first 30 days from birth. If the change request is completed after the first 30 days, but within 60 days of the qualifying event (birth, adoption or, placement for adoption), the new premium will be charged retroactive to the date of the qualifying event.

What if I submit a late request for a change in status qualifying event?

If the request is submitted beyond the required time frames, the change will not be processed. If the request is to delete an ineligible dependent, you will be responsible financially for any claims incurred by that ineligible dependent but the premium changes, if applicable, will not be processed. Late requests to add new dependents will not be processed. You will need to make the change during the annual benefits open enrollment or if you exercise an allowable HIPAA Special Enrollment Right.

CANCELLATION

May I cancel coverage outside the annual benefits open enrollment?

Employees may request cancellation of coverage during the year as permitted by Florida Statute. If there is an IRC Section 125 qualifying event, coverage and payroll deductions will continue through the end of the month that a timely cancellation request is received. However, for pre-tax benefits, if there is not an IRC Section 125 qualifying event, pre-tax premium payroll deductions will continue through the end of the current plan year. If you opt-out or cancel your coverage you may not reapply (a) until the annual benefits open enrollment period, which takes place in the fall of each year, or (b) if you may exercise a HIPAA Special Enrollment Right. Requests to cancel post-tax benefits during the year will be processed prospectively without a penalty. Employees will not be able to re-enroll until the next open enrollment. Applications to re-enroll for life insurance benefits are subject to evidence of insurability.

BENEFICIARY DESIGNATIONS

May I update my beneficiaries at any time?

Yes. If enrolled for life insurance, you are strongly encouraged to review your beneficiaries and update, if necessary, when you experience a change in status such as divorce, marriage, death, or any other changes. You are also encouraged to list contingent/secondary beneficiaries in the event your primary beneficiary(ies) predeceases you. Simply login to Selereix BenSelect to update your beneficiary designations.

Where may I find information on life insurance benefits and provisions?

Review the certificates of coverage at www.fortlauderdale.gov/benefits or on LauderShare at www.fortlauderdale.gov/laudershare or contact Standard Insurance Company at 1-888-937-4783.

FREQUENTLY ASKED QUESTIONS (FAQS)

City of FORT LAUDERDALE

HEALTH REIMBURSEMENT ACCOUNT (HRA)

What is an HRA?

An HRA is an employer-funded, tax-qualified spending account that may be used to pay for qualified medical expenses such as deductibles and coinsurance for covered medical expenses and prescription drugs.

Do all employees enrolled in the medical plans have an HRA account funded by the City?

No. HRA funding is only available to employees and their tax-qualified dependents enrolled for the Consumer Driven Health Plan (CDHP). Employees may not access funds remaining in the account upon separation of employment since the account is not portable. Retirees and non-tax qualified dependents (i.e. adult child dependents, domestic partners and domestic partner's child(ren)) are not eligible for HRA funding. These dependents can be insured and receive coverage as any other insured but will have their own deductible and out-of-pocket maximum that is separate from the employee and tax-qualified dependents. The employee will not receive the portion of the HRA attributable to coverage for a domestic partner, their dependents or an Adult Child Dependent.

How much HRA funding does the City provide for eligible Consumer Driven Health Plan (CDHP) participants for the plan year?

- Employee only = $1,000
- Employee + one tax-qualified dependent = $1,500
- Employee + two or more tax-qualified dependents = $2,000
- The funding is prorated for enrollments after January 1.

Is there a separate ID card for the HRA?

No. The Cigna ID card is presented to access the HRA funding.

How do I keep track of the funds remaining in my HRA or obtain more information?

You may keep track of your HRA balance by reviewing Explanation of Benefits (EOB) statements received, by logging on to www.myCigna.com, reviewing quarterly HRA statements received, or by contacting Cigna's customer service 24/7 toll-free at 1-800-244-6224. You may also review the Cigna summary plan descriptions on the Employee Benefits web page.

May the funds in my HRA be rolled over to another calendar year?

Yes; however, this is subject to changes in IRS guidelines and City policy.

SEPARATION FROM THE CITY OR LOSS OF BENEFITS ELIGIBILITY

What happens to my benefits if I separate from the City or lose eligibility?

Benefits coverage and payroll deductions will continue through the end of the month in which you separate from the City or lose eligibility. You are responsible for payment of employee deductions for the entire month in which you separate or lose eligibility. Depending on the coverage you are enrolled in, you will have the following option(s) to continue the coverage after the end of the month:

Medical, Dental, Vision, and Health Care Flexible Spending Account

There are two options to continue this coverage:

1. Retirement: You have the option to continue medical, dental, and vision coverage through the Retiree Group. Coverage is not automatic. You must complete a Retiree Enrollment Form if you wish to elect insurance through the Retiree Group.

   Although you are eligible to continue your health coverage through the City's Retiree Group, you will also receive a notice from Benefits Outsource, Inc. (BOI) of your eligibility to elect Consolidated Omnibus Budget Reconciliation Act (COBRA). As a retiree you also have the option to continue your health care flexible spending account through COBRA through the end of the calendar year.
2. COBRA: You are eligible for COBRA continued coverage (medical, dental, and vision) based on your qualifying event (termination of employment). COBRA benefits will commence effective the first of the month following termination of health benefits. You can expect to receive a COBRA enrollment packet from Benefits Outsource, Inc. (BOI). You also have the option to continue your health care flexible spending account through COBRA through the end of the calendar year (Dependent Care Flexible Spending Accounts cannot be continued).

City Paid Group Term Life Insurance and Voluntary Group Term Life Insurance

There are two options to continue this coverage:

1. The coverage can be ported, in this case meaning the coverage will stay the same as it is now (Term Life), but you will have to pay the insurance company (The Standard) directly. There is an application that will be provided by City Benefits Section. You can keep your current coverage amount or elect a lower coverage amount.
2. The coverage can be converted, meaning the coverage will change to a whole life policy, which provides a cash value at a certain point. This coverage premium will also have to be paid

directly to The Standard. There is an application to complete provided by The Standard.

- Employees who port or convert their life insurance coverage will continue their coverage directly with The Standard and will no longer be affiliated with the City Group Life Insurance.

Voluntary Group Aflac Benefits

- The Accident, Short Term Disability, Critical Life and Hospital Indemnity coverages through Aflac can be ported, in this case meaning the benefit will stay the same as it is now but you will have to pay Aflac directly. The contact number for Aflac is 1-800-433-3036. Upon your request, Aflac will mail you information on how to port your coverage(s).

Voluntary Group ARAG Legal Plan

- ARAG Legal offers two conversion plans that an employee can enroll in. The premium is subject to change and paid directly to ARAG. The contact number for ARAG is 1-800-247-4184. Upon your request, ARAG will mail you information on how to convert your coverage.

COBRA

What is COBRA?

- COBRA is the federal law that requires most group health plans, including medical, dental, vision, and Health Care Flex Spending Accounts, to give employees, their covered dependents and qualified beneficiaries the opportunity to continue their group health benefits when there is a "qualifying event" (i.e., termination of employment, retirement, divorce, death of employee, etc.) that would result in a loss of coverage under an employer's plan. Continuation coverage for each qualified beneficiary must be the identical coverage that the plan offers to active employees and covered dependents. COBRA rights may be exercised independently for each qualified beneficiary.
- The following individuals do not have the right to independently elect COBRA: domestic partners, grandchildren and/or stepchildren (unless adopted by the employee). However, if the employee elects COBRA continuation coverage for them-self, they may also cover their dependents even if they are not considered qualified beneficiaries under COBRA. Such individuals' coverage will terminate when the employee's COBRA continuation coverage terminates.
- The employee or family member must provide written notice to Benefits Section, HR within 60 days of the event when a covered spouse loses eligibility due to divorce or a dependent child loses eligibility.
- The law specifies the time frames within which qualified beneficiaries must be notified, be allowed to elect continuation coverage and make payments. The cost to qualified beneficiaries may not exceed 102% of the premium equivalent cost of insurance for the active group.

How will I and my qualified beneficiaries be notified of my COBRA rights?

The City has contracted with a Third Party Administrator (TPA), P&A Group, to administer the COBRA provisions, provide notification within the time frames specified by the federal law and to perform the accounts receivable functions for qualified beneficiaries who elect continuation. The City provides the TPA with information pertaining to new enrollees and employees losing group coverage due to termination of employment and other known qualifying events.

Where may I obtain more information on COBRA?

Go to the P&A Group posting at www.fortlauderdale.gov or contact the City's COBRA Administrator, P&A Group, at 1-716-852-2611.

APPROVED UNPAID LEAVES OF ABSENCE (LOA)/THE FAMILY AND MEDICAL LEAVE ACT FMLA

How do I maintain my group benefits while on unpaid leave and FMLA?

Going on an approved unpaid LOA or FMLA leave is considered a qualifying event that allows you to make changes to your coverage consistent with the event. For example, you may delete dependents or cancel coverage within 30 days of being in an unpaid LOA or FMLA leave. Since you will not receive a paycheck while on unpaid leave, the premiums to cover your plan elections cannot be payroll deducted. You must take steps to ensure there is no disruption in your coverage. Before you miss your first paycheck, please contact Benefits Section, HR for instructions on how much to pay, the frequency of payments and other pertinent information.

PRESCRIPTION COVERAGE AND MEDICARE

City of FORT LAUDERDALE

2022 IMPORTANT NOTICE FROM THE CITY OF FORT LAUDERDALE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE TO ACTIVE EMPLOYEES, RETIREES AND DEPENDENTS PARTICIPATING IN THE FOLLOWING CITY-SPONSORED HEALTH PLANS:

Cigna Open Access Plus In-Network 1 (OAPIN1, aka HMO1) and Cigna Open Access Plus In-Network 2 (OAPIN2, aka HMO2) and Consumer Driven Health Plan (CDHP)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Fort Lauderdale and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium

2. The City of Fort Lauderdale has determined that the prescription drug coverage under OAPIN1 (HMO1), OAPIN2 (HMO2) and Consumer Driven Health Plan (CDHP) are, on average, expected to pay out as much as standard Medicare prescription drug coverage pays for all plan participants and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you may keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current City of Fort Lauderdale coverage will not be affected.

For those individuals who elect Part D coverage and elect to drop coverage under the City of Fort Lauderdale's plan, coverage will end for the individual and all covered dependents. See the Centers for Medicare and Medicaid Services (CMS) Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage**), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

Your current City of Fort Lauderdale coverage pays for other medical expenses in addition to prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current City of Fort Lauderdale medical plan, which includes prescription drug benefits, please be aware that you (if actively employed) and your dependents may not be able to get this coverage back until the next annual benefits open enrollment period, which has an upcoming effective date of January 1. Retirees who drop their current City of Fort Lauderdale plan, which includes prescription drug coverage, must be aware that they will not be able to get this coverage back at a later date.

City of FORT LAUDERDALE

PRESCRIPTION COVERAGE AND MEDICARE

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with the City of Fort Lauderdale and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact the office listed below for further information and refer to the certificates of coverage issued by the prescription drug provider. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through the City of Fort Lauderdale changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number)
- For personalized help, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov** or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**October 14, 2021**
Name of Entity/Sender:	**City of Fort Lauderdale**
Contact-Position/Office:	**Benefits Section, Human Resources**
Address:	**100 North Andrews Avenue, 3rd Floor Fort Lauderdale, FL 33301**
Phone Number:	**954-828-5160**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact BENEFITS SECTION, HR.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
CITY OF FORT LAUDERDALE	59-6000319
5. Employer address	**6. Employer phone number**
100 N. ANDREWS AVENUE	954-828-5160

7. City	8. State	9. ZIP code
FORT LAUDERDALE	FL	33301

10. Who can we contact about employee health coverage at this job?	
BENEFITS MANAGER	
11. Phone number (if different from above)	**12. Email address**
	healthyliving@fortlauderdale.gov

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

All full-time employees and part-time employees who satisfy the criteria under the Affordable Care Act (ACA).

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouses, domestic partners, dependent children of employees up to the end of calendar year in which they turn age 26 and those who satisfy the guidlines under Florida Statute (FS627.6562)

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

CITY OF FORT LAUDERDALE NOTICE REGARDING COLLECTION, USE, AND DISCLOSURE OF SOCIAL SECURITY NUMBERS

The collection of social security numbers by the City of Fort Lauderdale ("City") is either specifically authorized by law or imperative for the performance of the City's duties and responsibilities as prescribed by law and the Florida Constitution. The following list identifies the purposes for which social security numbers may be collected, used, or disclosed, the relevant legal authority, and whether collection of the social security number for the stated purpose is mandatory or authorized.

- For employment eligibility, reports to the Internal Revenue Service, and income tax withholding, including for W-2's, W-4's, and I-9's. [Collection mandated by 26 U.S.C. §6051, 26 C.F.R. §31.6011(b)-2, 26 U.S.C. §3402, 26 C.F.R. §31.3402(f)(2)-1, 26 C.F.R. §31.3402(f)(5)-1, 8 U.S.C. §1324a, 8 C.F.R. §274a.2, 26 C.F.R. §31.6051-1, and 26 C.F.R. § 301.6109-1. Disclosure: 26 U.S.C. §6051, 26 C.F.R. §6051-1, §119.071(5)(a)6, Fla. Stat.];
- For reports to the Social Security Administration. [Disclosure: 26 C.F.R. §31.6051-2, §119.071(5)(a)6, Fla. Stat.];
- For administration of the City's health benefits, pension fund, deferred compensation plan, and defined contribution plan, [Disclosure: §119.071(5)(a)6, Fla. Stat.];
- For income deduction notices for child support, alimony, and child support enforcement. [Collection authorized by §§61.1301(2)(e) and 61.13, Fla. Stat. Disclosure: 42 U.S.C. §653a(b), §119.071(5)(a)6, Fla. Stat.];
- For unemployment compensation benefits. [Disclosure: §119.071(5)(a)6, Fla. Stat.];
- For reports of worker's compensation injury or death. [Disclosure: §§440.185, and 119.071(5)(a)6, Fla. Stat.];
- For worker's compensation petitions for benefits and responses. [Collection authorized by §60Q-6.103, Florida Administrative Code. Disclosure: §60Q-6.103, Florida Administrative Code, and §119.071(5)(a)6, Fla. Stat.];
- For notices of tort claim. [Collection mandated by §768.28(6), Fla. Stat.];
- For verification of identity, background investigations and criminal history checks. [Disclosure: §119.071(5)(a)6, Fla. Stat.];
- The social security number may be disclosed to facilitate the direct deposit of funds to a payee's account. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if it is expressly required by federal or state law or a court order. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if the individual expressly consents in writing to the disclosure of his or her social security number. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if the disclosure is necessary for the City to perform its duties and responsibilities. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if the disclosure is made to comply with the USA Patriot Act of 2001, Pub. L. No. 107-56, or Presidential Executive Order 13224. [§119.071(5)(a)6, Fla. Stat.]
- The social security number may be disclosed if the disclosure is made to a commercial entity for the permissible uses set forth in the federal Driver's Privacy Protection Act of 1994, 18 U.S.C. ss. 2721 et seq.; the Fair Credit Reporting Act, 15 U.S.C. ss. 1681 et seq.; or the Financial Services Modernization Act of 1999, 15 U.S.C. ss. 6801 et seq., provided that the authorized commercial entity complies with the requirements of Fla. Stat. § 119.071(5). [§119.071(5)(a)6, Fla. Stat.]

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Florida, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www .insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa .dol.gov or by calling toll-free 1-866-444-EBSA (3272).

For further information on eligibility in Florida:

FLORIDA - Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of LaborEmployee Benefits Security Administration
Website: **www.dol.gov/agencies/ebsa**
Phone: 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
Website: **www.cms.hhs.gov**
Phone: 1-877-267-2323, Menu Option 4, Ext. 61565

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICES

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Cigna Member Services at 1-800-244-6224.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Cigna Member Services at 1-800-244-6224.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the City's Medical Plans with respect to mental health or substance use disorder benefits, please contact Cigna Member Services at 1-800-244-6224.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact:

City of Fort Lauderdale
Benefits Section, Human Resources
100 North Andrews Avenue, 3rd Floor
Fort Lauderdale, Florida 33301
(954) 828-5160
healthyliving@fortlauderdale.gov

CITY OF FORT LAUDERDALE
Benefits Section | Risk Management Division | Human Resources
City Hall • 100 N. Andrews Avenue • Fort Lauderdale, FL 33301
(954) 828-5160 • www.fortlauderdale.gov/benefits • healthyliving@fortlauderdale.gov

BENEFITS DIRECTORY

MEDICAL AND DENTAL		
• CIGNA Medical and Dental	www.cigna.com	1-800-244-6224
• Personal CIGNA Web Portal	www.mycigna.com	
• Employee Assistance Program (EAP)	www.cignabehavioral.com (Employer ID: cofl)	1-877-622-4327 (24/7)
• Kerri Holden, CIGNA Onsite Wellness Coordinator		954-652-1306 Fax: 1-860-847-5126
VISION		
• UnitedHealthcare Vision	www.myuhcvision.com	1-800-638-3120 Fax: 1-248-733-6060
CITY HEALTH AND WELLNESS CENTER		
• Marathon Health (Administrator)	www.marathon-health.com/MyPhr/login	1-754-206-2420 Fax: 954-867-5583
LONG-TERM DISABILITY		
• Cigna Long-Term Disability Cigna	www.cigna.com	1-888-842-4462 1-866-561-8421
LIFE INSURANCE		
• Standard Insurance Company	www.standard.com	1-888-937-4783 Fax: 1-971-321-5994
INCOME PROTECTION		
• Aflac Group Products (Group Accident, Group Critical Illness Advantage, Group Short-Term Disability and Group Hospital Indemnity Insurance)	http://cofl.fbmc.com	1-800-433-3036
2021 FSA ADMINISTRATOR (Benefits Outsource, Inc.)		
• Health Care FSA • Dependent Care FSA	https://boi.wealthcareportal.com https://boi.wealthcareportal.com	954-680-7626 Fax: 954-680-7630
2022 FSA ADMINISTRATOR (P&A Group)		
• Health Care FSA • Dependent Care FSA	www.padmin.com www.padmin.com	1-716-852-2611 Fax: 1-877-855-7105
LEGAL SERVICES		
• ARAG Legal	http://cofl.fbmc.com	1-800-247-4184
DEFERRED COMPENSATION / LOANS		
• MissionSquare Retirement	www.icmarc.org	1-800-669-7400 Fax: 1-202-682-6439 / Attn: WMT
• Nationwide	www.nrsforu.com	1-877-677-3678 Fax: 1-877-677-4329
• BMG Loans at Work	www.loansatwork.com	1-800-316-8507

If you would like this publication in an alternate format, please call (954) 828-4755 or email strategiccommunications@fortlauderdale.gov

Utilized Providers (pages 443-459) have been redacted.

BUSINESS ASSOCIATE AGREEMENT - SAMPLE

This Agreement is made and entered into this ____day of _____, 2022, by and between the City of Fort Lauderdale, a Florida municipality (hereinafter referred to as the "Covered Entity" or “City”) and _____, a _____ corporation authorized to transact business in the State of Florida (hereinafter referred to as “Business Associate”).

WHEREAS, the Covered Entity and the Business Associate have established a business relationship in which Business Associate, acting for or on behalf of Covered Entity, receives Protected Health Information as defined by the Health Insurance Portability and Accountability Act of 1996 (“Act”); and

WHEREAS, the Covered Entity and the Business Associate desire to comply with the requirements of the Act’s Privacy Rule as further set out below.

NOW, THEREFORE, in consideration of the mutual covenants, promises and agreements set forth herein, the Covered Entity and the Business Associate agree as follows:

1. Definitions

a. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy and Security Rules (“Privacy Rule”), as codified in 45 Code of Federal Regulations Parts 160 through 164, as may be amended.

2. Obligations and Activities of Business Associate

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.

b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

e. Business Associate agrees to ensure that any agent or subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the

same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

f. Business Associate agrees to provide access, at the request of Covered Entity, and in a reasonable time and manner, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524, if the Business Associate has Protected Health Information in a Designated Record Set.

g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity or an Individual, in a reasonable time and manner, if Business Associate has Protected Health Information in a Designated Record Set, or take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. 164.526.

h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a reasonable time and manner or as designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

j. Business Associate agrees to provide to Covered Entity or an Individual, within thirty (30) days of receipt of a written request from the Covered Entity or an Individual, information collected in accordance with Section 2.i of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

k. Sections 164.308, 164.310, 164.312, and 164.316 of Title 45, Code of Federal Regulations, shall apply to Business Associate in the same manner that such sections apply to Covered Entity.

l. Business Associate shall comply with the privacy, security, and security breach notification provisions applicable to a business associate pursuant to Subtitle D of the Health Information Technology for Economic and Clinical Health Act which is Title XIII of Division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), 42 U.S.C.A. §17921 *et seq.* (2017), as may be amended or revised, ("HITECH"), any regulations promulgated thereunder, and any amendments to the Privacy Rule, all of which are hereby incorporated herein by reference.

3. Permitted Uses and Disclosures by Business Associate

a. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the **Agreement for _____ dated _____, 2022,** between the City of Fort Lauderdale and the Business Associate ("Original Contract"), provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

4. Specific Use and Disclosure Provisions

a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).

e. Business Associate may use Protected Health Information to deidentify the information in accordance with 45 C.F.R. 164.514(a)-(c).

f. Business Associate may use Protected Health Information as required by law.

g. Business Associate agrees to make uses and disclosures and requests for protected health information consistent with Covered Entity's minimum necessary policies and procedures.

h. Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except for the specific uses and disclosures set forth above.

5. Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any limitation(s) in the notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose his or her Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

c. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to or is required to abide by under 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

6. Permissible Requests by Covered Entity

a. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except that Business Associate may use or disclose Protected Health Information for data aggregation or management and administrative activities of Business Associate if required by the terms of the Original Contract.

7. Term and Termination

a. The Term of this Agreement shall be effective as of the effective date of the Original Contract, and shall terminate when the Original Contract terminates. Upon termination, all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, shall be destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, or if it is illegal to destroy Protected Health Information, the protections are extended to such information, in accordance with the termination provisions in this Section.

b. Upon either party's knowledge of a material breach by the other party, the nonbreaching party shall either:

1. Provide an opportunity of at least thirty (30) days for the breaching party to cure the breach or end the violation and terminate this Agreement and the Original Contract if the breaching party does not cure the breach or end the violation within the time specified by the nonbreaching party;

2. Immediately terminate this Agreement and the Original Contract if the breaching party has breached a material term of this Agreement and cure is not possible; or

3. If neither termination nor cure is feasible, the nonbreaching party shall report the violation to the Secretary.

c. Effect of Termination

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return, or destroy, except as prohibited by the Florida public records law, all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

2. In the event that Business Associate's return or destruction of the Protected Health Information would be infeasible or illegal, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible or illegal, for so long as Business Associate maintains such Protected Health Information. Upon written request from the Covered Entity, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible or illegal. At all times Business Associate shall comply with the Florida public records law and exemptions therefrom, and applicable Florida records retention requirements.

8. Miscellaneous

a. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended or revised.

b. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. If the parties are unable to reach agreement regarding an amendment to this Agreement, either Business Associate or Covered Entity may terminate this Agreement upon ninety (90) days written notice to the other party.

c. The respective rights and obligations of Business Associate under Sections 7(c)(1) and 7(c)(2) of this Agreement shall survive the termination of this Agreement.

d. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

e. Business Associate shall indemnify, hold harmless, and defend at Business Associate's expense, counsel being subject to Covered Entity's approval, the Covered Entity, and the Covered Entity's officers and employees (collectively "indemnitees"), against any and all claims, actions, lawsuits, damages, losses, liabilities, judgments, fines, penalties, costs, and expenses incurred by any of the indemnitees

arising out of or in connection with Business Associate's or any of Business Associate's officers', employees', agents', or subcontractors' breach of this Agreement or any act or omission by Business Associate or by any of Business Associate's officers, employees, agents, or subcontractors, including Business Associate's failure to perform any of its obligations under the Privacy Rule. Business Associate shall pay any and all expenses, fines, judgments, and penalties, including court costs and attorney fees, which may be imposed upon any of the indemnitees resulting from or arising out of Business Associate's or any of Business Associate's officers', employees', agents', or subcontractors' breach of this Agreement or other act or omission.

f. Venue for any lawsuit or any other legal proceedings brought by either party against the other party or otherwise arising out of this Agreement, shall be in Broward County, Florida, or, in the event of federal jurisdiction, in the United States District Court for the Southern District of Florida, with appellate jurisdiction in the respective corresponding appellate tribunals.

g. **IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS, AT 954-828-5002, PRRContract@fortlauderdale.gov, 100 North Andrews Avenue, Fort Lauderdale, Florida, 33301, Attention: City Clerk.**

Notwithstanding anything contained in this Agreement to the contrary, except as otherwise provided by federal law, Contractor shall:

1. Keep and maintain public records that ordinarily and necessarily would be required by the City in order to perform the service.

2. Upon request from the City's custodian of public records, provide the City with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes (2016), as may be amended or revised, or as otherwise provided by law.

3. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the contract term and following completion of this contract if the Contractor does not transfer the records to the City.

4. Upon completion of the Contract, transfer, at no cost, to the City all public records in possession of the Contractor or keep and maintain public records required by the City to perform the service. If the Contractor transfers all public records to the City upon completion of this Contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of this Contract, the Contractor shall meet all applicable requirements for

retaining public records. All records stored electronically must be provided to the City, upon request from the City's custodian of public records, in a format that is compatible with the information technology systems of the City.

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[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the City of Fort Lauderdale and _____, execute this Business Associate Agreement as follows:

ATTEST:

_____

CITY OF FORT LAUDERDALE

By: _____

By: _____

Approved as to form:

By: _____

WITNESSES:

(Vendor name)

_____
(Signature)
Print Name:

By _____

_____
(Signature)
Print Name:

(CORPORATE SEAL)

STATE OF_____:
COUNTY OF_____:

The foregoing Business Associate Agreement was acknowledged before me this day of _____, 2017, by _____ as President, and _____, as Secretary, for _____ (Vendors Name)

(SEAL)

_____
Notary Public, State of _____
(Signature of Notary Public - State of _____)

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

Cigna Dental Benefit Summary
City of Fort Lauderdale – For Firefighters
Plan Effective Date: 01/01/2018

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Cigna Dental PPO				
Network Options	***In-Network:*** **Cigna DPPO Advantage Network**		***Non-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Allowable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II, III, expenses	$1,500		$1,500	
Calendar Year Deductible Individual Family	$100 Unlimited		$100 Unlimited	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: Bridges, Crowns and Inlays Repairs: Dentures Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Denture Relines, Rebases and Adjustments	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Employee and All Dependents Lifetime Benefits Maximum: $1,500	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Allowable Charge. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III and IV services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.

Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	Teeth missing Prior to coverage under the Cigna Dental plan are not covered.
Oral Evaluations	2 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months
Diagnostic Casts	Payable only in conjunction with orthodontic workup
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy
Fluoride Application	1 per calendar year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;	
Prosthodontic: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Implants: implants or implant related services	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Allowable Charge.	

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Cigna Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company (CGLIC), with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms (for insured dental plans) in OK: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OR: HP-POL68; TN: HP-POL69/HC-CER2V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

BSDXXXXX

2020 Dental Rates

City of Fort Lauderdale										
Dental Plan Contributions										
	Rates Effective 1/2020									
	Monthly City Contribution Rates			Monthly Employee Contribution Rates				Bi-Weekly Employee Contribution Rates		
Group	**DHMO**	**DPPO**		**DHMO**	**DPPO**	**IAFF**		**DHMO**	**DPPO**	**IAFF**
Management, Supervisory, Professional										
Active										
Employee	$ 16.43	$ 51.59		$ -	$ -			$ -	$ -	
Employee & Spouse	$ 28.76	$ 96.67		$ -	$ -			$ -	$ -	
Employee & Child	$ 34.52	$ 99.38		$ -	$ -			$ -	$ -	
Employee & Children	$ 34.52	$ 99.38		$ -	$ -			$ -	$ -	
Family	$ 48.38	$ 125.26		$ -	$ -			$ -	$ -	
Confidental										
Employee	$ 8.22	$ 25.80		$ 8.21	$ 25.79			$ 3.79	$ 11.90	
Employee & Spouse	$ 14.38	$ 48.34		$ 14.38	$ 48.33			$ 6.64	$ 22.31	
Employee & Child	$ 17.26	$ 49.69		$ 17.26	$ 49.69			$ 7.97	$ 22.93	
Employee & Children	$ 17.26	$ 49.69		$ 17.26	$ 49.69			$ 7.97	$ 22.93	
Family	$ 24.19	$ 62.63		$ 24.19	$ 62.63			$ 11.16	$ 28.91	
Teamsters Active										
Employee				$ 16.43	$ 51.59			$ 7.58	$ 23.81	
Employee & Spouse				$ 28.76	$ 96.67			$ 13.27	$ 44.62	
Employee & Child				$ 34.52	$ 99.38			$ 15.93	$ 45.87	
Employee & Children				$ 34.52	$ 99.38			$ 15.93	$ 45.87	
Family				$ 48.38	$ 125.26			$ 22.33	$ 57.81	
Firefighters Active										
Employee		$ 39.00				$ 8.52				$ 3.93
Employee & Spouse		$ 39.00				$ 17.36				$ 8.01
Employee & Child		$ 39.00				$ 17.16				$ 7.92
Employee & Children		$ 39.00				$ 17.16				$ 7.92
Family		$ 39.00				$ 29.32				$ 13.53

CITY OF FORT LAUDERDALE

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

June 2019 thru May 2022

Funding Type : TRADITIONAL
Rating Type : PROSPECTIVE GUARANTEED COST
Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	BILLED PREMIUM	TOTAL LOSS RATIO	TOTAL SUBS	TOTAL MBRS
Jun-19	3335139	DENT	$80,473	$29,452	$109,925	$113,991	96.4%	1,450	3,382
	ACCOUNT Total		**$80,473**	**$29,452**	**$109,925**	**$113,991**	**96.4%**	**1,450**	**3,382**
Jun-2019 Total			**$80,473**	**$29,452**	**$109,925**	**$113,991**	**96.4%**	**1,450**	**3,382**
Jul-19	3335139	DENT	$84,308	$23,716	$108,025	$113,944	94.8%	1,453	3,388
	ACCOUNT Total		**$84,308**	**$23,716**	**$108,025**	**$113,944**	**94.8%**	**1,453**	**3,388**
Jul-2019 Total			**$84,308**	**$23,716**	**$108,025**	**$113,944**	**94.8%**	**1,453**	**3,388**
Aug-19	3335139	DENT	$93,015	$18,607	$111,622	$114,242	97.7%	1,456	3,399
	ACCOUNT Total		**$93,015**	**$18,607**	**$111,622**	**$114,242**	**97.7%**	**1,456**	**3,399**
Aug-2019 Total			**$93,015**	**$18,607**	**$111,622**	**$114,242**	**97.7%**	**1,456**	**3,399**
Sep-19	3335139	DENT	$74,393	$25,635	$100,028	$114,350	87.5%	1,457	3,406
	ACCOUNT Total		**$74,393**	**$25,635**	**$100,028**	**$114,350**	**87.5%**	**1,457**	**3,406**
Sep-2019 Total			**$74,393**	**$25,635**	**$100,028**	**$114,350**	**87.5%**	**1,457**	**3,406**
Oct-19	3335139	DENT	$89,619	$17,318	$106,937	$113,932	93.9%	1,450	3,394
	ACCOUNT Total		**$89,619**	**$17,318**	**$106,937**	**$113,932**	**93.9%**	**1,450**	**3,394**
Oct-2019 Total			**$89,619**	**$17,318**	**$106,937**	**$113,932**	**93.9%**	**1,450**	**3,394**
Nov-19	3335139	DENT	$84,427	$14,341	$98,768	$114,040	86.6%	1,445	3,388
	ACCOUNT Total		**$84,427**	**$14,341**	**$98,768**	**$114,040**	**86.6%**	**1,445**	**3,388**
Nov-2019 Total			**$84,427**	**$14,341**	**$98,768**	**$114,040**	**86.6%**	**1,445**	**3,388**
Dec-19	3335139	DENT	$88,925	$22,501	$111,426	$113,800	97.9%	1,440	3,377
	ACCOUNT Total		**$88,925**	**$22,501**	**$111,426**	**$113,800**	**97.9%**	**1,440**	**3,377**
Dec-2019 Total			**$88,925**	**$22,501**	**$111,426**	**$113,800**	**97.9%**	**1,440**	**3,377**
Jan-20	3335139	DENT	$108,847	$21,657	$130,505	$118,376	110.2%	1,499	3,442
	ACCOUNT Total		**$108,847**	**$21,657**	**$130,505**	**$118,376**	**110.2%**	**1,499**	**3,442**
Jan-2020 Total			**$108,847**	**$21,657**	**$130,505**	**$118,376**	**110.2%**	**1,499**	**3,442**

CITY OF FORT LAUDERDALE

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

June 2019 thru May 2022

Funding Type : TRADITIONAL
Rating Type : PROSPECTIVE GUARANTEED COST
Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	BILLED PREMIUM	TOTAL LOSS RATIO	TOTAL SUBS	TOTAL MBRS
Feb-20	3335139	DENT	$91,750	$14,862	$106,612	$117,552	90.7%	1,488	3,428
	ACCOUNT Total		**$91,750**	**$14,862**	**$106,612**	**$117,552**	**90.7%**	**1,488**	**3,428**
Feb-2020 Total			**$91,750**	**$14,862**	**$106,612**	**$117,552**	**90.7%**	**1,488**	**3,428**
Mar-20	3335139	DENT	$85,992	$19,074	$105,066	$115,649	90.8%	1,486	3,416
	ACCOUNT Total		**$85,992**	**$19,074**	**$105,066**	**$115,649**	**90.8%**	**1,486**	**3,416**
Mar-2020 Total			**$85,992**	**$19,074**	**$105,066**	**$115,649**	**90.8%**	**1,486**	**3,416**
Apr-20	3335139	DENT	$31,410	$8,173	$39,583	$115,523	34.3%	1,483	3,410
	ACCOUNT Total		**$31,410**	**$8,173**	**$39,583**	**$115,523**	**34.3%**	**1,483**	**3,410**
Apr-2020 Total			**$31,410**	**$8,173**	**$39,583**	**$115,523**	**34.3%**	**1,483**	**3,410**
May-20	3335139	DENT	$37,749	$13,155	$50,904	$455	11,177.2%	1,494	3,434
	ACCOUNT Total		**$37,749**	**$13,155**	**$50,904**	**$455**	**11,177.2%**	**1,494**	**3,434**
May-2020 Total			**$37,749**	**$13,155**	**$50,904**	**$455**	**11,177.2%**	**1,494**	**3,434**
Jun-20	3335139	DENT	$76,542	$23,330	$99,872	$115,578	86.4%	1,486	3,421
	ACCOUNT Total		**$76,542**	**$23,330**	**$99,872**	**$115,578**	**86.4%**	**1,486**	**3,421**
Jun-2020 Total			**$76,542**	**$23,330**	**$99,872**	**$115,578**	**86.4%**	**1,486**	**3,421**
Jul-20	3335139	DENT	$91,493	$26,283	$117,776	$115,775	101.7%	1,486	3,423
	ACCOUNT Total		**$91,493**	**$26,283**	**$117,776**	**$115,775**	**101.7%**	**1,486**	**3,423**
Jul-2020 Total			**$91,493**	**$26,283**	**$117,776**	**$115,775**	**101.7%**	**1,486**	**3,423**
Aug-20	3335139	DENT	$87,294	$17,466	$104,759	$115,755	90.5%	1,484	3,424
	ACCOUNT Total		**$87,294**	**$17,466**	**$104,759**	**$115,755**	**90.5%**	**1,484**	**3,424**
Aug-2020 Total			**$87,294**	**$17,466**	**$104,759**	**$115,755**	**90.5%**	**1,484**	**3,424**
Sep-20	3335139	DENT	$77,501	$19,340	$96,840	$115,477	83.9%	1,480	3,415
	ACCOUNT Total		**$77,501**	**$19,340**	**$96,840**	**$115,477**	**83.9%**	**1,480**	**3,415**
Sep-2020 Total			**$77,501**	**$19,340**	**$96,840**	**$115,477**	**83.9%**	**1,480**	**3,415**

CITY OF FORT LAUDERDALE

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

June 2019 thru May 2022

Funding Type : TRADITIONAL
Rating Type : PROSPECTIVE GUARANTEED COST
Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	BILLED PREMIUM	TOTAL LOSS RATIO	TOTAL SUBS	TOTAL MBRS
Oct-20	3335139	DENT	$89,298	$24,292	$113,590	$114,918	98.8%	1,474	3,405
	ACCOUNT Total		**$89,298**	**$24,292**	**$113,590**	**$114,918**	**98.8%**	**1,474**	**3,405**
Oct-2020 Total			**$89,298**	**$24,292**	**$113,590**	**$114,918**	**98.8%**	**1,474**	**3,405**
Nov-20	3335139	DENT	$72,834	$20,490	$93,324	$114,453	81.5%	1,470	3,397
	ACCOUNT Total		**$72,834**	**$20,490**	**$93,324**	**$114,453**	**81.5%**	**1,470**	**3,397**
Nov-2020 Total			**$72,834**	**$20,490**	**$93,324**	**$114,453**	**81.5%**	**1,470**	**3,397**
Dec-20	3335139	DENT	$86,391	$21,108	$107,499	$114,178	94.2%	1,468	3,391
	ACCOUNT Total		**$86,391**	**$21,108**	**$107,499**	**$114,178**	**94.2%**	**1,468**	**3,391**
Dec-2020 Total			**$86,391**	**$21,108**	**$107,499**	**$114,178**	**94.2%**	**1,468**	**3,391**
Jan-21	3335139	DENT	$82,869	$24,684	$107,553	$124,740	86.2%	1,548	3,511
	ACCOUNT Total		**$82,869**	**$24,684**	**$107,553**	**$124,740**	**86.2%**	**1,548**	**3,511**
Jan-2021 Total			**$82,869**	**$24,684**	**$107,553**	**$124,740**	**86.2%**	**1,548**	**3,511**
Feb-21	3335139	DENT	$92,230	$22,617	$114,847	$124,743	92.1%	1,542	3,491
	ACCOUNT Total		**$92,230**	**$22,617**	**$114,847**	**$124,743**	**92.1%**	**1,542**	**3,491**
Feb-2021 Total			**$92,230**	**$22,617**	**$114,847**	**$124,743**	**92.1%**	**1,542**	**3,491**
Mar-21	3335139	DENT	$101,767	$16,243	$118,010	$124,936	94.5%	1,544	3,489
	ACCOUNT Total		**$101,767**	**$16,243**	**$118,010**	**$124,936**	**94.5%**	**1,544**	**3,489**
Mar-2021 Total			**$101,767**	**$16,243**	**$118,010**	**$124,936**	**94.5%**	**1,544**	**3,489**
Apr-21	3335139	DENT	$93,417	$23,164	$116,581	$124,940	93.3%	1,546	3,490
	ACCOUNT Total		**$93,417**	**$23,164**	**$116,581**	**$124,940**	**93.3%**	**1,546**	**3,490**
Apr-2021 Total			**$93,417**	**$23,164**	**$116,581**	**$124,940**	**93.3%**	**1,546**	**3,490**
May-21	3335139	DENT	$84,663	$20,548	$105,212	$125,290	84.0%	1,548	3,494
	ACCOUNT Total		**$84,663**	**$20,548**	**$105,212**	**$125,290**	**84.0%**	**1,548**	**3,494**
May-2021 Total			**$84,663**	**$20,548**	**$105,212**	**$125,290**	**84.0%**	**1,548**	**3,494**

CITY OF FORT LAUDERDALE

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

June 2019 thru May 2022

Funding Type : TRADITIONAL
Rating Type : PROSPECTIVE GUARANTEED COST
Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	BILLED PREMIUM	TOTAL LOSS RATIO	TOTAL SUBS	TOTAL MBRS
Jun-21	3335139	DENT	$89,966	$21,728	$111,694	$124,997	89.4%	1,544	3,487
	ACCOUNT Total		**$89,966**	**$21,728**	**$111,694**	**$124,997**	**89.4%**	**1,544**	**3,487**
Jun-2021 Total			**$89,966**	**$21,728**	**$111,694**	**$124,997**	**89.4%**	**1,544**	**3,487**
Jul-21	3335139	DENT	$89,622	$14,201	$103,823	$124,767	83.2%	1,543	3,477
	ACCOUNT Total		**$89,622**	**$14,201**	**$103,823**	**$124,767**	**83.2%**	**1,543**	**3,477**
Jul-2021 Total			**$89,622**	**$14,201**	**$103,823**	**$124,767**	**83.2%**	**1,543**	**3,477**
Aug-21	3335139	DENT	$97,358	$21,921	$119,279	$124,788	95.6%	1,543	3,477
	ACCOUNT Total		**$97,358**	**$21,921**	**$119,279**	**$124,788**	**95.6%**	**1,543**	**3,477**
Aug-2021 Total			**$97,358**	**$21,921**	**$119,279**	**$124,788**	**95.6%**	**1,543**	**3,477**
Sep-21	3335139	DENT	$82,823	$22,436	$105,258	$124,338	84.7%	1,538	3,470
	ACCOUNT Total		**$82,823**	**$22,436**	**$105,258**	**$124,338**	**84.7%**	**1,538**	**3,470**
Sep-2021 Total			**$82,823**	**$22,436**	**$105,258**	**$124,338**	**84.7%**	**1,538**	**3,470**
Oct-21	3335139	DENT	$86,317	$27,045	$113,362	$124,928	90.7%	1,557	3,484
	ACCOUNT Total		**$86,317**	**$27,045**	**$113,362**	**$124,928**	**90.7%**	**1,557**	**3,484**
Oct-2021 Total			**$86,317**	**$27,045**	**$113,362**	**$124,928**	**90.7%**	**1,557**	**3,484**
Nov-21	3335139	DENT	$78,038	$18,846	$96,884	$124,051	78.1%	1,552	3,462
	ACCOUNT Total		**$78,038**	**$18,846**	**$96,884**	**$124,051**	**78.1%**	**1,552**	**3,462**
Nov-2021 Total			**$78,038**	**$18,846**	**$96,884**	**$124,051**	**78.1%**	**1,552**	**3,462**
Dec-21	3335139	DENT	$86,973	$32,651	$119,624	$124,320	96.2%	1,554	3,463
	ACCOUNT Total		**$86,973**	**$32,651**	**$119,624**	**$124,320**	**96.2%**	**1,554**	**3,463**
Dec-2021 Total			**$86,973**	**$32,651**	**$119,624**	**$124,320**	**96.2%**	**1,554**	**3,463**
Jan-22	3335139	DENT	$73,732	$20,377	$94,109	$132,294	71.1%	1,571	3,483
	ACCOUNT Total		**$73,732**	**$20,377**	**$94,109**	**$132,294**	**71.1%**	**1,571**	**3,483**
Jan-2022 Total			**$73,732**	**$20,377**	**$94,109**	**$132,294**	**71.1%**	**1,571**	**3,483**

CITY OF FORT LAUDERDALE

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

June 2019 thru May 2022

Funding Type : TRADITIONAL
Rating Type : PROSPECTIVE GUARANTEED COST
Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	BILLED PREMIUM	TOTAL LOSS RATIO	TOTAL SUBS	TOTAL MBRS
Feb-22	3335139	DENT	$102,013	$26,028	$128,041	$130,724	97.9%	1,556	3,454
	ACCOUNT Total		**$102,013**	**$26,028**	**$128,041**	**$130,724**	**97.9%**	**1,556**	**3,454**
Feb-2022 Total			**$102,013**	**$26,028**	**$128,041**	**$130,724**	**97.9%**	**1,556**	**3,454**
Mar-22	3335139	DENT	$97,298	$40,876	$138,174	$130,822	105.6%	1,555	3,455
	ACCOUNT Total		**$97,298**	**$40,876**	**$138,174**	**$130,822**	**105.6%**	**1,555**	**3,455**
Mar-2022 Total			**$97,298**	**$40,876**	**$138,174**	**$130,822**	**105.6%**	**1,555**	**3,455**
Apr-22	3335139	DENT	$93,066	$19,600	$112,667	$130,472	86.4%	1,552	3,448
	ACCOUNT Total		**$93,066**	**$19,600**	**$112,667**	**$130,472**	**86.4%**	**1,552**	**3,448**
Apr-2022 Total			**$93,066**	**$19,600**	**$112,667**	**$130,472**	**86.4%**	**1,552**	**3,448**
May-22	3335139	DENT	$97,676	$26,986	$124,662	$130,337	95.6%	1,550	3,443
	ACCOUNT Total		**$97,676**	**$26,986**	**$124,662**	**$130,337**	**95.6%**	**1,550**	**3,443**
May-2022 Total			**$97,676**	**$26,986**	**$124,662**	**$130,337**	**95.6%**	**1,550**	**3,443**
Grand Total			**$3,062,088**	**$780,753**	**$3,842,841**	**$4,223,474**	**91.0%**	**54,292**	**123,818**

City of Fort Lauderdale

DENTAL

IMPROVING WHOLE-PERSON HEALTH THROUGH DENTAL SOLUTIONS

Introductions

Agenda

Introductions

Cigna Dental Overview

Opioid Epidemic

Utilization Review

Wrap-up & Next Steps

Cigna Participants

Michelle Alperstein, Senior Account Manager

David Hamlin, DMD, MBA, Regional Dental Director

Kyle Boyd, Assistant Dental Underwriting Director Southeast/Midwest

Takia Johnson, Dental Underwriting

Lisa McDonald, Dental Sales Manager

Malena Maya, Senior Engagement Consultant

Mickey Bernardo, Client Service Partner

DENTAL SOLUTIONS
DESIGNED TO IMPROVE OVERALL HEALTH

CARE MADE MORE CONVENIENT

For real life

22% of adults with insurance who haven't seen a dentist in 12 months.[1]

33% avoid the dentist because it's inconvenient or they can't find one.[2]

More than **30%** of adults say dental appointments at the workplace is appealing.[3]

Onsite Care* helps:

- Make access easier
- Increase use of preventive services
- Improve health, productivity and satisfaction
- All at no additional charge**

*Availability may vary by market. **Services provided are subject to plan terms and conditions, including deducible, copay and/or coinsurance requirements.

1. Regional variation in private dental coverage and care among dentate adults aged 18–64 in the United States, 2014–2017. NCHS Data Brief, no 3; National Center for Health Statistics. 2019. 2. "Dentistry: A Profession in Transition" ADA Health Policy Institute, October 2015. 3. Cigna Dental study: Exploring the relationship between oral health and mental well-being. August 2019.

Cigna

DOING MORE TO IMPROVE WHOLE-PERSON HEALTH.

CIGNA DENTAL ORAL HEALTH INTEGRATION PROGRAM®

MORE ACCESS

All customers with qualifying conditions:

- Cancer of head/neck
- Diabetes
- Heart disease
- Kidney disease
- Maternity
- Organ transplant
- Stroke

MORE WELLNESS

Information on behavioral issues linked to oral health.

MORE COVERAGE

100% reimbursement prevention and periodontal*

MORE DISCOUNTS

Average 40% savings on qualifying dental RX products.**

*Covered employees must enroll in the program prior to receiving dental services to be eligible for reimbursement. This program provides reimbursement for certain eligible dental procedures for customers with qualifying medical conditions. Reimbursement is applied/subject to plan year maximums under DPPO plans. Contact your Cigna representative for a list of eligible procedures and related program limitations. **September 2016. Cigna Home Delivery Pharmacy Average Retail Price Surveys. Discounts are only available to customers with Cigna Pharmacy and are available through designated home delivery pharmacy only. **A discount program is NOT insurance and the customer must pay the entire discounted charge.** Discounts will vary.

Cigna Dental Oral Health Integration Program®[1]

MORE ACCESS
All customers
with qualifying conditions

MORE COVERAGE
100% reimbursement
Prevention and periodontal[1]

MORE WELLNESS
Information on behavioral issues linked to oral health

MORE DISCOUNTS
Average 40% savings on qualifying dental RX products[11]

Procedure[1]	Heart disease	Stroke	Diabetes	Maternity	Chronic kidney disease	Organ transplants	Head and neck cancer radiation
Periodontal Treatment & Maintenance[2] (D4341, D4342, D4910)	✓	✓	✓	✓	✓	✓	✓
Periodontal Evaluation[3] (D0180)				✓			
Oral Evaluation[4] (D0120, D0140, D0150				✓			
Cleaning[5] (D1110)				✓			
Scaling in the presence of inflammation – Full Mouth[5] (D4346)				✓			
Emergency Palliative Treatment[6] (D9110)				✓			
Topical application of fluoride varnish[7] (D1206)					✓	✓	✓
Topical application of fluoride– excluding varnish[8] (D1208)					✓	✓	✓
Sealants[9] (D1351)					✓	✓	✓
Sealant Repair – per tooth[10] (D1353)					✓	✓	✓

1. Covered employees must be enrolled in the program prior to receiving dental services to be eligible for reimbursement. This program provides reimbursement for certain eligible dental procedures for customers with qualifying medical conditions. Reimbursement is subject to plan year maximums under DPPO plans. 2. D4910 is limited to four times per year. D4341, D4342,: all limitations apply. 3. D0180: One additional evaluation 4. D0120, D0140, D0150: One additional evaluation. 5. D1110 or D4346: One additional cleaning 6. D9110; No limitations. 7. D1206: Age limits removed, all other limitations apply 8. D1208: Age limits removed, all other limitations apply. 9. D1351: Age limits removed, all other limitations apply 10. D1353: Age limits removed, all other limitations apply. 11. December 2019. Discounts are offered to customers with pharmacy benefits through Cigna and products are available through home delivery pharmacy only. **discount program is NOT insurance and the customer must pay the entire discounted charge.** Discounts will vary.

It's complex.

Our approach to opioid reduction.

- Identify individuals quickly
- Analyze integrated claims data
- Notify dental provider
- Prior authorization-Quantity Limits
- Dentist Education

HELPING DENTISTS MANAGE PAIN SAFELY.

9% fewer opioids prescribed[1]

19% reduction in dosage[1]

Mining data to drive action **Dental + Rx**

Coaching dentists on **use and dosage**

Safe prescribing measures **3-day limit***

*Cigna-administered pharmacy plans limit coverage to a 3 day supply, subject to applicable plan terms and conditions, including medical necessity, licensed prescriber/pharmacy, network and cost-share requirements. 1. Internal reporting based on 2015-2018 Cigna pharmacy claims and Cigna dental membership data.

DENTAL UTILIZATION

Dental Dashboard

City of Fort Lauderdale

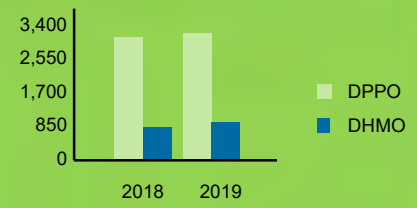
Member population

2019 Period
Family Size
Total Group
Norm

Employees & dependents all products

	2018	2019	Trend	Norm
Employees	1,926	2,024	5.1%	
Dependents	2,287	2,436	6.5%	
Family Size	2.19	2.20	0.8%	2.05
Total Members	4,214	4,460	5.9%	

Average plan members



	DPPO	DHMO
2018	3,302	911
2019	3,395	1,065
Trend	2.8%	16.9%

Month with greatest overall change:

2018	:	February	0.9%
2019	:	February	-0.4%

DPPO Oral Health Behavior

2019 Period
Members with 1 or More Cleanings
Total Plan Members
Norm

% of Unique members receiving cleaning

2018	2019	Trend	Norm
63.0%	63.0%	0.1%	61.2%

% of Unique members by service type

Healthy behaviors	2018	2019	Trend	Norm
Exams	58.7%	58.4%	-0.3%	59.3%
Cleanings	58.5%	57.3%	-1.2%	57.3%
Fluoride	18.1%	18.9%	0.9%	19.6%
Periodontal cleanings	4.5%	5.7%	1.3%	3.9%
Treatment				
Fillings	16.0%	15.1%	-0.9%	15.4%
Crowns	5.8%	5.1%	-0.7%	5.3%
Root canals	2.0%	1.4%	-0.5%	1.7%
Extractions - all	4.6%	4.2%	-0.4%	4.0%
Gum disease				
Non surg perio	3.6%	3.0%	-0.6%	1.8%

Savings

2019 Period
Total Network Charges
Total Submitted Charges
Norm

Network performance

	2018	2019	Trend	Norm
Total network charges	87.6%	84.5%	-3.2%	73.5%
Achieved discounts	39.7%	38.3%	-1.3%	33.7%

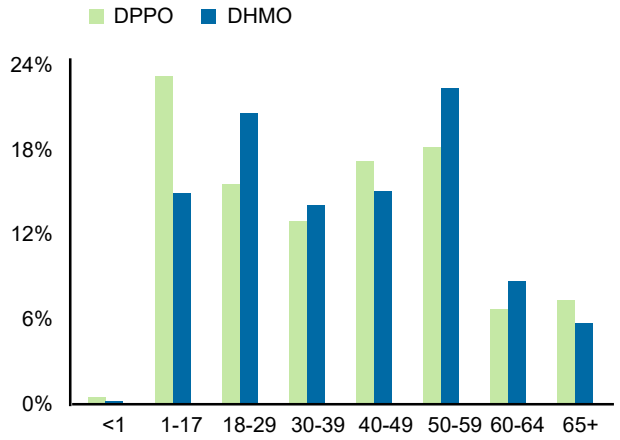
DPPO	2018	2019	Trend	Norm
Net effective discount	34.8%	32.4%	-2.4%	24.8%
Plan design savings	16.7%	15.0%	-1.7%	20.4%
Utilization management & review	8.7%	9.9%	1.3%	10.3%
Total savings	60.2%	57.4%	-2.8%	55.6%
Plan paid claims PMPM	$31.12	$28.55	-8.3%	$27.63
DHMO				
Member savings on services provided	85.0%	82.7%	-2.4%	82.2%

2019 Period reflects claims incurred between Jan. 2019 and Dec. 2019, paid through Dec. 2019
2018 Period reflects claims incurred between Jan. 2018 and Dec. 2018, paid through Dec. 2019

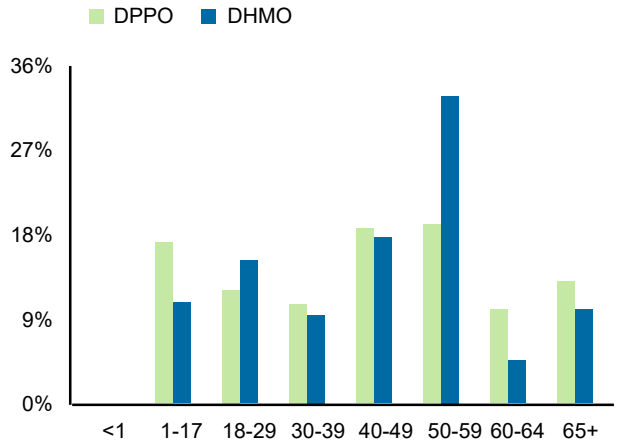
Dental - Membership Summary

City of Fort Lauderdale

Percent of membership by age band and product



Percent of spend by age band and product



Summary of membership

	2018					
Average Populations	Employees	Spouses & Dependents	Members	Average Family Size	Percent Female	Percent Male
DHMO	493	418	911	1.85	46.3%	53.7%
DPPO	1,433	1,869	3,302	2.30	46.4%	53.6%
Total	1,926	2,287	4,214	2.19	46.4%	53.6%

	2019					
Average Populations	Employees	Spouses & Dependents	Members	Average Family Size	Percent Female	Percent Male
DHMO	571	494	1,065	1.87	46.6%	53.4%
DPPO	1,453	1,942	3,395	2.34	46.8%	53.2%
Total	2,024	2,436	4,460	2.20	46.7%	53.3%

DPPO Demographic Summary	**2018**	**2019**	**Trend**	**Norm**
Average Number of Employees	1,433	1,453	1.4%	
Average Number of Members	3,302	3,395	2.8%	
Average Member Age	37.0	36.7	-0.8%	35.9
Services per Claimant	8.5	7.6	-10.6%	7.0
% of Members Using Plan	70.3%	70.7%	0.4%	69.6%
% of Unique Members Receiving a Cleaning	63.6%	63.4%	-0.2%	61.5%

Comments

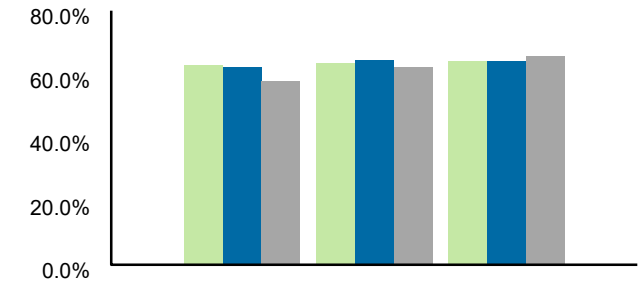
- Average membership in the 2019 period was 4,460, an increase of 5.9%
- Average family size increased from 2.19 to 2.20, an increase of 0.5%. Average family size measures the ratio of members to employees
- Employees represented 45.4% of the population in the 2019 period, spouses 20.6% and dependents 34.1%

2019 Period reflects claims incurred between Jan. 2019 and Dec. 2019, paid through Dec. 2019
2018 Period reflects claims incurred between Jan. 2018 and Dec. 2018, paid through Dec. 2019

Dental PPO - Cleanings Utilization

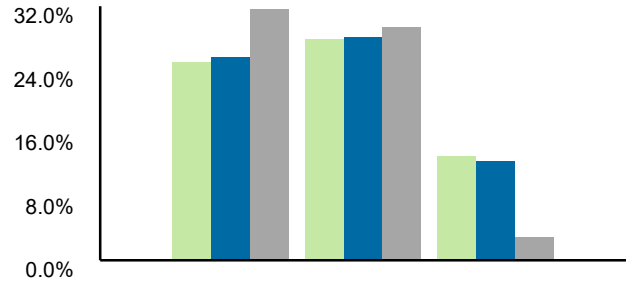
City of Fort Lauderdale

% of unique members receiving a cleaning by tier



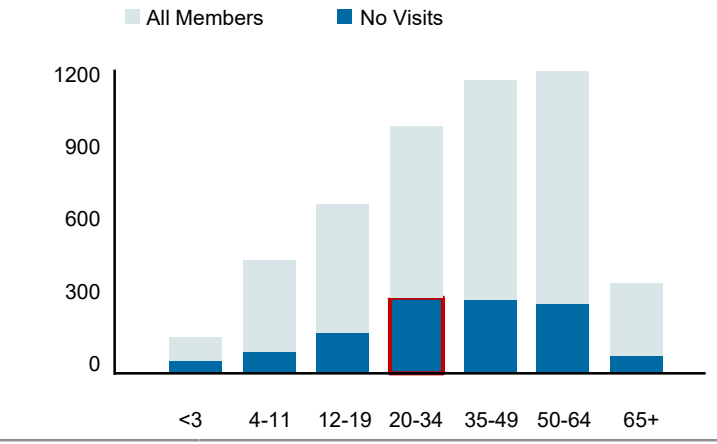
	Employee	Spouse	Children
2018	63.2%	63.5%	64.1%
2019	62.5%	64.6%	63.9%
Norm	58.2%	62.6%	65.7%

Cleanings utilization for total population

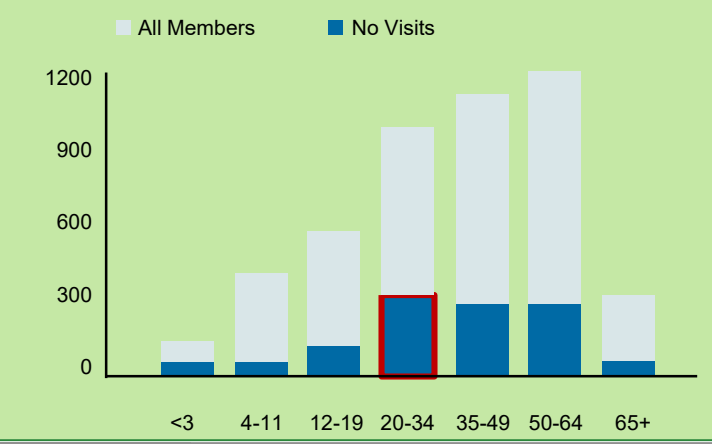


	1 Cleaning	2 Cleanings	3 or more Cleanings
2018	24.0%	26.8%	12.7%
2019	24.6%	26.9%	12.0%
Norm	30.5%	28.2%	2.8%

No visits by age in 2019 period



No visits by age in 2018 period



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CITY OF FORT LAUDERDALE-Request 1039687-View 1353382-RPT_ID 372_BCN-Tier 3

2018 & 2019 Dental PPO - Top 15 Procedure Types

City of Fort Lauderdale

Preventive Care
2018 57.4%
2019 60.3%

Restorative Care
2018 9.4%
2019 11.6%

Ranking			% of Total Unique		Unique Members		Number of Services		Percent of Total		
2019	2018	Top 15 Procedure Types	2019	2018	2019	2018	2019	2018	2019	2018	Norm
1	1	Prophylaxis – Adult	64.1%	64.3%	1,539	1,483	2,780	2,709	15.3%	14.3%	14.4%
2	2	Periodic Oral Evaluation	71.1%	69.0%	1,706	1,592	2,588	2,370	14.2%	12.5%	15.9%
3	3	Bitewings - Four Radiographic Images	45.0%	45.0%	1,079	1,037	1,131	1,088	6.2%	5.7%	7.2%
4	4	Intraoral - Periapical - First Radiographic Image	35.3%	34.8%	848	803	1,043	1,034	5.7%	5.5%	6.1%
5	5	Intraoral - Periapical - Each Additional Radiograph	26.8%	25.0%	642	576	987	895	5.4%	4.7%	5.5%
6	7	Prophylaxis – Child	17.3%	18.4%	415	425	670	727	3.7%	3.8%	3.6%
7	8	Topical Application Of Fluoride - Excluding Varnish	19.1%	19.8%	459	457	593	618	3.3%	3.3%	2.6%
9	6	Comprehensive Oral Evaluation	19.9%	28.0%	478	647	502	678	2.8%	3.6%	2.7%
13	13	Intraoral - Complete Series Of Radiographic Images	14.7%	16.3%	353	377	359	382	2.0%	2.0%	1.5%
15	14	Sealant - Per Tooth	3.0%	3.9%	72	90	302	371	1.7%	2.0%	1.8%
8	9	Periodontal Maintenance Procedures (Following Active Treatment)	10.7%	10.6%	257	245	540	516	3.0%	2.7%	1.7%
10	10	Resin-Based Composite - Two Surfaces, Posterior	11.2%	12.4%	269	286	493	489	2.7%	2.6%	3.0%
11	12	Limited Oral Evaluation - Problem Focused	13.6%	14.7%	326	338	403	431	2.2%	2.3%	2.3%
12	15	Resin-Based Composite - One Surface, Posterior	8.9%	9.1%	214	211	363	337	2.0%	1.8%	2.2%
14	NR	Periodontal Scaling And Root Planing, Per Quadrant	3.8%	NR	90	NR	305	NR	1.7%	NR	1.5%
NR	11	Comprehensive Orthodontic Treatment of the Transition…	NR	2.5%	NR	57	NR	488	NR	2.6%	1.3%

Comments

- 2018 had Orthodontia in Transition in the top 15.
- 2019 & 2018 had preventive care in the top 5 procedures.

*2019 Dental Terminology © American Dental Association
NR = Not Ranked in Top 15

2018 Dental PPO - Plan Fundamentals

City of Fort Lauderdale

Plan Year Maximum in 2018 Period

Paid Amount Range	No.of Members	% of Total Members
$0	1,010	30.6%
$1 - $499	1,600	48.5%
$500 - $999	382	11.6%
$1000 - $1249	87	2.6%
$1250 - $1499	78	2.4%
$1500 - $1749	144	4.4%
>= $2000	1	0.0%
Total Members	3,302	

Orthodontia Utilization in 2018 Period

	Adults	Children	Total
Unique Members	46	66	112
Paid Amounts	$43,107	$64,429	$107,536
Mbrs Ortho-in-Progress	44	63	107
Mbrs Reaching Ortho Max	2	3	5

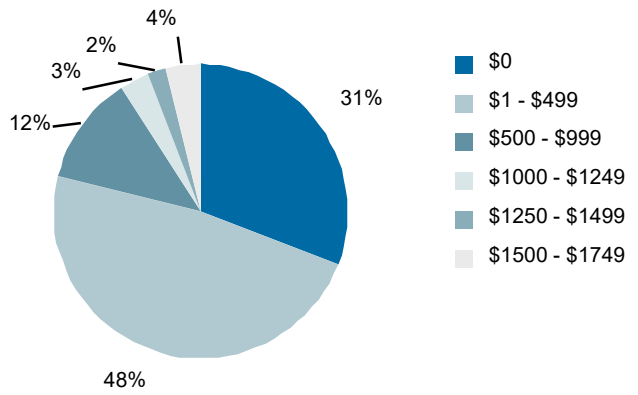
Additional Covered Benefits Summary

	2018	2019	Trend
Surgical Implants	$11,649	$11,822	1.5%
Prosthetics over Implants	$7,303	$13,439	84.0%

Additional Covered Benefits PMPM

	2018	2019	Trend	Norm
Surgical Implants	$0.29	$0.29	-1.3%	$0.34
Prosthetics over Implants	$0.18	$0.33	79.0%	$0.34

Plan Year Maximum in 2018 Period



Comments

- Norm for percentage of members reaching the Plan Year maximums vary depending on region, industry and maximum amount.
- Please note that percentages in the Plan Year Maximum exhibit may be over the actual maximum(s) if the reporting periods differ from the plan year period.

2019 Dental PPO - Plan Fundamentals

City of Fort Lauderdale

Plan Year Maximum in 2019 Period

Paid Amount Range	No.of Members	% of Total Members
$0	1,012	29.8%
$1 - $499	1,717	50.6%
$500 - $999	362	10.7%
$1000 - $1249	73	2.1%
$1250 - $1499	75	2.2%
$1500 - $1749	154	4.5%
$1750 - $1999	2	0.1%
Total Members	3,395	

Orthodontia Utilization in 2019 Period

	Adults	Children	Total
Unique Members	40	52	92
Paid Amounts	$29,029	$47,436	$76,465
Mbrs Ortho-in-Progress	38	47	85
Mbrs Reaching Ortho Max	2	5	7

Additional Covered Benefits Summary

	2018	2019	Trend
Surgical Implants	$11,649	$11,822	1.5%
Prosthetics over Implants	$7,303	$13,439	84.0%

Additional Covered Benefits PMPM

	2018	2019	Trend	Norm
Surgical Implants	$0.29	$0.29	-1.3%	$0.34
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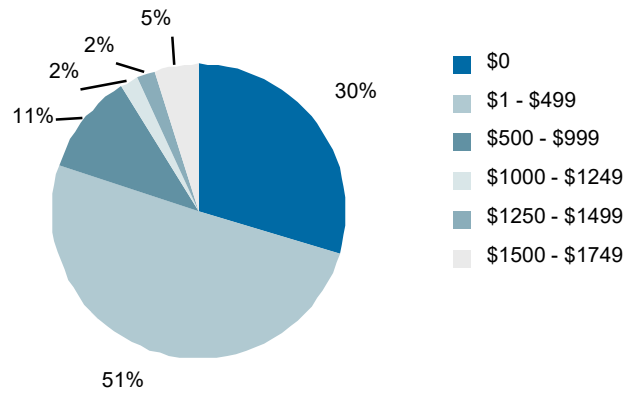
Plan Year Maximum in 2019 Period



Comments

- Norm for percentage of members reaching the Plan Year maximums vary depending on region, industry and maximum amount.
- Please note that percentages in the Plan Year Maximum exhibit may be over the actual maximum(s) if the reporting periods differ from the plan year period.

2019 Period reflects claims incurred between Jan. 2019 and Dec. 2019, paid through Dec. 2019
2018 Period reflects claims incurred between Jan. 2018 and Dec. 2018, paid through Dec. 2019

2018 Dental PPO - Claim Cost and Savings - Network

City of Fort Lauderdale

				PMPM		
2018 Period Network Utilization	**Total Network**	**Out of Network**	**Total**	**Total Network**	**Out of Network**	**Total**
Number of Unique Claimants	2,083	416	2,499			
Number of Claims Submitted	6,225	992	7,217			
Submitted Charges	$2,572,765	$372,770	$2,945,535	$64.92	$9.41	$74.33
Employer Paid	$996,311	$186,422	$1,182,734	$25.14	$4.70	$29.85
Discount Dollars	$1,024,895	$0	$1,024,895	$25.86	$0.00	$25.86
Achieved Discount / Net Effective Discount	39.8%	0.0%	34.8%			
Plan Design Savings						
Deductible	$18,346	$14,142	$32,488	$0.46	$0.36	$0.82
Coinsurance	$200,651	$64,510	$265,160	$5.06	$1.63	$6.69
Coordination of Benefits	$2,723	$569	$3,293	$0.07	$0.01	$0.08
Annual/Lifetime Maximum	$71,886	$14,049	$85,935	$1.81	$0.35	$2.17
Maximum Reimbursable Charge	$0	$53,789	$53,789	$0.00	$1.36	$1.36
Scheduled Plan Savings	$0	$0	$0	$0.00	$0.00	$0.00
Other Savings	$20,883	$12,416	$33,299	$0.53	$0.31	$0.84
Total	$314,489	$159,474	$473,963	$7.94	$4.02	$11.96
Savings as % of submitted	12.2%	42.8%	16.1%			
Utilization Management and Utilization Review Savings						
Missing Tooth Limitation	$0	$0	$0	$0.00	$0.00	$0.00
Age/Frequency Limitation	$17,920	$3,810	$21,730	$0.45	$0.10	$0.55
Additional Plan Design	$53,754	$9,445	$63,199	$1.36	$0.24	$1.59
Alternative Benefit Provision	$50,467	$2,321	$52,788	$1.27	$0.06	$1.33
Utilization Review	$114,929	$11,297	$126,227	$2.90	$0.29	$3.19
Total	$237,070	$26,873	$263,943	$5.98	$0.68	$6.66
Savings as % of submitted	9.2%	7.2%	9.0%			
Total Savings	$1,576,454	$186,348	$1,762,801	$39.78	$4.70	$44.48
Total Savings as % of submitted	61.3%	50.0%	59.8%			

Comments

• Total savings represents total submitted dollars not paid due to plan design mechanics (e.g.deductible, coordination of benefits, discounts, utilization management etc) while net effective discount represents total network discount savings

2019 Dental PPO - Claim Cost and Savings - Network

City of Fort Lauderdale

				PMPM		
2019 Period Network Utilization	**Total Network**	**Out of Network**	**Total**	**Total Network**	**Out of Network**	**Total**
Number of Unique Claimants	2,104	443	2,547			
Number of Claims Submitted	5,785	979	6,764			
Submitted Charges	$2,305,770	$423,568	$2,729,338	$56.59	$10.40	$66.99
Employer Paid	$934,172	$229,170	$1,163,343	$22.93	$5.62	$28.55
Discount Dollars	$884,161	$0	$884,161	$21.70	$0.00	$21.70
Achieved Discount / Net Effective Discount	38.3%	0.0%	32.4%			
Plan Design Savings						
Deductible	$20,468	$15,985	$36,453	$0.50	$0.39	$0.89
Coinsurance	$169,050	$75,309	$244,359	$4.15	$1.85	$6.00
Coordination of Benefits	$1,985	$-0	$1,985	$0.05	$-0.00	$0.05
Annual/Lifetime Maximum	$52,390	$14,461	$66,851	$1.29	$0.35	$1.64
Maximum Reimbursable Charge	$0	$34,141	$34,141	$0.00	$0.84	$0.84
Scheduled Plan Savings	$0	$0	$0	$0.00	$0.00	$0.00
Other Savings	$15,153	$11,703	$26,856	$0.37	$0.29	$0.66
Total	$259,047	$151,598	$410,645	$6.36	$3.72	$10.08
Savings as % of submitted	11.2%	35.8%	15.0%			
Utilization Management and Utilization Review Savings						
Missing Tooth Limitation	$9,686	$0	$9,686	$0.24	$0.00	$0.24
Age/Frequency Limitation	$28,601	$5,162	$33,763	$0.70	$0.13	$0.83
Additional Plan Design	$52,335	$13,439	$65,774	$1.28	$0.33	$1.61
Alternative Benefit Provision	$49,741	$3,430	$53,171	$1.22	$0.08	$1.30
Utilization Review	$88,027	$20,768	$108,795	$2.16	$0.51	$2.67
Total	$228,390	$42,799	$271,189	$5.61	$1.05	$6.66
Savings as % of submitted	9.9%	10.1%	9.9%			
Total Savings	$1,371,598	$194,398	$1,565,995	$33.66	$4.77	$38.43
Total Savings as % of submitted	59.5%	45.9%	57.4%			

Comments

• Total savings represents total submitted dollars not paid due to plan design mechanics (e.g.deductible, coordination of benefits, discounts, utilization management etc) while net effective discount represents total network discount savings

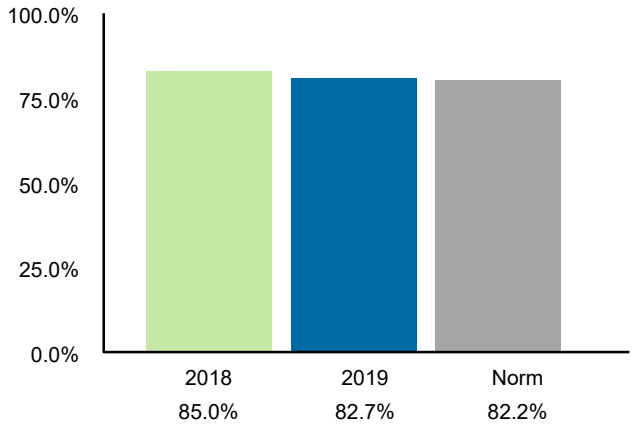
Dental - DHMO Summary

City of Fort Lauderdale

Demographic Summary	2018	2019	Trend
Average Number of Employees	493	571	15.7%
Average Number of Members	911	1,065	16.9%

Key Statistics	2018	2019	Trend	Norm
Services	1,605	2,051	27.8%	
Services per 1,000	1,761.5	1,926.3	9.4%	2,789.4
Total Patient Copays	$44,249	$68,322	54.4%	
National Average Charges	$295,799	$393,896	33.2%	
Savings on Dental Services	$251,550	$325,583	29.4%	
Savings Percentage	85.0%	82.7%	-2.3%	82.2%

Savings percentage



Comments

- DHMO reporting is limited to encounter data submitted by providers, therefore service counts can be understated when utilization detail is not provided
- Savings percentage decreased from 85.0% to 82.7%, and compares to a norm of 82.2%

APPENDIX

2018 & 2019 Dental - Utilization by Type of Service (DHMO Only)

City of Fort Lauderdale

Gross Services by Type	2018		2019		Trend	Norm
	Count	Percent of Total	Count	Percent of Total		Percent of Total
Diagnostic/Preventive	911	56.8%	1,076	52.5%	18.1%	70.1%
Basic Restorative	142	8.8%	159	7.8%	12.0%	7.2%
Major Restorative	65	4.0%	98	4.8%	50.8%	3.8%
Endodontics	26	1.6%	16	0.8%	-38.5%	1.1%
Periodontics	192	12.0%	287	14.0%	49.5%	6.6%
Oral Surgery	103	6.4%	131	6.4%	27.2%	3.7%
Orthodontics	69	4.3%	158	7.7%	129.0%	4.6%
Other Services	97	6.0%	126	6.1%	29.9%	2.9%
Total	**1,605**	**100.0%**	**2,051**	**100.0%**	**27.8%**	**100.0%**

Services per 1,000 Members by Type	2018		2019		Trend	Norm	
	Count	Percent of Total	Count	Percent of Total		Count	Percent of Total
Diagnostic/Preventive	999.8	56.8%	1,010.6	52.5%	1.1%	1,954.1	70.1%
Basic Restorative	155.8	8.8%	149.3	7.8%	-4.2%	200.4	7.2%
Major Restorative	71.3	4.0%	92.0	4.8%	29.0%	107.0	3.8%
Endodontics	28.5	1.6%	15.0	0.8%	-47.3%	31.6	1.1%
Periodontics	210.7	12.0%	269.5	14.0%	27.9%	182.9	6.6%
Oral Surgery	113.0	6.4%	123.0	6.4%	8.8%	102.6	3.7%
Orthodontics	75.7	4.3%	148.4	7.7%	96.0%	129.2	4.6%
Other Services	106.5	6.0%	118.3	6.1%	11.2%	81.5	2.9%
Total	**1,761.5**	**100.0%**	**1,926.3**	**100.0%**	**9.4%**	**2,789.4**	**100.0%**

Comments

- There is an increase in utilization per thousand in 6 categories and a decrease in utilization per thousand in 2 categories for an overall utilization trend of 9.4%
- High utilization for Diagnostic/Preventive services can lead to lower usage of other service categories

Product availability may vary depending on location and plan type and is subject to change. All group dental benefit plans and dental insurance policies contain exclusions and limitations. For costs and complete details of coverage, contact your Cigna representative.

*The term DHMO ("Dental HMO") is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The Cigna DHMO is not available in the following states: AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. Cigna Dental Care (DHMO) plans are insured by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (KS & NB), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, Cigna Dental Care plans are insured by Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company (CGLIC), or Cigna HealthCare of Connecticut, Inc., and administered by Cigna Dental Health, Inc. Cigna Dental PPO plans are insured or administered by CHLIC or CGLIC, with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network. Policy forms: OK – DPPO: HP-POL99 (CHLIC) and GM6000 ELI288 et al (CGLIC), DHMO: POL115 (CHLIC) and GM6000 DEN201V1 (CGLIC); TN – DPPO: HP-POL69/HC-CER2V1 et al, DHMO: HP-POL134/HC-CER17V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. All pictures are used for illustrative purposes only.

REAL LIFE. REAL SOLUTIONS.

City of Fort Lauderdale

Dental Review

June 30, 2021

945581 10/20

Cigna

Offered by Cigna Health and Life Insurance Company, or its affiliates.

Introductions

AGENDA

- Introductions
- Updates & Capabilities
- Utilization
- Wrap-up & next steps

CIGNA PARTICIPANTS

Michelle Alperstein, Senior Account Manager

Deborah L. Fuller, DMD, MS, MPH, FICD National Dental Director

Lisa McDonald, Dental Sales Manager

Malena Maya, Senior Engagement Consultant

Mickey Bernardo, Client Service Partner

When it matters most, you can count on us.

During COVID-19, our proactive response in supporting our customers, clients, and providers never wavered.

Supporting our customers

No-cost virtual dental care

Smile Together free discount dental access for furloughed employees

Resources to manage stress

Free COVID-19 risk assessment

Coronavirus Resource Center: webinars, podcasts, and articles

Waiving plan maximums and frequency limitations

Guidance for seeking emergency dental care

Supporting our providers

Health Information Line

Resources to manage stress

PPE coverage for dental providers

Supporting our clients

Client relief program

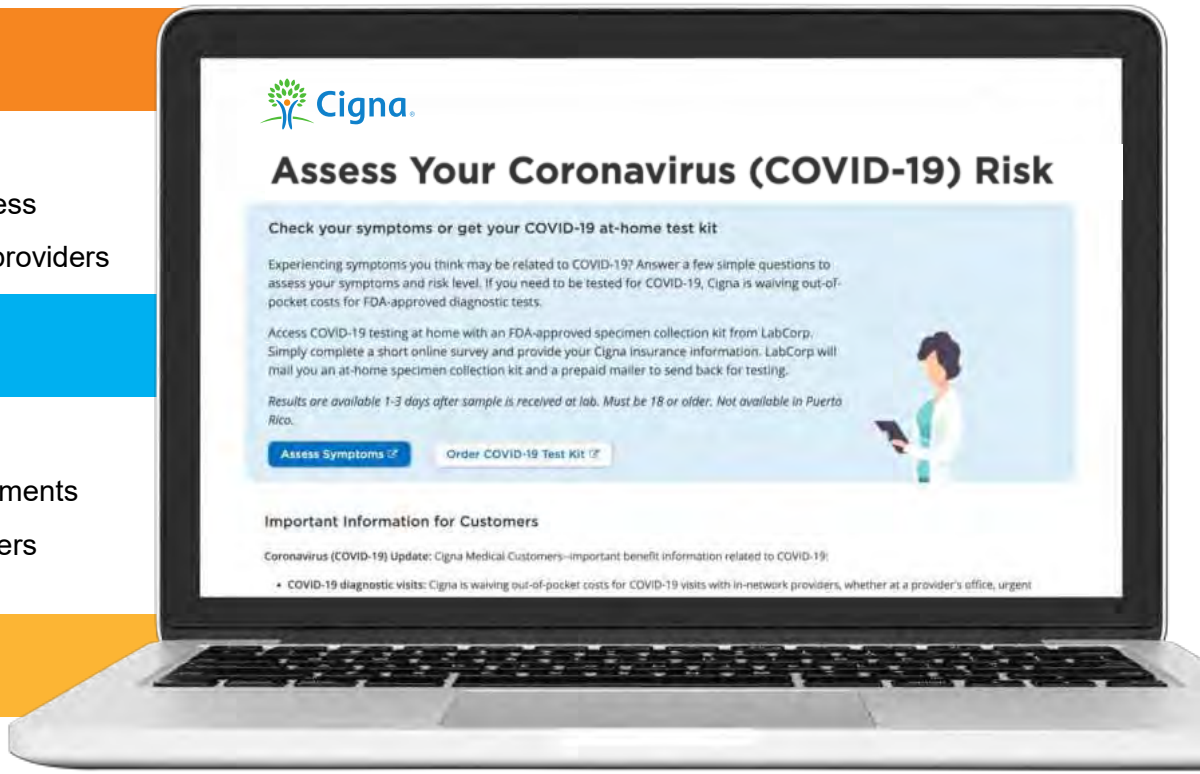
Relaxing eligibility requirements

Peace of mind for employers facing furloughs

Supporting our community

The Brave of Heart Fund

Financial and emotional support for families of frontline workers



Cigna

Doing more to improve whole person health.

Cigna Dental Oral Health Integration Program®*

New in 2021

- Expanding list of covered conditions
- Two new dental procedures

Delivering better outcomes for customers with qualifying medical conditions.

13.6%

lower total medical costs**

For customers with heart disease and diabetes who received treatment for gum disease.

*Covered employees must enroll in the program prior to receiving dental services to be eligible for reimbursement. This program provides reimbursement for certain eligible dental procedures for customers with qualifying medical conditions. Reimbursement is applied/subject to plan year maximums under DPPO plans. Contact your Cigna representative for a list of eligible procedures and related program limitations. **"Preventive Dental Treatment Associated with Lower Medical Utilization and Costs." National study of Cigna customers with dental and medical coverage, July 2019. First year TMC savings: 6%, second year TMC savings additional 2% for total of 8%. Individual results may vary.

Cigna Dental
Oral Health Integration Program®[1]

Procedure description	Procedure code(s)	Heart disease	Stroke	Diabetes	Maternity	Chronic Kidney Disease	Organ Transplants	Head and Neck Cancer Radiation
Periodontal Treatment & Maintenance[2]	D4341, D4342, D4910	x	x	x	x	x	x	x
Periodontal Evaluation[3]	D0180				x			
Oral Evaluation[4]	D0120, D0140, D0150				x			
Cleaning[5]	D1110				x			
Scaling in presence of inflammation full mouth[5]	D4346				x			
Emergency Palliative Treatment[6]	D9110				x			
Topical application of fluoride varnish[7]	D1206					x	x	x
Topical application of fluoride– excl varnish[8]	D1208					x	x	x
Sealants[9]	D1351					x	x	x
Sealant Repair – per tooth[10]	D1353					x	x	x

1. Covered employees must be enrolled in the program prior to receiving dental services to be eligible for reimbursement. This program provides reimbursement for certain eligible dental procedures for customers with qualifying medical conditions. Reimbursement is subject to plan year maximums under DPPO plans. 2. D4910 is limited to four times per year. D4341, D4342,: all limitations apply. 3. D0180: One additional evaluation 4. D0120, D0140, D0150: One additional evaluation. 5. D1110 or D4346: One additional cleaning 6. D9110; No limitations. 7. D1206: Age limits removed, all other limitations apply 8. D1208: Age limits removed, all other limitations apply. 9. D1351: Age limits removed, all other limitations apply 10. D1353: Age limits removed, all other limitations apply

Launching in 2021

More covered conditions implemented for Cigna Dental Outreach and Oral Health Integration* Programs

Condition Category	Condition Name	Specific Oral Health Risks
Autoimmune Disorders	Rheumatoid Arthritis	Bidirectional linkage with periodontal disease; Sjogren's syndrome; caries (tooth decay)
	Sjogren's Syndrome	Xerostomia (dry mouth); mouth sores; caries; difficulty chewing/swallowing/ speech/taste; difficulty with dentures; parotid/salivary gland dysfunction
	Lupus	Secondary Sjogren's Syndrome; caries
Neurologic Disorders	Parkinson's Disease	Poor oral hygiene; changes in denture fit; bruxism; angular cheilitis; dry mouth; caries
	Amyotrophic Lateral Sclerosis	Periodontal (gum) disease; caries; xerostomia; ill-fitting prosthesis
	Huntington's Disease	Periodontal disease; caries
Substance Abuse Disorders	Opioid Misuse and Addiction	Caries; periodontal disease; mucosal dysplasia; bruxism; tooth loss; xerostomia; burning mouth; taste impairment; eating difficulties; mucosal infections; candidosis

Launch date subject to change. *Covered employees must be enrolled in the program prior to receiving dental services to be eligible for reimbursement. This program provides reimbursement for certain eligible dental procedures for customers with qualifying medical conditions. Reimbursement is subject to plan year maximums under DPPO plans.

Cigna Dental Virtual Care

Dental care designed for our world.

Speak with a dentist 24/7/365[1]:

- Urgent care needs: Tooth pain, gum inflammation, broken teeth, infection
- Non-narcotic medications and antibiotics prescribed
- Guide follow-up care

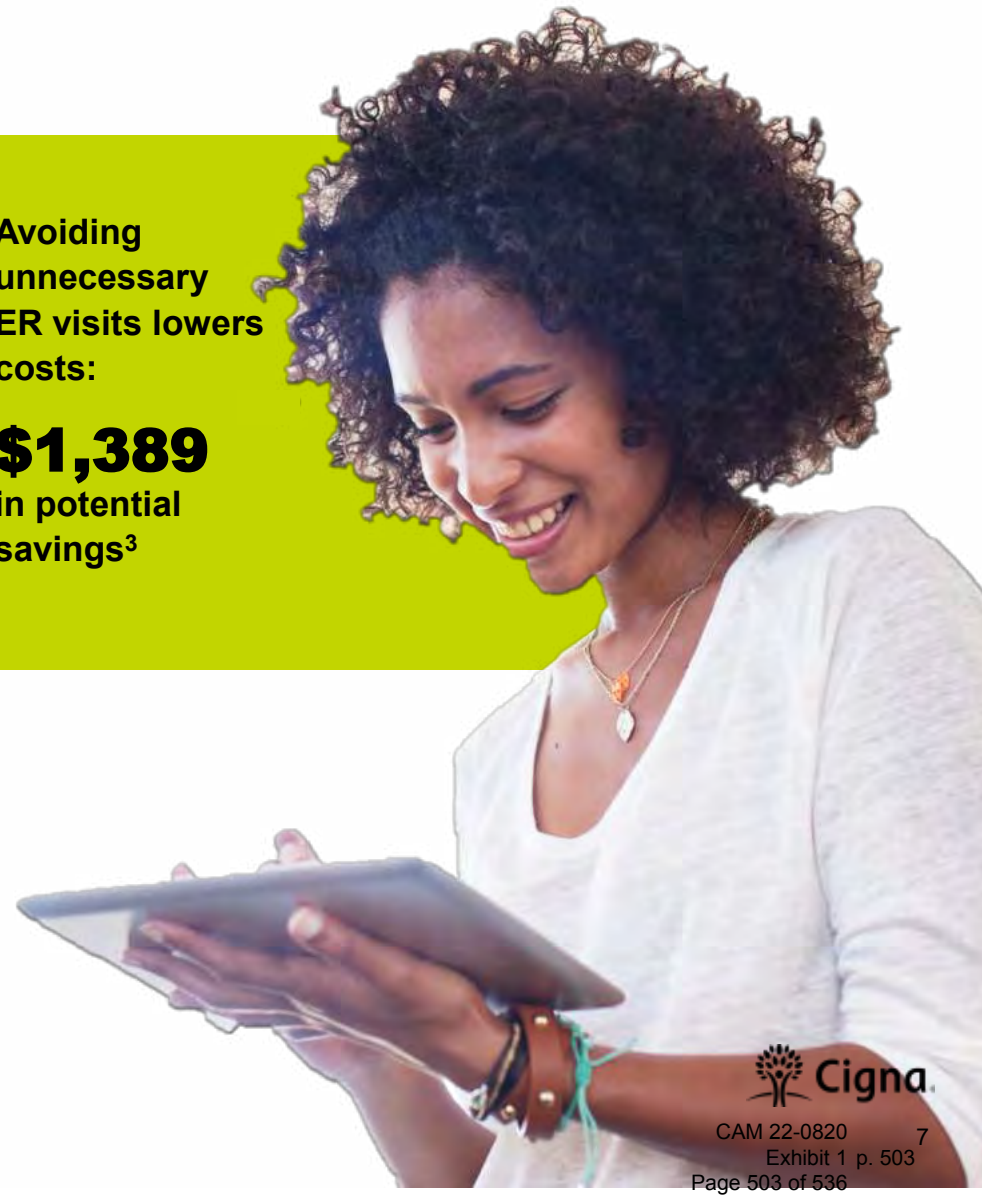
Virtual consult costs on average:

17%
less than in-network exam and

48%
less than out-of-network exam[2]

Avoiding unnecessary ER visits lowers costs:

$1,389
in potential savings[3]



See Appendix FN8

Care made more convenient

Cigna Onsite Dental[SM1]

- Removes barrier to care with 45-minute appointments where and when your employees need it
- Increase use of preventive services
- Helps improve health, productivity and satisfaction
- All at no additional charge to client or customer[1]

42% of Americans don't see a dentist as often as they would like.[3]

More than **33%** avoid the dentist because it's inconvenient or they can't find one.[3]

33% of adults say dental appointments at the workplace is appealing.[4]

1. Availability may vary by market. Services provided are subject to plan terms and conditions, including deductible, copay and/or coinsurance requirements. 2. "Regional variation in private dental coverage and care among dentate adults aged 18–64 in the United States," 2014–2017. NCHS Data Brief, no 3; National Center for Health Statistics. 2019. 3. "More Americans Want to Visit the Dentist" ADA Survey, March 2018. 4. Cigna Dental study: Exploring the relationship between oral health and mental well-being. August 2019.

Dental Dashboard
City of Fort Lauderdale

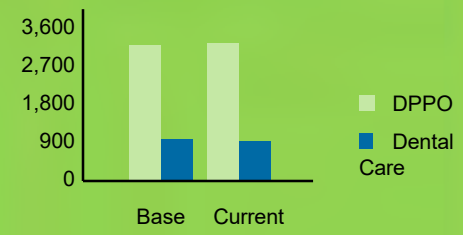
Member population

Current Period
Family Size
Total Group
Norm

Employees & dependents all products

	Base	Current	Trend	Norm
Employees	2,020	2,039	1.0%	
Dependents	2,435	2,389	-1.9%	
Family Size	2.21	2.17	-1.5%	2.03
Total Members	4,454	4,428	-0.6%	

Average plan members



	DPPO	Dental Care
Base	3,391	1,063
Current	3,422	1,006
Trend	0.9%	-5.4%

Month with greatest overall change:

Base	:	February	-0.5%
Current	:	May	0.8%

DPPO Oral Health Behavior

Current Period
Members with 1 or More Cleanings
Total Plan Members
Norm

% of Unique members receiving cleaning

Base	Current	Trend	Norm
64.0%	57.3%	-6.7%	52.5%

% of Unique members by service type

Healthy behaviors	Base	Current	Trend	Norm
Exams	58.9%	52.9%	-6.1%	50.9%
Cleanings	59.6%	52.8%	-6.8%	49.8%
Fluoride	19.0%	17.1%	-1.9%	17.3%
Periodontal cleanings	5.7%	5.4%	-0.3%	3.3%
Treatment				
Fillings	15.3%	12.9%	-2.4%	12.3%
Crowns	6.9%	6.2%	-0.7%	6.0%
Root canals	1.6%	1.5%	-0.1%	1.6%
Extractions - all	4.3%	3.4%	-0.9%	3.4%
Gum disease				
Non surg perio	4.0%	3.1%	-0.9%	1.5%

Savings

Current Period
Total Network Charges
Total Submitted Charges
Norm

Network performance

Base	Current	Trend	Norm
Total network charges			
84.5%	82.7%	-1.7%	74.5%
Achieved discounts			
38.3%	39.1%	0.8%	34.9%

DPPO

	Base	Current	Trend	Norm
Net effective discount				
	32.4%	32.4%	-0.0%	26.0%
Plan design savings				
	15.0%	15.3%	0.3%	19.9%
Utilization management & review				
	9.9%	10.9%	1.0%	12.2%
Total savings				
	57.4%	58.6%	1.3%	58.1%
Plan paid claims PMPM				
	$28.59	$25.29	-11.5%	$23.63

Dental Care

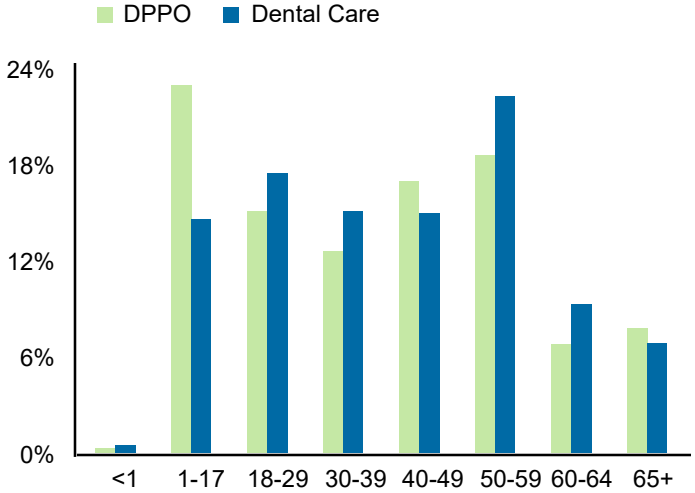
	Base	Current	Trend	Norm
Member savings on services provided				
	82.8%	85.7%	3.0%	81.8%

Current Period reflects claims incurred between Jan. 2020 and Dec. 2020, paid through Dec. 2020
Base Period reflects claims incurred between Jan. 2019 and Dec. 2019, paid through Dec. 2019

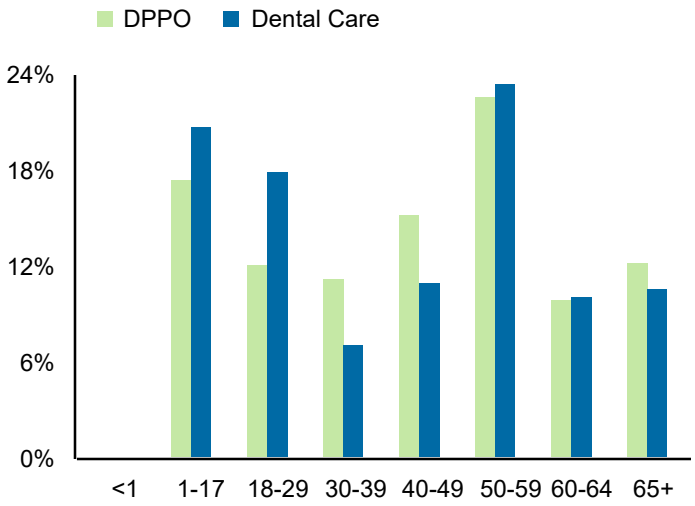
Dental - Membership Summary

City of Fort Lauderdale

Percent of membership by age band and product



Percent of spend by age band and product



Summary of membership

	Base					
Average Populations	Employees	Spouses & Dependents	Members	Average Family Size	Percent Female	Percent Male
Dental Care	569	494	1,063	1.87	48.9%	51.1%
DPPO	1,451	1,941	3,391	2.34	48.9%	51.1%
Total	2,020	2,435	4,454	2.21	48.9%	51.1%

	Current					
Average Populations	Employees	Spouses & Dependents	Members	Average Family Size	Percent Female	Percent Male
Dental Care	554	452	1,006	1.82	48.7%	51.3%
DPPO	1,485	1,938	3,422	2.31	49.1%	50.9%
Total	2,039	2,389	4,428	2.17	49.0%	51.0%

DPPO Demographic Summary	**Base**	**Current**	**Trend**	**Norm**
Average Number of Employees	1,451	1,485	2.3%	
Average Number of Members	3,391	3,422	0.9%	
Average Member Age	36.7	37.1	1.1%	36.1
Services per Claimant	7.6	7.7	1.3%	7.2
% of Members Using Plan	70.8%	64.7%	-6.1%	60.6%
% of Unique Members Receiving a Cleaning	64.0%	57.3%	-6.7%	52.5%

Comments

- Average membership in the current period was 4,428, a decrease of 0.6%
- Average family size decreased from 2.21 to 2.17, a decrease of 1.8%. Average family size measures the ratio of members to employees
- Employees represented 46.0% of the population in the current period, spouses 20.7% and dependents 33.2%

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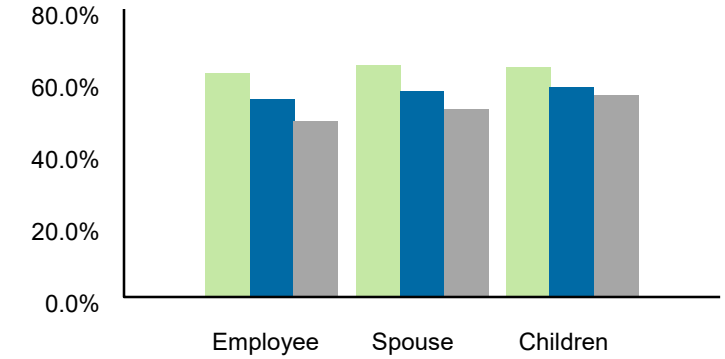
Dental PPO - Cleanings Utilization

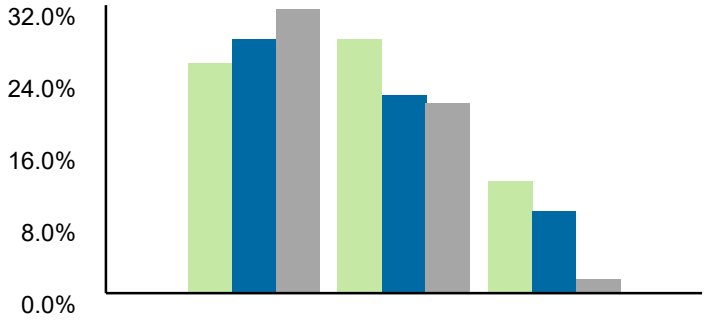
City of Fort Lauderdale

% of unique members receiving a cleaning by tier



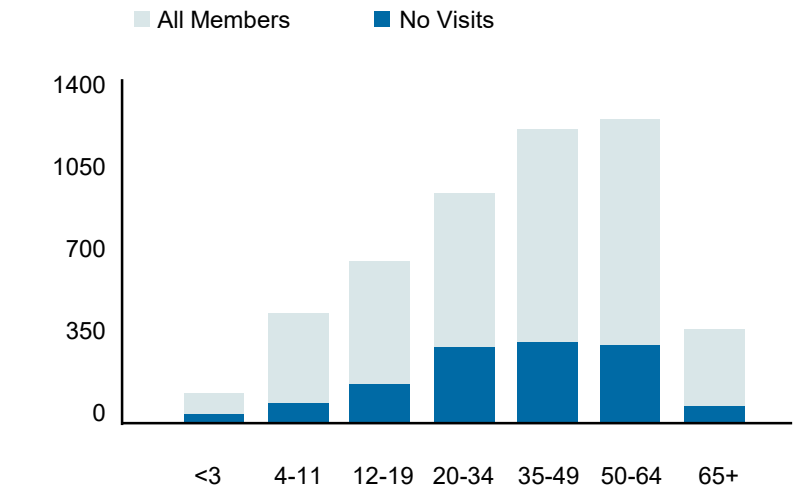
	Employee	Spouse	Children
Base	62.6%	64.7%	63.9%
Current	55.5%	57.3%	58.5%
Norm	49.4%	52.6%	56.2%

Cleanings utilization for total population



	1 Cleaning	2 Cleanings	3 or more Cleanings
Base	24.7%	27.3%	12.0%
Current	27.3%	21.2%	8.8%
Norm	30.4%	20.4%	1.7%

No visits by age in current period



Comments

- The percentage of the population having at least one cleaning decreased from 64.0% to 57.3%, and compares to a norm of 52.5%
- 30.0% of the population had two or more cleanings during the current period
- Includes all submitted cleanings for procedures 1110*(adult cleaning), 1120*(child cleaning) and 4910*(periodontal cleaning) without regard to coverage
- The percentage of No Visits population increased from 29.7% to 35.8%, and compares to a norm of 40.0%

*Current Dental Terminology © American Dental Association

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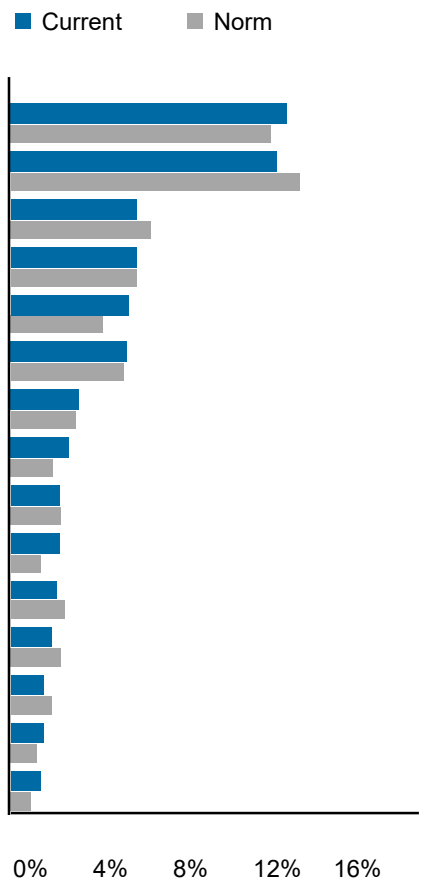
Dental PPO - Top 15 Procedure Types

City of Fort Lauderdale

Ranking						Percent of Total	
Current	Base	Top 15 Procedure Types*	% of Total Uniques	Unique Members	Number of Services	Current	Norm
1	1	Prophylaxis - Adult	62.5%	1,384	2,349	13.7%	12.9%
2	2	Periodic Oral Evaluation - established patient	70.2%	1,553	2,263	13.2%	14.3%
3	3	Bitewings - Four Radiographic Images	46.8%	1,036	1,080	6.3%	7.0%
4	4	Intraoral - Periapical - First Radiographic Image	38.8%	858	1,072	6.3%	6.3%
5	NR	**Unspecified Preventive Procedure, By Report**	30.9%	683	1,005	5.9%	4.6%
6	5	Intraoral - Periapical - Each Additional Radiograp	29.3%	648	988	5.8%	5.6%
7	6	Prophylaxis - Child	17.5%	387	585	3.4%	3.2%
8	7	Topical Application Of Fluoride - Excluding Varnis	17.7%	392	500	2.9%	2.1%
9	11	Limited Oral Evaluation - Problem Focused	14.4%	319	417	2.4%	2.5%
10	8	Periodontal Maintenance Procedures (Following Acti	10.2%	225	416	2.4%	1.5%
11	10	Resin-Based Composite - Two Surfaces, Posterior	10.7%	237	400	2.3%	2.7%
12	9	Comprehensive Oral Evaluation - New or established	14.8%	327	337	2.0%	2.5%
13	12	Resin-Based Composite - One Surface, Posterior	7.8%	173	276	1.6%	2.0%
14	14	Periodontal Scaling And Root Planing, Per Quadrant	3.7%	81	271	1.6%	1.3%
15	NR	Resin-Based Composite - Three Surfaces, Posterior	6.2%	138	262	1.5%	1.0%

*NR is No Ranking



Comments

- The top three procedure types represented 33.2% of services for the current period

*Current Dental Terminology © American Dental Association

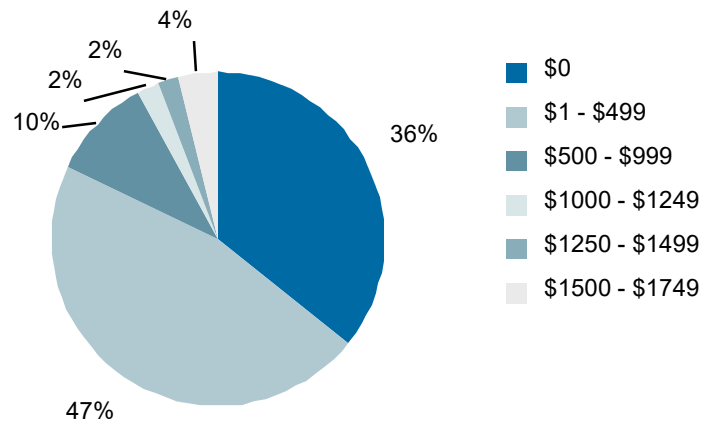
Dental PPO - Plan Fundamentals

City of Fort Lauderdale

Plan Year Maximum in Current Period

Paid Amount Range	No.of Members	% of Total Members
$0	1,224	35.8%
$1 - $499	1,600	46.8%
$500 - $999	330	9.6%
$1000 - $1249	79	2.3%
$1250 - $1499	66	1.9%
$1500 - $1749	123	3.6%
Total Members	3,422	

Plan Year Maximum in Current Period



Orthodontia Utilization in Current Period

	Adults	Children	Total
Unique Members	36	59	95
Paid Amounts	$27,084	$46,779	$73,864
Mbrs Ortho-in-Progress	36	54	90
Mbrs Reaching Ortho Max	0	5	5

Additional Covered Benefits Summary

	Base	Current	Trend	Norm
Surgical Implants	$11,822	$19,064	61.3%	
Prosthetics over Implants	$13,439	$7,877	-41.4%	

Additional Covered Benefits PMPM (or PMPY)

Surgical Implants	$0.29	$0.46	59.8%	$0.33
Prosthetics over Implants	$0.33	$0.19	-41.9%	$0.31

Comments

- Norm for percentage of members reaching the Plan Year maximums vary depending on region, industry and maximum amount.
- Please note that percentages in the Plan Year Maximum exhibit may be over the actual maximum(s) if the reporting periods differ from the plan year period.

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Dental PPO - Claim Cost and Savings Summary

City of Fort Lauderdale

Account Summary	Base	Current	PMPM Base	PMPM Current	Trend	Norm
Submitted Charges	$2,729,338	$2,510,930	$67.06	$61.14	-8.8%	$56.47
Employer Paid	$1,163,343	$1,038,756	$28.59	$25.29	-11.5%	$23.63
Discount Dollars	$884,161	$813,347	$21.73	$19.81	-8.8%	$14.72
Net Effective Discount	32.4%	32.4%				
Plan Design Savings						
Deductible	$36,453	$31,177	$0.90	$0.76	-15.2%	$1.12
Coinsurance	$244,359	$231,899	$6.00	$5.65	-6.0%	$7.06
Coordination of Benefits	$1,985	$1,493	$0.05	$0.04	-25.5%	$0.22
Annual/Lifetime Maximum	$66,851	$62,900	$1.64	$1.53	-6.8%	$1.21
Maximum Reimbursable Charge	$34,141	$39,018	$0.84	$0.95	13.3%	$1.24
Scheduled Plan Savings	$0	$0	$0.00	$0.00	0.0%	$0.12
Other Savings	$26,856	$17,823	$0.66	$0.43	-34.2%	$0.26
Total	$410,645	$384,309	$10.09	$9.36	-7.3%	$11.22
Savings as % of submitted	15.0%	15.3%				
Utilization Management and Utilization Review Savings						
Missing Tooth Limitation	$9,686	$3,268	$0.24	$0.08	-66.6%	$0.07
Age/Frequency Limitation	$33,763	$32,083	$0.83	$0.78	-5.8%	$0.92
Additional Plan Design	$65,774	$69,884	$1.62	$1.70	5.3%	$1.84
Alternative Benefit Provision	$53,171	$51,408	$1.31	$1.25	-4.2%	$0.98
Utilization Review	$108,795	$117,875	$2.67	$2.87	7.4%	$3.08
Total	$271,189	$274,517	$6.66	$6.68	0.3%	$6.90
Savings as % of submitted	9.9%	10.9%				
Total Savings	$1,565,995	$1,472,174	$38.48	$35.85	-6.8%	$32.84
Total Savings as % of submitted	57.4%	58.6%				

Comments

- Total savings represents total submitted dollars not paid due to plan design mechanics (e.g.deductible, coordination of benefits, discounts, utilization management etc) while net effective discount represents total network discount savings

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Dental PPO - Utilization by Type of Service and Network

City of Fort Lauderdale

Plan Paid by Service Type - PMPM	Base	Current	Trend	Norm	% Network Current	% Network Norm
Diagnostic/Preventive	$13.11	$11.36	-13.4%	$11.03		
Basic Restorative	$3.33	$2.90	-13.0%	$3.10		
Major Restorative	$3.87	$3.54	-8.5%	$3.78		
Endodontics	$1.60	$1.39	-13.2%	$1.47		
Periodontics	$2.69	$2.30	-14.4%	$1.35		
Oral Surgery	$1.59	$1.52	-4.5%	$1.46		
Orthodontics	$1.88	$1.80	-4.1%	$1.18		
Other Services	$0.52	$0.49	-5.4%	$0.49		
Total	**$28.59**	**$25.29**	**-11.5%**	**$23.63**		

Services per 1,000 Members by Type	Base	Current	Trend	Norm	% Network Current	% Network Norm
Diagnostic/Preventive	3,747.7	3,628.6	-3.2%	3,191.3		
Basic Restorative	431.7	369.3	-14.4%	371.4		
Major Restorative	207.9	192.6	-7.4%	185.5		
Endodontics	48.7	44.4	-8.7%	42.5		
Periodontics	435.5	353.0	-18.9%	190.3		
Oral Surgery	152.4	123.0	-19.3%	144.3		
Orthodontics	168.1	139.4	-17.1%	115.0		
Other Services	167.2	161.0	-3.7%	133.0		
Total	**5,359.1**	**5,011.3**	**-6.5%**	**4,373.3**		

Comments

- There is a decrease in cost in all categories categories for an overall cost trend of -11.5%
- There is a decrease in services per thousand in all categories for an overall utilization trend of -6.5%
- High utilization for Diagnostic/Preventive services can lead to lower usage of other service categories

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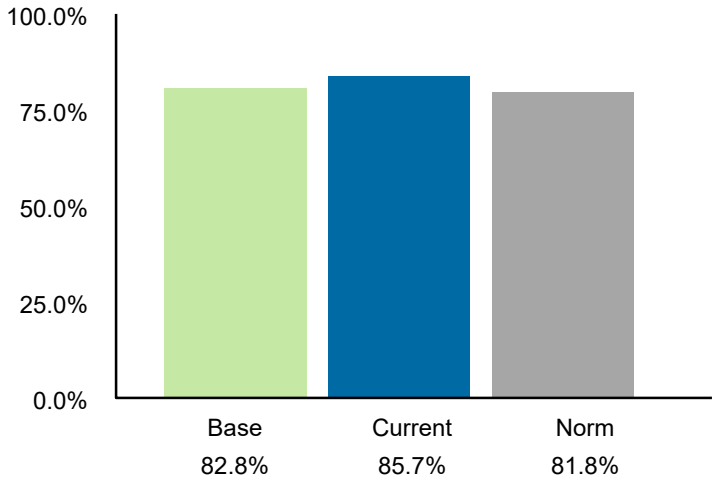
Dental Care - Summary

City of Fort Lauderdale

Demographic Summary	Base	Current	Trend
Average Number of Employees	569	554	-2.6%
Average Number of Members	1,063	1,006	-5.4%

Key Statistics	Base	Current	Trend	Norm
Services	2,093	2,022	-3.4%	
Services per 1,000	1,969.6	2,010.4	2.1%	2,337.3
Total Patient Copays	$69,486	$52,563	-24.4%	
National Average Charges	$403,331	$368,255	-8.7%	
Savings on Dental Services	$333,854	$315,710	-5.4%	
Savings Percentage	82.8%	85.7%	2.9%	81.8%

Savings percentage



Comments

- Dental Care reporting is limited to encounter data submitted by providers, therefore service counts can be understated when utilization detail is not provided
- Savings percentage increased from 82.8% to 85.7%, and compares to a norm of 81.8%
- Cigna DHMO is also known as Cigna Dental Care and includes Cigna Dental Care Access and Cigna Dental Care Access Plus

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Dental Care - Utilization by Type of Service

City of Fort Lauderdale

Gross Services by Type	Base		Current		Trend	Norm
	Count	Percent of Total	Count	Percent of Total		Percent of Total
Diagnostic/Preventive	1,103	52.7%	1,107	54.7%	0.4%	69.7%
Basic Restorative	161	7.7%	184	9.1%	14.3%	7.0%
Major Restorative	99	4.7%	79	3.9%	-20.2%	4.0%
Endodontics	20	1.0%	20	1.0%	0.0%	1.2%
Periodontics	291	13.9%	259	12.8%	-11.0%	6.3%
Oral Surgery	131	6.3%	125	6.2%	-4.6%	3.9%
Orthodontics	158	7.5%	143	7.1%	-9.5%	5.1%
Other Services	130	6.2%	105	5.2%	-19.2%	2.8%
Total	**2,093**	**100.0%**	**2,022**	**100.0%**	**-3.4%**	**100.0%**

Services per 1,000 Members by Type	Base		Current		Trend	Norm	
	Count	Percent of Total	Count	Percent of Total		Count	Percent of Total
Diagnostic/Preventive	1,038.0	52.7%	1,100.7	54.7%	6.0%	1,628.5	69.7%
Basic Restorative	151.5	7.7%	182.9	9.1%	20.8%	162.8	7.0%
Major Restorative	93.2	4.7%	78.5	3.9%	-15.7%	93.9	4.0%
Endodontics	18.8	1.0%	19.9	1.0%	5.7%	28.9	1.2%
Periodontics	273.8	13.9%	257.5	12.8%	-6.0%	147.5	6.3%
Oral Surgery	123.3	6.3%	124.3	6.2%	0.8%	91.9	3.9%
Orthodontics	148.7	7.5%	142.2	7.1%	-4.4%	119.5	5.1%
Other Services	122.3	6.2%	104.4	5.2%	-14.7%	64.4	2.8%
Total	**1,969.6**	**100.0%**	**2,010.4**	**100.0%**	**2.1%**	**2,337.3**	**100.0%**

Comments

- There is an increase in utilization per thousand in 4 categories and a decrease in utilization per thousand in 4 categories for an overall utilization trend of 2.1%
- High utilization for Diagnostic/Preventive services can lead to lower usage of other service categories

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Next Steps & Follow-Up Items

- **July 28th, 2021 Dr. Fuller Presentation**
- **Open Enrollment Discussions**
- **Continuous Preventive Care Education (MotivateMe)**

Thank you for your time!

Glossary

Additional Plan Design Savings
Savings generated from contractual limitations and benefits exclusions.

Adjunctive General Services
Palliative treatments, consultations, emergency care, second opinions and anesthesia.

Age Maximum
Savings due to age limits on fluoride treatments, sealants, orthodontic services and other services.

Alternate Benefit Provision
This provision includes a three-tier claim review process monitored by Dental Claim Analysts, Dental Reviewers and Dental Consultants. Under this process, proposed treatment plans are examined by Dental Reviewers and approved, denied, or referred to Dental Consultants for alternate treatment decisions. Where appropriate, the Dental Consultant will recommend alternate treatments considered to be less costly and consistent with professional dental standards.

Annual Maximum
Savings due to a patient reaching the maximum payment under the plan, often per calendar year.

Average Area Charge
Average charge based on the number of dentist in the geographical area pertaining to your membership.

Basic Restorative
Dental treatments or procedures performed to repair and restore individual teeth due to decay, erosion, trauma or improper function. Basic services may include fillings, oral surgery, endodontics (root canals) and periodontics (tissue/bone treatment).

Benefit Option
This code is used to identify different Cigna product lines purchased by a customer.

Charges
The amount charged by a dentist for dental services rendered.

Children
Children are defined as child, step-child, handicapped child, eligible students and adult dependent.

Claim Branch
This term describes the different ways an account can be sub-divided into groups for reporting purposes based on the account structure.

Coinsurance
The percentage of covered expenses paid by the member when costs are being shared by both the plan and the individual member.

Coordination of Benefits (COB)
The amount saved when Cigna is the secondary insurer. It represents the difference between what Cigna pays and (COB) what it would have paid if it were primary.

Covered Employees
The number of Covered Employees for the reporting period equals the number of active employees in the first reporting period month and includes any active employee additions made in the following months within the reporting period. To be counted as a covered employee addition the employee must have had atone day of coverage.

Deductible
An amount specified in plan design that must be paid by member for covered expenses in a benefit period before the plan will pay benefits.

Glossary

Dental care
The term utilized to represent the Cigna Dental Care product (formerly represented as DHMO). In most states, the Cigna Dental Care plan requires the selection of a general dentist for routine, preventive, diagnostic and emergency care. Referrals to specialists are provided, as needed. Data for this product can be found in the sections labeled Dental Care.

DHMO
Dental Health Maintenance Organization. Cigna's DHMO product is called Cigna Dental Care. In most states, the Cigna Dental Care plan requires the selection of a general dentist for routine, preventive, diagnostic and emergency care. Referrals to specialists are provided, as needed. Data for this product can be found in the sections labeled Dental Care.

Diagnostic/Preventive
Dental treatments or procedures focused on the prevention and diagnosis of dental diseases. These services may include oral examinations, cleanings, X-rays, sealants and fluoride treatments.

DPPO
Cigna Dental Preferred Provider Organization. With the Dental Preferred Provider Organization plan (DPPO), customers can see any licensed dentist or specialist, but may pay less for covered services when utilizing in-network dentists for care. Data for this product can be found in the sections labeled DPPO.

Endodontics
The dental specialty that concentrates on the treatment of root canals or other injuries/diseases of the pulp, or nerve, of the tooth.

Frequency Maximum
Savings due to frequency limits on examinations, cleanings, radiographs, crowns and other services.

Ineligible Charges
Ineligible Charges include savings attributable to limitations of the plan (Missing Tooth Limitation, Age/Frequency, Annual/Lifetime Maximums); charges submitted for ineligible participants; application of Alternate Benefit Provisions which may be a result of the Pre-Determination of Benefits (PDB) process; services that exceed the maximum reimbursable charge limits per service, or the Scheduled Plan benefits, if applicable; and Utilization Management Services.

In-Network
Services rendered by providers who are part of a network and with whom Cigna has a contractual relationship.

Major Restorative
Dental treatments or procedures targeting the restoration of teeth using services such as crowns, inlays, or onlays. Major services also may include prosthodontics (i.e. dentures).

Member
An individual who is eligible for coverage and enrolled under a dental plan. Includes employee and any covered dependents.

Missing Tooth Limitation
A contractual provision which limits or excludes payment for the replacement of teeth that are missing prior to the patient's effective date of plan coverage.

Norm
Norm refers to the comparison group based on book of business or industry experience for the defined parameters. Norms are annualized unless otherwise stated.

Oral Surgery
Non-surgical and surgical extractions, and other surgical procedures.

Glossary

Orthodontics
Dental treatments or procedures performed to correct misalignments of the teeth and restore the teeth to their proper alignment and bite function. Services may include braces or retainers.

Other Savings
Other Savings is a category in which savings is captured when a claim has multiple plan design savings reasons.

Out-of-Network
Services rendered by providers who are not part of the Cigna network based on your benefit plan design.

Paid Claims
That portion of the dentist's charges paid by Cigna to a patient or provider for dental services covered under the benefit plan.

Patient
A unique individual participant (employee or dependent) who received one or more dental services during the reporting period in-network and/or out-of-network.

Periodontics
Scaling and root planing, surgical procedures of the gingiva/bone, and other gum-related treatment.

Pre-Determination of Benefits (PDB)
A process that allows the patient and dentist learn what benefits are provided by the dental plan in advance of treatment. The PDB process provides the dentist and participant with a detailed explanation of what specific benefits are available at the time the claim is reviewed so that the dentist may discuss the information with the patient before treatment is rendered and expenses are incurred. Savings from this process are also realized through the avoidance of more costly dental treatments where a less costly alternative is recommended.

Provider Discounts
The difference between the contracted payment amount and the average area charge for a procedure.

Scheduled Plan Savings
Savings due to the application of set scheduled dollar payment amounts for dental services set forth in a scheduled benefit plan.

Services
The number of individual dental procedures rendered by dental care providers.

Utilization Management
The set of administrative practices used on behalf of purchasers of dental benefits to manage the necessity, appropriateness, frequency and mix of dental services. It entails practices used in claims review for predetermination or payment of benefits, statistical review of individual provider utilization profiles and appropriate follow-up procedures.

Registration Rate –Is the calculated result of the registered employee/subscriber divided by eligible employee/subscriber. Is calculated at the subscriber level and is only available for myCigna.com and not available within the mobile app environment. This number a cumulative number based on that specific time period.

Eligible" & "Registered Users – Refers to employees, or subscribers, who have elected into Cigna benefits. Does not include dependent data. Registration rate is only available within myCigna.com and not the mobile app.

Unique user - A unique individuals accessing myCigna or myCigna App based on unique user enterprise ID. This does include Spouses and Dependents.

Visit - A visit is an instance of continuous activity for one visitor on the myCigna.com. The visit starts the moment the customer logs into myCigna.com and continues until they either leave through inactivity, navigation to another site, or the browser is closed.

Total Visits" - Overall number of visits to myCigna.

NON-COLLUSION STATEMENT:

By signing this offer, the vendor/contractor certifies that this offer is made independently and *free* from collusion. Vendor shall disclose below any City of Fort Lauderdale, FL officer or employee, or any relative of any such officer or employee who is an officer or director of, or has a material interest in, the vendor's business, who is in a position to influence this procurement.

Any City of Fort Lauderdale, FL officer or employee who has any input into the writing of specifications or requirements, solicitation of offers, decision to award, evaluation of offers, or any other activity pertinent to this procurement is presumed, for purposes hereof, to be in a position to influence this procurement.

For purposes hereof, a person has a material interest if they directly or indirectly own more than 5 percent of the total assets or capital stock of any business entity, or if they otherwise stand to personally gain if the contract is awarded to this vendor.

In accordance with City of Fort Lauderdale, FL Policy and Standards Manual, 6.10.8.3,

> 3.3. City employees may not contract with the City through any corporation or business entity in which they or their immediate family members hold a controlling financial interest (e.g. ownership of five (5) percent or more).
>
> 3.4. Immediate family members (spouse, parents and children) are also prohibited from contracting with the City subject to the same general rules.

Failure of a vendor to disclose any relationship described herein shall be reason for debarment in accordance with the provisions of the City Procurement Code.

NAME	RELATIONSHIPS

In the event the vendor does not indicate any names, the City shall interpret this to mean that the vendor has indicated that no such relationships exist.

Authorized Signature

Title

Name (Printed)

Date

QUESTIONNAIRE SHEET

PLEASE PRINT OR TYPE:
Firm Name:
President
Business Address:
Telephone: Fax:
E-Mail Address:

What was the last project of this nature which you completed? Include the year, description, and contract value.

The following are named as three corporations and representatives of those corporations for which you have performed work similar to that required by this contract, and which the City may contact as your references (include addresses, telephone numbers and e-mail addresses). Include the project title, year, description, and contract value.

How many years has your organization been in business?

Have you ever failed to complete work awarded to you; if so, where and why?

The name of the qualifying agent for the firm and his position is:

Certificate of Competency Number of Qualifying Agent:

Effective Date: Expiration Date:

Licensed in: Contractor's License/Certification #

(County/State)

Expiration Date:

NOTE: Contractor must have proper licensing prior to submitting bid and must provide copy of same with his proposal.

NOTE: To be considered for award of this contract, the bidder must submit a financial statement upon request.

QUESTIONNAIRE SHEET

1. Have you personally inspected the proposed work and have you a complete plan for its performance?

2. Will you sublet any part of this work? If so, list the portions or specialties of the work that you will
   a)
   b)
   c)
   d)
   e)
   f)
   g)

3. What equipment do you own that is available for the work?

4. What equipment will you purchase for the proposed work?

5. What equipment will you rent for the proposed work?

CONTRACT PAYMENT METHOD

The City of Fort Lauderdale has implemented a Procurement Card (P-Card) program which changes how payments are remitted to its vendors. The City has transitioned from traditional paper checks to credit card payments via MasterCard or Visa as part of this program.

This allows you as a vendor of the City of Fort Lauderdale to receive your payments fast and safely. No more waiting for checks to be printed and mailed.

In accordance with the contract, payments on this contract will be made utilizing the City's P-Card (MasterCard or Visa). Accordingly, bidders must presently have the ability to accept these credit cards or take whatever steps necessary to implement acceptance of a card before the start of the contract term, or contract award by the City.

All costs associated with the Contractor's participation in this purchasing program shall be borne by the Contractor. The City reserves the right to revise this program as necessary.

By signing below you agree with these terms.

Please indicate which credit card payment you prefer:

- ☐ MasterCard
- ☐ Visa

Company Name

Name (Printed)

Signature

Date

Title

CONTRACTOR'S CERTIFICATE OF COMPLIANCE WITH NON-DISCRIMINATION PROVISIONS OF THE CONTRACT

The completed and signed form should be returned with the Contractor's submittal. If not provided with submittal, the Contractor must submit within three business days of City's request. Contractor may be deemed non-responsive for failure to fully comply within stated timeframes.

Pursuant to City Ordinance Sec. 2-187(c), bidders must certify compliance with the Non-Discrimination provision of the ordinance.

The Contractor shall not, in any of his/her/its activities, including employment, discriminate against any individual on the basis of race, color, national origin, religion, creed, sex, disability, sexual orientation, gender, gender identity, gender expression, or marital status.

1. The Contractor certifies and represents that he/she/it will comply with Section 2-187, Code of Ordinances of the City of Fort Lauderdale, Florida, as amended by Ordinance C-18-33 (collectively, "Section 2-187").

2. The failure of the Contractor to comply with Section 2-187 shall be deemed to be a material breach of this Agreement, entitling the City to pursue any remedy stated below or any remedy provided under applicable law.

3. The City may terminate this Agreement if the Contractor fails to comply with Section 2-187.

4. The City may retain all monies due or to become due until the Contractor complies with Section 2-187.

5. The Contractor may be subject to debarment or suspension proceedings. Such proceedings will be consistent with the procedures in section 2-183 of the Code of Ordinances of the City of Fort Lauderdale, Florida.

Authorized Signature

Print Name and Title

Date

CITY OF FORT LAUDERDALE
GENERAL CONDITIONS

These instructions and conditions are standard for all contracts for commodities or services issued through the City of Fort Lauderdale Procurement Services Division. The City may delete, supersede, or modify any of these standard instructions for a particular contract by indicating such change in the Invitation to Bid (ITB) Special Conditions, Technical Specifications, Instructions, Proposal Pages, Addenda, and Legal Advertisement. In this general conditions document, Invitation to Bid (ITB), Request for Qualifications (RFQ), and Request for Proposal (RFP) are interchangeable.

PART I BIDDER PROPOSAL PAGE(S) CONDITIONS:

1.01 **BIDDER ADDRESS**: The City maintains automated vendor address lists that have been generated for each specific Commodity Class item through our bid issuing service, BidSync. Notices of Invitations to Bid (ITB'S) are sent by e-mail to the selection of bidders who have fully registered with BidSync or faxed (if applicable) to every vendor on those lists, who may then view the bid documents online. Bidders who have been informed of a bid's availability in any other manner are responsible for registering with BidSync in order to view the bid documents. There is no fee for doing so. If you wish bid notifications be provided to another e-mail address or fax, please contact BidSync. If you wish purchase orders sent to a different address, please so indicate in your bid response. If you wish payments sent to a different address, please so indicate on your invoice.

1.02 **DELIVERY:** Time will be of the essence for any orders placed as a result of this ITB. The City reserves the right to cancel any orders, or part thereof, without obligation if delivery is not made in accordance with the schedule specified by the Bidder and accepted by the City.

1.03 **PACKING SLIPS:** It will be the responsibility of the awarded Contractor, to attach all packing slips to the OUTSIDE of each shipment. Packing slips must provide a detailed description of what is to be received and reference the City of Fort Lauderdale purchase order number that is associated with the shipment. Failure to provide a detailed packing slip attached to the outside of shipment may result in refusal of shipment at Contractor's expense.

1.04 **PAYMENT TERMS AND CASH DISCOUNTS:** Payment terms, unless otherwise stated in this ITB, will be considered to be net 45 days after the date of satisfactory delivery at the place of acceptance and receipt of correct invoice at the office specified, whichever occurs last. Bidder may offer cash discounts for prompt payment but they will not be considered in determination of award. If a Bidder offers a discount, it is understood that the discount time will be computed from the date of satisfactory delivery, at the place of acceptance, and receipt of correct invoice, at the office specified, whichever occurs last**.**

1.05 **TOTAL BID DISCOUNT:** If Bidder offers a discount for award of all items listed in the bid, such discount shall be deducted from the total of the firm net unit prices bid and shall be considered in tabulation and award of bid**.**

1.06 **BIDS FIRM FOR ACCEPTANCE:** Bidder warrants, by virtue of bidding, that the bid and the prices quoted in the bid will be firm for acceptance by the City for a period of one hundred twenty (120) days from the date of bid opening unless otherwise stated in the ITB**.**

1.07 **VARIANCES:** For purposes of bid evaluation, Bidder's must indicate any variances, no matter how slight, from ITB General Conditions, Special Conditions, Specifications or Addenda in the space provided in the ITB. No variations or exceptions by a Bidder will be considered or deemed a part of the bid submitted unless such variances or exceptions are listed in the bid and referenced in the space provided on the bidder proposal pages. If variances are not stated, or referenced as required, it will be assumed that the product or service fully complies with the City's terms, conditions, and specifications**.**

By receiving a bid, City does not necessarily accept any variances contained in the bid. All variances submitted are subject to review and approval by the City. If any bid contains material variances that, in the City's sole opinion, make that bid conditional in nature, the City reserves the right to reject the bid or part of the bid that is declared by the City as conditional.

1.08 **NO BIDS:** If you do not intend to bid please indicate the reason, such as insufficient time to respond, do not offer product or service, unable to meet specifications, schedule would not permit, or any other reason, in the space provided in this ITB. Failure to bid or return no bid comments prior to the bid due and opening date and time, indicated in this ITB, may result in your firm being deleted from our Bidder's registration list for the Commodity Class Item requested in this ITB.

1.09 **MINORITY AND WOMEN BUSINESS ENTERPRISE PARTICIPATION AND BUSINESS DEFINITIONS:** The City of Fort Lauderdale wants to increase the participation of Minority Business Enterprises (MBE), Women Business Enterprises (WBE), and Small Business Enterprises (SBE) in its procurement activities. If your firm qualifies in accordance with the below definitions please indicate in the space provided in this ITB.

Minority Business Enterprise (MBE) "A Minority Business" is a business enterprise that is owned or controlled by one or more socially or economically disadvantaged persons. Such disadvantage may arise from cultural, racial, chronic economic circumstances or background or other similar cause. Such persons include, but are not limited to: Blacks, Hispanics, Asian Americans, and Native Americans.

The term "Minority Business Enterprise" means a business at least 51 percent of which is owned by minority group members or, in the case of a publicly owned business, at least 51 percent of the stock of which is owned by minority group members. For the purpose of the preceding sentence, minority group members are citizens of the United States who include, but are not limited to: Blacks, Hispanics, Asian Americans, and Native Americans.

Women Business Enterprise (WBE) a "Women Owned or Controlled Business" is a business enterprise at least 51 percent of which is owned by females or, in the case of a publicly owned business, at least 51 percent of the stock of which is owned by females.

Small Business Enterprise (SBE) "Small Business" means a corporation, partnership, sole proprietorship, or other legal entity formed for the purpose of making a profit, which is independently owned and operated, has either fewer than 100 employees or less than $1,000,000 in annual gross receipts.

BLACK, which includes persons having origins in any of the Black racial groups of Africa.

WHITE, which includes persons whose origins are Anglo-Saxon and Europeans and persons of Indo-European decent including Pakistani and East Indian.
HISPANIC, which includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or other Spanish culture or origin, regardless of race.
NATIVE AMERICAN, which includes persons whose origins are American Indians, Eskimos, Aleuts, or Native Hawaiians.
ASIAN AMERICAN, which includes persons having origin in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands.

1.10 MINORITY-WOMEN BUSINESS ENTERPRISE PARTICIPATION

It is the desire of the City of Fort Lauderdale to increase the participation of minority (MBE) and women-owned (WBE) businesses in its contracting and procurement programs. While the City does not have any preference or set aside programs in place, it is committed to a policy of equitable participation for these firms. Proposers are requested to include in their proposals a narrative describing their past accomplishments and intended actions in this area. If proposers are considering minority or women owned enterprise participation in their proposal, those firms, and their specific duties have to be identified in the proposal. If a proposer is considered for award, he or she will be asked to meet with City staff so that the intended MBE/WBE participation can be formalized and included in the subsequent contract.

1.11 SCRUTINIZED COMPANIES

As to any contract for goods or services of $1 million or more and as to the renewal of any contract for goods or services of $1 million or more, subject to *Odebrecht Construction, Inc., v. Prasad*, 876 F.Supp.2d 1305 (S.D. Fla. 2012), *affirmed*, *Odebrecht Construction, Inc., v. Secretary, Florida Department of Transportation*, 715 F.3d 1268 (11th Cir. 2013), with regard to the "Cuba Amendment," the Contractor certifies that it is not on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, and that it does not have business operations in Cuba or Syria, as provided in section 287.135, Florida Statutes (2019), as may be amended or revised. As to any contract for goods or services of any amount and as to the renewal of any contract for goods or services of any amount, the Contractor certifies that it is not on the Scrutinized Companies that Boycott Israel List created pursuant to Section 215.4725, Florida Statutes (2019), and that it is not engaged in a boycott of Israel. The City may terminate this Agreement at the City's option if the Contractor is found to have submitted a false certification as provided under subsection (5) of section 287.135, Florida Statutes (2019), as may be amended or revised, or been placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List or the Scrutinized Companies that Boycott Israel List created pursuant to Section 215.4725, Florida Statutes (2019), or is engaged in a boycott of Israel, or has been engaged in business operations in Cuba or Syria, as defined in Section 287.135, Florida Statutes (2019), as may be amended or revised.

1.12 DEBARRED OR SUSPENDED BIDDERS OR PROPOSERS

The bidder or proposer certifies, by submission of a response to this solicitation, that neither it nor its principals and subcontractors are presently debarred or suspended by any Federal department or agency.

Part II DEFINITIONS/ORDER OF PRECEDENCE:

2.01 BIDDING DEFINITIONS The City will use the following definitions in its general conditions, special conditions, technical specifications, instructions to bidders, addenda and any other document used in the bidding process:

INVITATION TO BID (ITB) The solicitation document used for soliciting competitive sealed bids for goods or services.
INVITATION TO NEGOTIATE (ITN) All solicitation documents, regardless of medium, whether attached to or incorporated by reference in solicitations for responses from firms that invite proposals from interested and qualified firms so the city may enter into negotiations with the firm(s) determined most capable of providing the required goods or services.
REQUEST FOR PROPOSALS (RFP) A solicitation method used for soliciting competitive sealed proposals to determine the best value among proposals for goods or services for which price may not be the prevailing factor in award of the contract, or the scope of work, specifications or contract terms and conditions may be difficult to define. Such solicitation will consider the qualifications of the proposers along with evaluation of each proposal using identified and generally weighted evaluation criteria. RFPs may include price criteria whenever feasible, at the discretion of the city.
REQUEST FOR QUALIFICATIONS (RFQ) A solicitation method used for requesting statements of qualifications in order to determine the most qualified proposer for professional services.
BID – a price and terms quote received in response to an ITB.
PROPOSAL – a proposal received in response to an RFP.
BIDDER – Person or firm submitting a Bid.
PROPOSER – Person or firm submitting a Proposal.
RESPONSIVE BIDDER – A firm who has submitted a bid, offer, quote, or response which conforms in all material respects to the competitive solicitation document and all of its requirements.
RESPONSIBLE BIDDER – A firm who is fully capable of meeting all requirements of the solicitation and subsequent contract. The respondent must possess the full capability, including financial and technical, ability, business judgment, experience, qualifications, facilities, equipment, integrity, capability, and reliability, in all respects to perform fully the contract requirements and assure good faith performance as determined by the city.
FIRST RANKED PROPOSER – That Proposer, responding to a City RFP, whose Proposal is deemed by the City, the most advantageous to the City after applying the evaluation criteria contained in the RFP.
SELLER – Successful Bidder or Proposer who is awarded a Purchase Order or Contract to provide goods or services to the City.
CONTRACTOR – Any firm having a contract with the city. Also referred to as a "Vendor".
CONTRACT – All types of agreements, including purchase orders, for procurement of supplies, services, and construction, regardless of what these agreements may be called.
CONSULTANT – A firm providing professional services for the city.

2.02 **SPECIAL CONDITIONS:** Any and all Special Conditions contained in this ITB that may be in variance or conflict with these General Conditions shall have precedence over these General Conditions. If no changes or deletions to General Conditions are made in the Special Conditions, then the General Conditions shall prevail in their entirety,

PART III BIDDING AND AWARD PROCEDURES:

3.01 **SUBMISSION AND RECEIPT OF BIDS:** To receive consideration, bids must be received prior to the bid opening date and time. Unless otherwise specified, Bidders should use the proposal forms provided by the City. These forms may be duplicated, but failure to use the forms may cause the bid to be rejected. Any erasures or corrections on the bid must be made in ink and initialed by Bidder in ink. All information submitted by the Bidder shall be printed, typewritten or filled in with pen and ink. Bids shall be signed in ink. Separate bids must be submitted for each ITB issued by the City in separate sealed envelopes properly marked. When a particular ITB or RFP requires multiple copies of bids or proposals they may be included in a single envelope or package properly sealed and identified. Only send bids via facsimile transmission (FAX) if the ITB specifically states that bids sent via FAX will be considered. If such a statement is not included in the ITB, bids sent via FAX will be rejected. Bids will be publicly opened in the Procurement Office, or other designated area, in the presence of Bidders, the public, and City staff. Bidders and the public are invited and encouraged to attend bid openings. Bids will be tabulated and made available for review by Bidder's and the public in accordance with applicable regulations.

3.02 **MODEL NUMBER CORRECTIONS:** If the model number for the make specified in this ITB is incorrect, or no longer available and replaced with an updated model with new specifications, the Bidder shall enter the correct model number on the bidder proposal page. In the case of an updated model with new specifications, Bidder shall provide adequate information to allow the City to determine if the model bid meets the City's requirements.

3.03 **PRICES QUOTED:** Deduct trade discounts, and quote firm net prices. Give both unit price and extended total. In the case of a discrepancy in computing the amount of the bid, the unit price quoted will govern. All prices quoted shall be F.O.B. destination, freight prepaid (Bidder pays and bears freight charges, Bidder owns goods in transit and files any claims), unless otherwise stated in Special Conditions. Each item must be bid separately. No attempt shall be made to tie any item or items contained in the ITB with any other business with the City.

3.04 **TAXES:** The City of Fort Lauderdale is exempt from Federal Excise and Florida Sales taxes on direct purchase of tangible property. Exemption **number for EIN is 59-6000319, and State Sales tax exemption number is 85-8013875578C-1.**

3.05 **WARRANTIES OF USAGE:** Any quantities listed in this ITB as estimated or projected are provided for tabulation and information purposes only. No warranty or guarantee of quantities is given or implied. It is understood that the Contractor will furnish the City's needs as they arise.

3.06 **APPROVED EQUAL:** When the technical specifications call for a brand name, manufacturer, make, model, or vendor catalog number with acceptance of APPROVED EQUAL, it shall be for the purpose of establishing a level of quality and features desired and acceptable to the City. In such cases, the City will be receptive to any unit that would be considered by qualified City personnel as an approved equal. In that the specified make and model represent a level of quality and features desired by the City, the Bidder must state clearly in the bid any variance from those specifications. It is the Bidder's responsibility to provide adequate information, in the bid, to enable the City to ensure that the bid meets the required criteria. If adequate information is not submitted with the bid, it may be rejected. The City will be the sole judge in determining if the item bid qualifies as an approved equal.

3.07 **MINIMUM AND MANDATORY TECHNICAL SPECIFICATIONS:** The technical specifications may include items that are considered minimum, mandatory, or required. If any Bidder is unable to meet or exceed these items, and feels that the technical specifications are overly restrictive, the bidder must notify the Procurement Services Division immediately. Such notification must be received by the Procurement Services Division prior to the deadline contained in the ITB, for questions of a material nature, or prior to five (5) days before bid due and open date, whichever occurs first. If no such notification is received prior to that deadline, the City will consider the technical specifications to be acceptable to all bidders.

3.08 **MISTAKES:** Bidders are cautioned to examine all terms, conditions, specifications, drawings, exhibits, addenda, delivery instructions and special conditions pertaining to the ITB. Failure of the Bidder to examine all pertinent documents shall not entitle the bidder to any relief from the conditions imposed in the contract.

3.09 **SAMPLES AND DEMONSTRATIONS:** Samples or inspection of product may be requested to determine suitability. Unless otherwise specified in Special Conditions, samples shall be requested after the date of bid opening, and if requested should be received by the City within seven (7) working days of request. Samples, when requested, must be furnished free of expense to the City and if not used in testing or destroyed, will upon request of the Bidder, be returned within thirty (30) days of bid award at Bidder's expense. When required, the City may request full demonstrations of units prior to award. When such demonstrations are requested, the Bidder shall respond promptly and arrange a demonstration at a convenient location. Failure to provide samples or demonstrations as specified by the City may result in rejection of a bid.

3.10 **LIFE CYCLE COSTING**: If so specified in the ITB, the City may elect to evaluate equipment proposed on the basis of total cost of ownership. In using Life Cycle Costing, factors such as the following may be considered: estimated useful life, maintenance costs, cost of supplies, labor intensity, energy usage, environmental impact, and residual value. The City reserves the right to use those or other applicable criteria, in its sole opinion that will most accurately estimate total cost of use and ownership.

3.11 **BIDDING ITEMS WITH RECYCLED CONTENT:** In addressing environmental concerns, the City of Fort Lauderdale encourages Bidders to submit bids or alternate bids containing items with recycled content. When submitting bids containing items with recycled content, Bidder shall provide documentation adequate for the City to verify the recycled content. The City prefers packaging consisting of materials that are degradable or able to be recycled. When specifically stated in the ITB, the City may give preference to bids containing items manufactured with recycled material or packaging that is able to be recycled.

3.12 **USE OF OTHER GOVERNMENTAL CONTRACTS:** The City reserves the right to reject any part or all of any bids received and utilize other available governmental contracts, if such action is in its best interest**.**

3.13 **QUALIFICATIONS/INSPECTION:** Bids will only be considered from firms normally engaged in providing the types of commodities/services specified herein. The City reserves the right to inspect the Bidder's facilities, equipment, personnel, and organization at any time, or to take any other action necessary to determine Bidder's ability to perform. The Procurement Director reserves the right to reject bids where evidence or evaluation is determined to indicate inability to perform**.**

3.14 **BID SURETY:** If Special Conditions require a bid security, it shall be submitted in the amount stated. A bid security can be in the form of a bid bond or cashier's check. Bid security will be returned to the unsuccessful bidders as soon as practicable after opening of bids. Bid security will be returned to the successful bidder after acceptance of the performance bond, if required; acceptance of insurance coverage, if required; and full execution of contract documents, if required; or conditions as stated in Special Conditions**.**

3.15 **PUBLIC RECORDS/TRADE SECRETS/COPYRIGHT:** The Proposer's response to the RFP is a public record pursuant to Florida law, which is subject to disclosure by the City under the State of Florida Public Records Law, Florida Statutes Chapter 119.07 ("Public Records Law"). The City shall permit public access to all documents, papers, letters or other material submitted in connection with this RFP and the Contract to be executed for this RFP, subject to the provisions of Chapter 119.07 of the Florida Statutes.

Any language contained in the Proposer's response to the RFP purporting to require confidentiality of any portion of the Proposer's response to the RFP, except to the extent that certain information is in the City's opinion a Trade Secret pursuant to Florida law, shall be void. If a Proposer submits any documents or other information to the City which the Proposer claims is Trade Secret information and exempt from Florida Statutes Chapter 119.07 ("Public Records Laws"), the Proposer shall clearly designate that it is a Trade Secret and that it is asserting that the document or information is exempt. The Proposer must specifically identify the exemption being claimed under Florida Statutes 119.07. The City shall be the final arbiter of whether any information contained in the Proposer's response to the RFP constitutes a Trade Secret. The city's determination of whether an exemption applies shall be final, and the proposer agrees to defend, indemnify, and hold harmless the City and the City's officers, employees, and agents, against any loss or damages incurred by any person or entity as a result of the City's treatment of records as public records. In addition, the proposer agrees to defend, indemnify, and hold harmless the City and the City's officers, employees, and agents, against any loss or damages incurred by any person or entity as a result of the City's treatment of records as exempt from disclosure or confidential. Proposals bearing copyright symbols or otherwise purporting to be subject to copyright protection in full or in part may be rejected. The proposer authorizes the City to publish, copy, and reproduce any and all documents submitted to the City bearing copyright symbols or otherwise purporting to be subject to copyright protection.

EXCEPT FOR CLEARLY MARKED PORTIONS THAT ARE BONA FIDE TRADE SECRETS PURSUANT TO FLORIDA LAW, DO NOT MARK YOUR RESPONSE TO THE RFP AS PROPRIETARY OR CONFIDENTIAL. DO NOT MARK YOUR RESPONSE TO THE RFP OR ANY PART THEREOF AS COPYRIGHTED.

3.16 **PROHIBITION OF INTEREST:** No contract will be awarded to a bidding firm who has City elected officials, officers or employees affiliated with it, unless the bidding firm has fully complied with current Florida State Statutes and City Ordinances relating to this issue. Bidders must disclose any such affiliation. Failure to disclose any such affiliation will result in disqualification of the Bidder and removal of the Bidder from the City's bidder lists and prohibition from engaging in any business with the City**.**

3.17 **RESERVATIONS FOR AWARD AND REJECTION OF BIDS:** The City reserves the right to accept or reject any or all bids, part of bids, and to waive minor irregularities or variations to specifications contained in bids, and minor irregularities in the bidding process. The City also reserves the right to award the contract on a split order basis, lump sum basis, individual item basis, or such combination as shall best serve the interest of the City. The City reserves the right to make an award to the responsive and responsible bidder whose product or service meets the terms, conditions, and specifications of the ITB and whose bid is considered to best serve the City's interest. In determining the responsiveness of the offer and the responsibility of the Bidder, the following shall be considered when applicable: the ability, capacity and skill of the Bidder to perform as required; whether the Bidder can perform promptly, or within the time specified, without delay or interference; the character, integrity, reputation, judgment, experience and efficiency of the Bidder; the quality of past performance by the Bidder; the previous and existing compliance by the Bidder with related laws and ordinances; the sufficiency of the Bidder's financial resources; the availability, quality and adaptability of the Bidder's supplies or services to the required use; the ability of the Bidder to provide future maintenance, service or parts; the number and scope of conditions attached to the bid**.**

If the ITB provides for a contract trial period, the City reserves the right, in the event the selected bidder does not perform satisfactorily, to award a trial period to the next ranked bidder or to award a contract to the next ranked bidder, if that bidder has successfully provided services to the City in the past. This procedure to continue until a bidder is selected or the contract is re-bid, at the sole option of the City.

3.18 **LEGAL REQUIREMENTS:** Applicable provisions of all federal, state, county laws, and local ordinances, rules and regulations, shall govern development, submittal and evaluation of all bids received in response hereto and shall govern any and all claims and disputes which may arise between person(s) submitting a bid response hereto and the City by and through its officers, employees and authorized representatives, or any other person, natural or otherwise; and lack of knowledge by any bidder shall not constitute a cognizable defense against the legal effect thereof**.**

3.19 **BID PROTEST PROCEDURE:** Any proposer or bidder who is not recommended for award of a contract and who alleges a failure by the city to follow the city's procurement ordinance or any applicable law may protest to the chief procurement officer, by delivering a letter of protest to the director of finance within five (5) days after a notice of intent to award is posted on the city's web site at the following url: https://www.fortlauderdale.gov/departments/finance/procurement-services/notices-of-intent-to-award

The complete protest ordinance may be found on the city's web site at the following url: https://library.municode.com/fl/fort_lauderdale/codes/code_of_ordinances?nodeid=coor_ch2ad_artvfi_div2pr_s2-182direpr

PART IV BONDS AND INSURANCE

4.01 **PERFORMANCE BOND:** If a performance bond is required in Special Conditions, the Contractor shall within fifteen (15) working days after notification of award, furnish to the City a Performance Bond, payable to the City of Fort Lauderdale, Florida, in the face amount specified in Special Conditions as surety for faithful

performance under the terms and conditions of the contract. If the bond is on an annual coverage basis, renewal for each succeeding year shall be submitted to the City thirty (30) days prior to the termination date of the existing Performance Bond. The Performance Bond must be executed by a surety company of recognized standing, authorized to do business in the State of Florida and having a resident agent.

Acknowledgement and agreement is given by both parties that the amount herein set for the Performance Bond is not intended to be nor shall be deemed to be in the nature of liquidated damages nor is it intended to limit the liability of the Contractor to the City in the event of a material breach of this Agreement by the Contractor**.**

4.02 **INSURANCE:** The Contractor shall assume full responsibility and expense to obtain all necessary insurance as required by City or specified in Special Conditions**.**

The Contractor shall provide to the Procurement Services Division original certificates of coverage and receive notification of approval of those certificates by the City's Risk Manager prior to engaging in any activities under this contract. The Contractor's insurance is subject to the approval of the City's Risk Manager. The certificates must list the City as an ADDITIONAL INSURED for General Liability Insurance and shall have no less than thirty (30) days written notice of cancellation or material change. Further modification of the insurance requirements may be made at the sole discretion of the City's Risk Manager if circumstances change or adequate protection of the City is not presented. Bidder, by submitting the bid, agrees to abide by such modifications**.**

PART V PURCHASE ORDER AND CONTRACT TERMS:

5.01 **COMPLIANCE WITH SPECIFICATIONS, LATE DELIVERIES/PENALTIES:** Items offered may be tested for compliance with bid specifications. Items delivered which do not conform to bid specifications may be rejected and returned at Contractor's expense. Any violation resulting in contract termination for cause or delivery of items not conforming to specifications, or late delivery may also result in:

- Bidder's name being removed from the City's bidder's mailing list for a specified period and Bidder will not be recommended for any award during that period.
- All City Departments being advised to refrain from doing business with the Bidder.
- All other remedies in law or equity.

5.02 **ACCEPTANCE, CONDITION, AND PACKAGING:** The material delivered in response to ITB award shall remain the property of the Seller until a physical inspection is made and the material accepted to the satisfaction of the City. The material must comply fully with the terms of the ITB, be of the required quality, new, and the latest model. All containers shall be suitable for storage and shipment by common carrier, and all prices shall include standard commercial packaging. The City will not accept substitutes of any kind. Any substitutes or material not meeting specifications will be returned at the Bidder's expense. Payment will be made only after City receipt and acceptance of materials or services.

5.03 **SAFETY STANDARDS:** All manufactured items and fabricated assemblies shall comply with applicable requirements of the Occupation Safety and Health Act of 1970 as amended.

5.04 **ASBESTOS STATEMENT:** All material supplied must be 100% asbestos free. Bidder, by virtue of bidding, certifies that if awarded any portion of the ITB the bidder will supply only material or equipment that is 100% asbestos free.

5.05 **OTHER GOVERNMENTAL ENTITIES:** If the Bidder is awarded a contract as a result of this ITB, the bidder may, if the bidder has sufficient capacity or quantities available, provide to other governmental agencies, so requesting, the products or services awarded in accordance with the terms and conditions of the ITB and resulting contract. Prices shall be F.O.B. delivered to the requesting agency.

5.06 **VERBAL INSTRUCTIONS PROCEDURE:** No negotiations, decisions, or actions shall be initiated or executed by the Contractor as a result of any discussions with any City employee. Only those communications which are in writing from an authorized City representative may be considered. Only written communications from Contractors, which are assigned by a person designated as authorized to bind the Contractor, will be recognized by the City as duly authorized expressions on behalf of Contractors.

5.07 **INDEPENDENT CONTRACTOR:** The Contractor is an independent contractor under this Agreement. Personal services provided by the Proposer shall be by employees of the Contractor and subject to supervision by the Contractor, and not as officers, employees, or agents of the City. Personnel policies, tax responsibilities, social security, health insurance, employee benefits, procurement policies unless otherwise stated in this ITB, and other similar administrative procedures applicable to services rendered under this contract shall be those of the Contractor.

5.08 **INDEMNITY/HOLD HARMLESS AGREEMENT:** Contractor shall protect and defend at Contractor's expense, counsel being subject to the City's approval, and indemnify and hold harmless the City and the City's officers, employees, volunteers, and agents from and against any and all losses, penalties, fines, damages, settlements, judgments, claims, costs, charges, expenses, or liabilities, including any award of attorney fees and any award of costs, in connection with or arising directly or indirectly out of any act or omission by the Contractor or by any officer, employee, agent, invitee, subcontractor, or sublicensee of the Contractor. Without limiting the foregoing, any and all such claims, suits, or other actions relating to personal injury, death, damage to property, defects in materials or workmanship, actual or alleged violations of any applicable statute, ordinance, administrative order, rule or regulation, or decree of any court shall be included in the indemnity hereunder.

5.09 **TERMINATION FOR CAUSE:** If, through any cause, the Contractor shall fail to fulfill in a timely and proper manner its obligations under this Agreement, or if the Contractor shall violate any of the provisions of this Agreement, the City may upon written notice to the Contractor terminate the right of the Contractor to proceed under this Agreement, or with such part or parts of the Agreement as to which there has been default, and may hold the Contractor liable for any damages caused to the City by reason of such default and termination. In the event of such termination, any completed services performed by the Contractor under this Agreement shall, at the option of the City, become the City's property and the Contractor shall be entitled to receive equitable compensation for any work completed to the satisfaction of

the City. The Contractor, however, shall not be relieved of liability to the City for damages sustained by the City by reason of any breach of the Agreement by the Contractor, and the City may withhold any payments to the Contractor for the purpose of setoff until such time as the amount of damages due to the City from the Contractor can be determined.

5.10 TERMINATION FOR CONVENIENCE: The City reserves the right, in the City's best interest as determined by the City, to cancel any contract by giving written notice to the Contractor thirty (30) days prior to the effective date of such cancellation.

5.11 CANCELLATION FOR UNAPPROPRIATED FUNDS: The obligation of the City for payment to a Contractor is limited to the availability of funds appropriated in a current fiscal period, and continuation of the contract into a subsequent fiscal period is subject to appropriation of funds, unless otherwise authorized by law.

5.12 RECORDS/AUDIT: The Contractor shall maintain during the term of the contract all books of account, reports and records in accordance with generally accepted accounting practices and standards for records directly related to this contract. The Contractor agrees to make available to the City Auditor or the City Auditor's designee, during normal business hours and in Broward, Miami-Dade or Palm Beach Counties, all books of account, reports, and records relating to this contract. The Contractor shall retain all books of account, reports, and records relating to this contract for the duration of the contract and for three years after the final payment under this Agreement, until all pending audits, investigations or litigation matters relating to the contract are closed, or until expiration of the records retention period prescribed by Florida law or the records retention schedules adopted by the Division of Library and Information Services of the Florida Department of State, whichever is later.

5.13 PERMITS, TAXES, LICENSES: The successful Contractor shall, at his/her/its own expense, obtain all necessary permits, pay all licenses, fees and taxes, required to comply with all local ordinances, state and federal laws, rules and regulations applicable to business to be carried out under this contract.

5.14 LAWS/ORDINANCES: The Contractor shall observe and comply with all Federal, state, local and municipal laws, ordinances rules and regulations that would apply to this contract.

NON-DISCRIMINATION: The Contractor shall not, in any of its activities, including employment, discriminate against any individual on the basis of race, color, national origin, age, religion, creed, sex, disability, sexual orientation, gender, gender identity, gender expression, marital status, or any other protected classification as defined by applicable law.

1. The Contractor certifies and represents that the Contractor will comply with Section 2-187, Code of Ordinances of the City of Fort Lauderdale, Florida, (2019), as may be amended or revised, ("Section 2-187"), during the entire term of this Agreement.
2. The failure of the Contractor to comply with Section 2-187 shall be deemed to be a material breach of this Agreement, entitling the City to pursue any remedy stated below or any remedy provided under applicable law.
3. The City may terminate this Agreement if the Contractor fails to comply with Section 2-187.
4. The City may retain all monies due or to become due until the Contractor complies with Section 2-187.
5. The Contractor may be subject to debarment or suspension proceedings. Such proceedings will be consistent with the procedures in section 2-183 of the Code of Ordinances of the City of Fort Lauderdale, Florida.

5.15 UNUSUAL CIRCUMSTANCES: If during a contract term where costs to the City are to remain firm or adjustments are restricted by a percentage or CPI cap, unusual circumstances that could not have been foreseen by either party of the contract occur, and those circumstances significantly affect the Contractor's cost in providing the required prior items or services, then the Contractor may request adjustments to the costs to the City to reflect the changed circumstances. The circumstances must be beyond the control of the Contractor, and the requested adjustments must be fully documented. The City may, after examination, refuse to accept the adjusted costs if they are not properly documented, increases are considered to be excessive, or decreases are considered to be insufficient. In the event the City does not wish to accept the adjusted costs and the matter cannot be resolved to the satisfaction of the City, the City will reserve the following options:

1. The contract can be canceled by the City upon giving thirty (30) days written notice to the Contractor with no penalty to the City or Contractor. The Contractor shall fill all City requirements submitted to the Contractor until the termination date contained in the notice.

2. The City requires the Contractor to continue to provide the items and services at the firm fixed (non-adjusted) cost until the termination of the contract term then in effect.

3. If the City, in its interest and in its sole opinion, determines that the Contractor in a capricious manner attempted to use this section of the contract to relieve Contractor of a legitimate obligation under the contract, and no unusual circumstances had occurred, the City reserves the right to take any and all action under law or equity. Such action shall include, but not be limited to, declaring the Contractor in default and disqualifying Contractor from receiving any business from the City for a stated period of time.

If the City does agree to adjusted costs, these adjusted costs shall not be invoiced to the City until the Contractor receives notice in writing signed by a person authorized to bind the City in such matters.

5.16 ELIGIBILITY: If applicable, the Contractor must first register with the Florida Department of State in accordance with Florida Statutes, prior to entering into a contract with the City.

5.17 PATENTS AND ROYALTIES: The Contractor, without exception, shall defend, indemnify, and hold harmless the City and the City's employees, officers, employees, volunteers, and agents from and against liability of any nature and kind, including cost and expenses for or on account of any copyrighted, patented or un-patented invention, process, or article manufactured or used in the performance of the contract, including their use by the City. If the Contractor uses any design, device, or materials covered by letters, patent or copyright, it is mutually agreed and understood without exception that the bid prices shall include any and all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

5.18 **ASSIGNMENT:** Contractor shall not transfer or assign the performance required by this ITB without the prior written consent of the City. Any award issued pursuant to this ITB, and the monies, which may become due hereunder, are not assignable except with the prior written approval of the City Commission or the City Manager or City Manager's designee, depending on original award approval.

5.19 **GOVERNING LAW; VENUE:** The Contract shall be governed by and construed in accordance with the laws of the State of Florida. Venue for any lawsuit by either party against the other party or otherwise arising out of the Contract, and for any other legal proceeding, shall be in the courts in and for Broward County, Florida, or in the event of federal jurisdiction, in the Southern District of Florida.

5.20 **PUBLIC RECORDS:**

IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT PRRCONTRACT@FORTLAUDERDALE.GOV, 954-828-5002, CITY CLERK'S OFFICE, 100 N. ANDREWS AVENUE, FORT LAUDERDALE, FLORIDA 33301.

Contractor shall comply with public records laws, and Contractor shall:

1. Keep and maintain public records required by the City to perform the service.

2. Upon request from the City's custodian of public records, provide the City with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes (2019), as may be amended or revised, or as otherwise provided by law.

3. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the contract term and following completion of the contract if the Contractor does not transfer the records to the City.

4. Upon completion of the Contract, transfer, at no cost, to the City all public records in possession of the Contractor or keep and maintain public records required by the City to perform the service. If the Contractor transfers all public records to the City upon completion of the Contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of the Contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the City, upon request from the City's custodian of public records, in a format that is compatible with the information technology systems of the City.

E-VERIFY AFFIRMATION STATEMENT

RFP/Bid /Contract No:

Project Description:

Contractor/Proposer/Bidder acknowledges and agrees to utilize the U.S. Department of Homeland Security's E-Verify System to verify the employment eligibility of,

(a) all persons employed by Contractor/Proposer/Bidder to perform employment duties within Florida during the term of the Contract, and,

(b) all persons (including subcontractors/vendors) assigned by Contractor/Proposer/Bidder to perform work pursuant to the Contract.

The Contractor/Proposer/Bidder acknowledges and agrees that use of the U.S. Department of Homeland Security's E-Verify System during the term of the Contract is a condition of the Contract.

Contractor/Proposer/ Bidder Company Name:

Authorized Company Person's Signature:

Authorized Company Person's Title:

Date:

9/15/2020

Question and Answers for Bid #12702-525 - Group DHMO and DPPO Dental Plan Benefits

Overall Bid Questions

Question 1

Section VIII - Network Information states: the City has provided two excel files DHMO providers with members assigned and DPPO providers utilized by City members and that Vendors are to indicate which of these providers participate in the DHMO & DPPO plans. We do not see these files attached please provide or confirm which files are to be used for this request **(Submitted: Jun 6, 2022 11:58:43 AM EDT)**

Answer

- Exhibit 15 - Current Dental Providers Utilization DHMO DPPO has been added. In the Excel document, one tab is for DHMO providers and the other tab is for DPPO providers. **(Answered: Jun 6, 2022 1:28:55 PM EDT)**

Question 2

Will the City considered alternate Low option plans in place of a DHMO? **(Submitted: Jun 8, 2022 6:59:28 PM EDT)**

Answer

- No. The option of a DHMO plan is a necessity for the city's employees and retirees. **(Answered: Jun 9, 2022 8:47:25 AM EDT)**

Question 3

Does the City still use the Choicelinx benefit enrollment system or just Selerix? **(Submitted: Jun 9, 2022 10:53:39 AM EDT)**

Answer

- The City only utilizes Selerix as the online benefits system. **(Answered: Jun 9, 2022 3:55:55 PM EDT)**

Question 4

What is the 2016 turnover percentage for your DHMO network of general dentists? **(Submitted: Jun 9, 2022 10:53:57 AM EDT)**

Answer

- Less than 10%. **(Answered: Jun 10, 2022 9:45:04 AM EDT)**

Question 5

2.35 Service Organization Controls â‘ Page 11: The RFP requests a current SSAE 19, SOC 2, Type I or SOC 3 report. We are unable to release the requested report without a signed NDA. Would the group be willing to sign a NDA agreement? **(Submitted: Jun 10, 2022 11:01:58 AM EDT)**

Answer

- Please see section 5.1.5 regarding Proposer's responses becoming public record due to Florida Law. A non-disclosure agreement would not be within the City Staff's authority to execute. The City of Fort Lauderdale will not agree to anything that would contravene Florida law. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 6

2.36 Business Associate Agreement - Page 11: The RFP references Exhibit 14 as the City's BAA however the Exhibit provided is the 2022 Benefits Handbook. Please provide the referenced BAA. **(Submitted: Jun 10, 2022 11:11:31 AM EDT)**

Answer

- Exhibit 16 - Business Associate Agreement Sample has been added through an Addendum. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 7

5.2 Contents of the Proposal- Page 18: Please confirm if the proposal is limited to 100 pages? If so, does the 100 page limit apply to requested samples, brochures, Accessibility Reports and disruption results? If it does not, is there a maximum number of pages the City is willing to accept? **(Submitted: Jun 10, 2022 11:12:23 AM EDT)**

Answer

- As per Section 5.2, the City would prefer that the proposal be no more than 100 pages, however; a proposal will not be disqualified for being over that amount when adding in samples, brochures, etc. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 8

5.2 Contents of the Proposal – Page 18: May we provide additional information section after the required section for additional information we feel is pertinent to the case? **(Submitted: Jun 10, 2022 11:12:43 AM EDT)**

Answer

- Yes, provided that the information is necessary, concise and specifically addresses the issues of this RFP. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 9

5.2.1 Table of Contents – page 19: Please confirm that the page number requirement is that each document have a page number. **(Submitted: Jun 10, 2022 11:13:01 AM EDT)**

Answer

- As per Section 5.2, we ask that the proposals be organized, divided and indexed into sections that are indicated in Section 5.2.1. Page number would be helpful with the organization of the response and for referencing materials. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 10

5.2.4 Approach to Scope of Work â‘ Page 19: The last paragraph states that â€œAdditionally, the proposal should specifically address the following items.â However no specific items are noted that we need to address. Please confirm the reference is to items then outlined in 5.2.5 to 5.2.20 or is there something additional the City is looking for? **(Submitted: Jun 10, 2022 11:13:17 AM EDT)**

Answer

- "The following items" referenced in Section 5.2.4 are referring to the items that are listed in 5.2.5 to 5.2.21. Each item should be presented in the requested order, separated by tabs and listed in a table of contents. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 11

5.2.8 National DHMO and DPPO Networks/Geo Access Reports – Page 20: Please provide the GeoAccess criteria you would like us to use for the reports. **(Submitted: Jun 10, 2022 11:13:36 AM EDT)**

Answer

- Please reference Section 5.2.8. The Geo Access report should be based on the census provided that includes zip codes. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 12

Section VIII – Network Information – Page 25: It references flash drives, please confirm that the proposal is to be submitted electronic only. **(Submitted: Jun 10, 2022 11:17:25 AM EDT)**

Answer

- Confirmed. The sentence has been removed through an addendum. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 13

Section VIII – Network Information – Page 25: It asks that we complete the requested disruption reports as Excel however the RFP requests that we provide our responses back as one PDF Proposal. Please confirm that we should only be providing our results in PDF format. **(Submitted: Jun 10, 2022 11:17:42 AM EDT)**

Answer

- Confirmed. The sentence has been removed through an addendum. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 14

Questionnaire Sheet – There is a section on the requested form that asks for information about a “qualifying agent” however it appears that this is specific to a physical product/inspection. Please confirm that this section as well as questions 1, 3, 4, and 5 are not applicable, or please provide additional clarification on the intention of these questions. **(Submitted: Jun 10, 2022 11:18:02 AM EDT)**

Answer

- Agent, within the Dental RFP, refers to either the Gehring Group or a City employee. The only section that would apply to a third-party would be within the "Security Breach Section". Questions 1, 3, 4 and 5 regarding property and equipment do not apply. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 15

Please confirm that an individual with binding authority can sign the required documents. **(Submitted: Jun 10, 2022 11:18:23 AM EDT)**

Answer

- Confirmed. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 16

The firefighters benefit summary from 2018 shows the OON allowance is MAC (maximum allowable charge), but the cert dated 2022 shows OON is 80th. So my questions are:
a. Was there a plan change from MAC to 80th out of network on the firefighters plan, and if so, when did this change occur?
b. Have there been any plan changes to the âœnon-firefighter active & retireeâ plans, and if so, what were the changes and when did the changes occur? **(Submitted: Jun 10, 2022 11:18:41 AM EDT)**

Answer

- Exhibit 17 - Benefit Summary DPPOF CoFL has been added. The DPPO for Firefighters was 80 - 20 in 2018. There have been no other changes to either the firefighter plan or non-firefighter plans. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 17

Please confirm that Fire/Rescue are only offered the PPO plan. The census is showing 25 Fire/Rescue EE's enrolled in the DMO and a note in the RFP states that Fire/Rescue are only offered the PPO plan. **(Submitted: Jun 10, 2022 11:19:00 AM EDT)**

Answer

- Confirmed. The job class for those 25 employees has changed and they are no longer in the Fire-Rescue department in the City. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 18

Please confirm whether or not Police are supposed to be part of the eligible group as there is PPO and DMO enrollment included in the census for Police. There was a note in the RFP stating that Police are excluded. **(Submitted: Jun 10, 2022 11:19:13 AM EDT)**

Answer

- Within Police, there are teamsters, management, supervisors and professionals that are not actual officers. These positions are covered underneath the City's dental plan (i.e. teletype operator, records clerks) **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 19

Please provide monthly claims/lives/premium experience, by plan, for the last 36 months. **(Submitted: Jun 10, 2022 11:19:27 AM EDT)**

Answer

- The City does not have this information, but has requested it from the current provider. The answer will be updated once the information is received. **(Answered: Jun 14, 2022 7:51:49 AM EDT)**

Question 20

Are the PPO rates for the "non-firefighter TX" and "all other non-firefighter" plans the same? (The TX plan is the passive PPO plan). **(Submitted: Jun 10, 2022 11:19:43 AM EDT)**

Answer

- Yes. **(Answered: Jun 13, 2022 8:19:33 AM EDT)**

Question 21

• Please provide a 36 month rate history for all dental plans (we only received 2021 & 2022 rates)
• If the dental renewal is available, please provide
• If there have been any dental plan changes in the past 24 months, please advise
• Exhibit 1 – DPPO Experience report is basically a provider report. Please provide the dental PPO claim experience for the past 36 months to include by month, the claims paid, premium and enrollment separated by plan(s) and utilization (par vs non-par). Please separate the PPO experience by Firefighters and all other eligible employees.
• Please provide a PPO member report including a count of each subscriber and all dependent members (spouse and all children) by month for the most recent 12 months

• Please provide an electronic claims file (Excel) for the past 12 months including date of service (incurred period if DOS not available), procedure code (CDT Compliant codes), provider information, provider location (TIN/SSN, address, zip), network status (par vs non-par), submitted charge, allowed charge, paid amount and denied claim amount for each individual service per claim line. **(Submitted: Jun 10, 2022 3:38:38 PM EDT)**

Answer

- Q21 Answer 1: Please refer to Exhibit 18.
Q21 Answer 2: Not available.
Q21 Answer 3: No changes.
Q21 Answer 4: Please refer to Exhibits 19, 20 and 21.
Q21 Answer 5: Please refer to Exhibits 3 and 15.
Q21 Answer 6: The City does not have this information, but has requested it from the current provider. The answer will be updated once the information is received. **(Answered: Jun 14, 2022 7:51:49 AM EDT)**

Question 22

Will an inability to accept a P-Card for premium payment disqualify us from this opportunity? **(Submitted: Jun 10, 2022 4:39:52 PM EDT)**

Answer

- Payments on this contract will be made utilizing the City's P-Card (MasterCard or Visa). Proposer's must presently have the ability to accept these credit cards or take whatever steps necessary to implement acceptance of a card before the start of the contract term, or contract award by the City. **(Answered: Jun 13, 2022 9:13:41 AM EDT)**

Question 23

This is an e-submission but the procedure comparison is asked for in a thumb drive...is this correct? If so where do we mail it? **(Submitted: Jun 10, 2022 4:40:15 PM EDT)**

Answer

- Please disregard. Sentences regarding submission of a physical thumb drive and/or CD have been removed through an addendum. **(Answered: Jun 13, 2022 9:13:41 AM EDT)**

Question 24

Must both HMO and PPO networks be available nationally? **(Submitted: Jun 10, 2022 4:40:34 PM EDT)**

Answer

- Yes. Both plans currently have national networks and want to keep that benefit with any new provider. **(Answered: Jun 14, 2022 7:51:49 AM EDT)**

Question 25

Where to include proposer's identification & warranty pages? **(Submitted: Jun 10, 2022 4:40:55 PM EDT)**

Answer

- This information can be included in-between your References and Proposing Company History (Section 5.2.15 - 5.2.16). **(Answered: Jun 14, 2022 7:51:49 AM EDT)**

Question 26

5.2.8 National DHMO and DPPO Networks/Geo Access Reports – Page 20: Please provide the access parameters you would like us to use for the reports. For example: 2 General Dentists in 10 miles and 1 Dental

Specialist in 15 miles **(Submitted: Jun 13, 2022 11:34:11 AM EDT)**

Answer

- For retirees with zip codes outside Florida, use the criteria five (5) miles for the geo-access report. For all other active participants, we would prefer a minimum of two (2) providers withing five (5) miles for the geo-access report. **(Answered: Jun 14, 2022 7:51:49 AM EDT)**

Question 27

For this question: What is the 2016 turnover percentage for your DHMO network of general dentists?

Can Vendors respond with 2021 stats? **(Submitted: Jun 13, 2022 11:52:26 AM EDT)**

Answer

- Yes, please use 2021 stats. **(Answered: Jun 14, 2022 7:51:49 AM EDT)**

Question 28

Section 2.9 Payment Method on page 4 of the RFP: Would the City allow ETF/bank transfer for payment of premium, or is a Procurement Card the only option for the City to pay vendor bills? **(Submitted: Jun 13, 2022 12:12:26 PM EDT)**

Answer

- As per the RFP, the P-Card is our method of payment. Vendors should have the ability to accept the P-Card or the ability to implement access so that the P-card can be accepted before the commencement of the contract. **(Answered: Jun 14, 2022 7:51:49 AM EDT)**