

State of Tennessee

CIGNA DENTAL CARE INSURANCE
PPDN Plan

EFFECTIVE DATE: March 1, 2021

CN008
3339070

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

Printed in U.S.A.

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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: State of Tennessee

GROUP POLICY(S) — COVERAGE

3339070 - PPDN/PPRN CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: March 1, 2021

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.



Anna Krishtul, Corporate Secretary

Explanation of Terms

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

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>.

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 연락해주시십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시십시오.

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 deyè 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 ناشنوايان: شماره 711 را شماره‌گیری کنید).

Eligibility - Effective Date

Employee/Retiree Insurance

This plan is offered to you as an Employee or Retiree.

Eligibility for Employee/Retiree Insurance

You will become eligible for insurance on the day you complete any applicable waiting period if the following applies to you:

State

Employee

1. Any person employed by the employer who is regularly scheduled to work not less than thirty (30) hours per week;
2. Any person hired prior to July 1, 2015 who has received a seasonal appointment and who meets the requirements set forth in TCA 8-27-204 (a) (3); or
3. All other persons deemed eligible by applicable federal law, state law, or action of the State Insurance Committee.

Retiree – A person who:

- a. has left active employment and
- b. receives a benefit from the Tennessee Consolidated Retirement System (TCRS) or is a member of one of the Higher Education Optional Retirement Plan(s) (ORP); or

LOCAL EDUCATION

Employee

1. Is a teacher as defined in Tennessee Code Annotated, Section 8-34-101-(46);
2. An interim teacher whose salary is based on the local school system's schedule;
3. Employees not defined above who are regularly scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position;
4. A non-certified Employee who has completed 12 months of employment with a local education agency that participates in the plan and works a minimum of 25 hours per week [a resolution passed by the school system's governing body authorizing the expanded 25 hour rule for the local education agency must be sent to Benefits Administration before enrollment]; or
5. All other persons deemed eligible by applicable federal law, state law, or action of the Local Education Insurance Committee.

Retiree – A person who:

- a. has retired from the employer and
- b. receives a benefit from the Tennessee Consolidated Retirement System (TCRS).

Local Government

Employee

1. Any person employed by the employer, who is regularly scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position;
2. A member of the chief legislative body of the county or municipal government (defined as only those elected officials who have the authority to pass local legislation);
3. Utility board members appointed or elected pursuant to TCA 7-82-307, but only during their term of service;
4. County officials as defined in TCA 8-34-101, regardless of whether the county participates in the plan, pursuant to TCA 8-27-704(a); or
5. All other persons deemed eligible by applicable federal law, state law, or action of the Local Government Insurance Committee.

Retiree – A person who:

- a. has retired from the employer; and
- b. receives a benefit from the Tennessee Consolidated Retirement System (TCRS).

If you were previously insured and your insurance ceased, you must satisfy the appropriate Waiting Period shown below to become insured again.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

Your Dependents will become eligible for Dependent insurance on the later of:

- the date that you become eligible for coverage as an employee; or
- the date that the dependents become your eligible dependents.

Special Enrollment Provisions

An Employee experiencing one of the events below may enroll in Employee only or family coverage. Previously eligible Dependents (those who were not enrolled when initially eligible and are otherwise still eligible) may also be enrolled.

- A new Dependent spouse is acquired through marriage.
- A new Dependent newborn is acquired through birth.
- A new Dependent is acquired through adoption or legal custody.

The above events are only subject to special enrollment if the Employee wants to use the event to enroll or add other

previously eligible Dependents at the same time as the new Dependent. If the Employee already has coverage and only wants to add a newly acquired Dependent, this is treated as a regular enrollment change.

Options for coverage start dates due to the events above are:

- Day on which the event occurred if enrollment is due to birth, adoption or placement for adoption.
- Day on which the event occurred or the first day of the next month if enrollment is due to marriage.

Other events allow enrollment if the event results in a loss of dental coverage under another group plan:

- Death of a spouse or ex-spouse.
- Divorce.
- Legal separation.
- Loss of eligibility (does not include loss due to failure to pay premiums or termination of coverage for cause).
- Termination of spouse's or ex-spouse's employment.
- Employer ends total premium support to the spouse's, ex-spouse's or Dependent's insurance coverage (not partial)
- Spouse's or ex-spouse's work hours reduced
- Spouse maintaining coverage where lifetime maximum has been met
- Loss of TennCare (does not include loss due to non-payment of premiums)

Participation Requirements:

An agency must be participating in the State of Tennessee Sponsored Group Health Plan in order to offer the State of Tennessee Voluntary Prepaid Dental Program to eligible persons. A person does not have to participate in the State Group Health Plan to qualify for the State Dental Program, but an Employee or Retiree must enroll in the Dental Program in order to enroll eligible dependents in the Dental Program. Participation by those enrolled in the Prepaid Dental Program is on a calendar year basis, and enrollment may only be dropped by the members during the Annual Enrollment Period for the beginning of the next calendar year or due to a special enrollment provision event. We will also allow dropping of prepaid if there is no participating general dentist within a 25-mile radius of your home address.

Transfer from Prior Contract

Members enrolled under the prior contract with the State as of December 31, 2020 shall be automatically enrolled under the new contract with the State, if premium payments are current and the member did not make a change during the State's annual enrollment period, effective January 1, 2021, with no break in coverage. Benefit frequencies and other limitations under this contract shall not incorporate member's experience



under the prior contract, except for orthodontic treatment in process the vendor may choose to continue.

Election of Insurance

You elect insurance for yourself and your eligible Dependents, by completing electronic enrollment or by signing an approved payroll deduction or enrollment form, as applicable, within 30 days after you become eligible, but no earlier than the date you become eligible to request coverage. Once enrolled, you may elect insurance for a new Dependent within 60 calendar days following the date the Dependent is acquired (for example, the date of marriage or date of birth). If you are requesting enrollment for yourself or an eligible Dependent as a Late Entrant, you may only elect the insurance during an Annual Enrollment Period, unless you have a special enrollment provision event.

Waiting Period

Initial Employee Group: None.

New Employee Group:

State - New hire enrollment coverage shall become effective on the first day of the month following one full calendar month of employment. Open enrollment coverage shall become effective on the following January 1 or on another date specified by the State.

Local Education – New hire coverage shall become effective on the first day of the month after the Employee’s eligibility date. Open enrollment coverage shall become effective on the following January 1 or on another date specified by the State.

Local Government - New hire coverage shall become effective on the first day of the month following date of hire or the first day of the month following the end of the Employee’s probationary period (if the employing agency applies a probationary period to insurance coverage). Open enrollment coverage shall become effective on the following January 1 or on another date specified by the State.

Dependent - The effective date will be the same as the Employee’s effective date unless the dependent is enrolled subsequent to the employee’s enrollment. The effective date for dependents enrolled subsequent to the employee will be the first of a month determined by the State, except for certain qualifying events for which the coverage will be effective on the event date, such as birth.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

Your insurance will become effective on the first day of the month following satisfaction of all eligibility requirements, including any applicable waiting period, and completion of

insurance 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.

Annual Enrollment Period

Annual Enrollment Period means a period in each calendar year as designated by the Policyholder.

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 following satisfaction of all eligibility requirements, including any applicable waiting period, and completion of insurance election. Your dependents can only be insured if you are insured. The effective date of coverage for any eligible dependent shall be the later of the effective date of your coverage as an employee or the date that the dependent becomes your eligible dependent.

Choice of Dental Office

When you elect Employee Insurance, you may select a Dental Office from the list provided by Cigna Dental Health. If your choice of a Dental Office is not available or if you do not choose a Dental Office, you will receive a letter with further instructions. You and each of your insured Dependents may select your own designated Dental Office. A transfer from one Dental Office to another Dental Office may be requested by you through CDH (see Office Transfers provision below). 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. Other than Emergency Dental Treatment no Dental Benefits are covered unless the Dental Service is received from your designated Dental Office, you are referred by a Network General Dentist at your designated Dental Office to a specialist approved by CDH, or services are otherwise authorized by CDH.

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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 1-800-997-1617. 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 1-800-997-1617 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 Cigna.com/sites/stateoftn, or call the Dental Office Locator at 1-800-997-1617, 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 coverage is available 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.
- prior to the effective date of coverage;
- after the covered person's coverage under this plan is terminated.

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 orthodontic treatment, 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 1-800-997-1617. To obtain a list of Dental Offices near you, visit our website at myCigna.com or Cigna.com/sites/stateoftn, or call the Dental Office Locator at 1-800-997-1617.

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 our website at myCigna.com or Cigna.com/sites/stateoftn, or by calling us at 1-800-997-1617.

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

An appropriate referral is required by your Network General Dentist to a network specialty endodontist, periodontist, or oral surgeon. A referral is not required for specialty care at a network specialty pediatric Dentist or orthodontist. Pre-authorization 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. If a pre-determination of treatment has been approved by Cigna Dental, such 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 treatment plan, 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.

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 1-800-997-1617 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.

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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.

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Expenses for Which a Third Party May Be Responsible

Cigna shall, to the extent permitted by Tennessee 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 (made whole). 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

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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: 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.

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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

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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 of the month for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- Local Education and Local Government - the end of the following month after termination/retirement except as described below.
- State - the end of the month of separation of employment except as described below.
- the date you relocate to an area where the Dental plan is not offered.
- the date, as determined by Cigna, of a continuing lack of a participating Dental Office within a 25-mile radius of your home address.
- the date upon a determination of fraud or misuse of dental services and/or dental facilities.

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

Temporary Layoff or Leave of Absence

An employee on an approved leave of absence that is not covered under the Family and Medical Leave Act of 1993 (as amended) may continue coverage as described in this subsection. An employee on an approved leave of absence may continue coverage under the plan for two continuous years provided he/she pays the full monthly premium (both the employer and employee portions) during such leave of absence. Employees who return to work after a two-year leave of absence must be in a positive pay status for one full calendar month before they may be eligible for a subsequent leave of absence to continue coverage. If an employee does not return to active work status and has completed a two-year leave of absence, coverage will be discontinued and COBRA continuation coverage will not be offered.

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 the insurance.

Retirement

If your Active Service ends because you retire, and you are eligible to continue coverage as a retiree, you may choose to

continue your insurance subject to application and payment of the required monthly premiums. COBRA (see “COBRA Continuation Rights Under Federal Law” later in this document) will be offered as an option to continue coverage prior to enrolling as a retiree to continue coverage or if you are not eligible to continue insurance as a retiree.

Dependents

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

- the date your insurance ceases, except when you die.
- 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.

Dependent Dental Insurance After Your Death

Upon the employee or retiree’s death, surviving dependents covered under this plan on the date of an employee or retiree’s death may continue their enrollment in this dental plan with one of the two options listed below.

- Deceased employee or retiree was eligible for continuation of coverage as a retiree at time of death = dependents may elect COBRA or RETIREE continuation of dental elections in effect for them on the date of employee or retiree’s death; or
- Deceased employee or retiree was not eligible for continuation of coverage as a retiree at time of death = dependents may elect COBRA continuation for dental elections in effect for them on the date of employee or retiree’s death.

Survivor in Current Plan

Upon the employee or retiree’s death, surviving dependents covered under this dental plan on the date of an employee or retiree’s death may continue their enrollment in this dental plan with one of the two options listed below.

- Deceased employee or retiree was eligible for continuation of coverage as a retiree at time of death - dependents may elect COBRA or RETIREE continuation of dental elections in effect for them on the date of employee or retiree’s death; or
- Deceased employee or retiree was not eligible for continuation of coverage as a retiree at time of death - dependents may elect COBRA continuation for dental elections in effect for them on the date of employee or retiree’s death.

Survivor with a New Agency Joining the Plan

Upon a new agency joining the State Group Insurance Plan (SGIP), surviving dependents of deceased employees or retirees may enroll in this dental plan if the following criteria is satisfied.

- The new agency opts to offer the SGIP dental plan to its employees; and
- Surviving dependents were enrolled in COBRA or the new agency’s regular dental plan in the month prior to the new agency joining the SGIP; and
- The deceased employee or retiree was eligible to receive a pension from the Tennessee Consolidated Retirement System (TCRS) (note: this does not apply to COBRA participants).

HC-TRM184

09-20

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 Cigna.com/sites/stateoftn 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. 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.

F. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

G. Enrollment in a Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED95

04-17

Eligibility for Coverage for Adopted Children

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

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

HC-FED67V1

09-14

Group Plan Coverage Instead of Medicaid

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

HC-FED13

10-10

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

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

HC-FED93

10-17

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

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

Continuation of Coverage

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

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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

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

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

Any Employee or Dependent whose Dental Insurance ceases for a reason other than failure to pay any required contribution or cancellation of the policy may be eligible for coverage under another 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.

Conversion is not available if your insurance ceased due to:

- nonpayment of required premiums;
- selection of alternate dental insurance by your group;
- fraud or misuse of the Dental Plan.

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 Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you 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

Non-Federal Governmental Fully Insured and Self-Funded Plans (including State of Tennessee employee, higher education, local education, and local government plans):

State Division of Benefits Administration at 1-866-576-0029.

U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1-888-393-2789.

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 Coverage for Treatment in progress

Any dental procedure, including those listed on the Patient Charge Schedule, that has been started (and not yet completed) by a Dentist prior to your coverage by Cigna Dental Care is/are not covered.

HC-DFS1419 12-19

Dental Coverage with Pre-existing medical and/or Dental Conditions

Pre-existing medical and or dental conditions or diagnoses that you have or have had prior to your coverage by Cigna Dental Care will not limit the coverage of procedures listed in your Patient Charge Schedule, unless specifically outlined in your plan booklet.

HC-DFS1420 12-19

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:

- a legally married spouse of an eligible Employee or retiree of a State of Tennessee agency, Local Education

participating agency, or Local Government participating agency; and

- any child of yours who is:
 - less than 26 years old.
 - 26 or more years old, and primarily supported by you and incapable of self-sustaining employment by reason of intellectual 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. After a two-year period following the child's attainment of the limiting age, then 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 or a child for whom you are the legal guardian.

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

Anyone who is eligible as an Employee will not be considered as a Dependent. No one may be considered as a Dependent of more than one Employee.

HC-DFS1518 09-20

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