Millennium Health, LLC

CIGNA DENTAL CHOICE
For Texas Residents
Basic Plan

EFFECTIVE DATE: January 1, 2023

CN064
3339798

This document printed in January, 2023 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Certification **4**

Important Notices **6**

How To File Your Claim **8**

Eligibility - Effective Date **8**

Employee Insurance 8

Waiting Period 8

Dependent Insurance 9

Important Information about Your Dental Plan **9**

Cigna Dental Choice **10**

The Schedule 10

Covered Dental Expense 11

Cigna Dental Choice 11

Expenses Not Covered 13

General Limitations **14**

Dental Benefits 14

Coordination Of This Contract's Benefits With Other Benefits **14**

Expenses For Which A Third Party May Be Responsible **18**

Payment of Benefits **19**

Termination of Insurance **20**

Employees 20

Dependents 20

Dental Benefits Extension **20**

Notice of an Appeal or a Grievance **20**

When You Have A Complaint Or An Adverse Determination Appeal **20**

Definitions **23**

Federal Requirements **25**

Qualified Medical Child Support Order (QMCSO) 25

Effect of Section 125 Tax Regulations on This Plan 25

Eligibility for Coverage for Adopted Children 26

Group Plan Coverage Instead of Medicaid 26

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA) 27

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) 27

Claim Determination Procedures under ERISA 27

COBRA Continuation Rights Under Federal Law 28

ERISA Required Information 31

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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

POLICYHOLDER: Millennium Health, LLC

GROUP POLICY(S) — COVERAGE
3339798 - DENT1 CIGNA DENTAL CHOICE

EFFECTIVE DATE: January 1, 2023

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.

Geneva Cambell Brown, Corporate Secretary

Explanation of Terms

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

The Schedule

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

Important Notices

Discrimination is Against the Law

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

Cigna:

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

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

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

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

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

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

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

HC-NOT96 07-17

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HC-NOT97 07-17

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Cigna Health and Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: National Appeal Unit at 1-855-363-5836

Toll-free: 1-800-244-6224

Email: DenisonAppealTeam@cigna.com

Mail: P.O. Box 188044

Chattanooga. TN 37422

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Cigna Health and Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o

HMO:

Llame a: National Appeal Unit al 1-855-363-5836

Teléfono gratuito: 1-800-244-6224

Correo electrónico: DenisonAppealTeam@cigna.com

Dirección postal: P.O. Box 188044

Chattanooga. TN 37422

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: ww.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

HC-IMP195 05-21
V2

How To File Your Claim

Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

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

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

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

TIMELY FILING

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

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

HC-CLM24 04-10
V1

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

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

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

Eligibility for Dependent Insurance

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

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

Waiting Period

The first day of the month following date of hire.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

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

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

Late Entrant - Employee

You are a Late Entrant if:

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

Dependent Insurance

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

Effective Date of Dependent Insurance

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

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

HC-ELG1 04-10
V6 M

Late Entrant Limit

Coverage for late entrants:

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

HC-LEL1 04-10
V3

Important Information about Your Dental Plan

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

- **Cigna Dental Care; or**
- **Cigna Dental Choice**

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

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

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

Change in Option Elected

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

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

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

Effective Date of Change

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

HC-IMP2 04-10
HC-IMP74 V1

Cigna Dental Choice

The Schedule

For You and Your Dependents

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

Deductibles

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

BENEFIT HIGHLIGHTS	
Classes I, II, III, IX Calendar Year Maximum	$1,000
Class IV Lifetime Maximum	$1,000
Calendar Year Deductible	
Individual	$50 per person Not Applicable to Class I
Family Maximum	$150 per family Not Applicable to Class I

BENEFIT HIGHLIGHTS	
Class I	
Preventive Care	100%
Class II	
Basic Restorative	80% after plan deductible
Class III	
Major Restorative	50% after plan deductible
Class IV	
Orthodontia	50%
Class IX	
Implants	50% after plan deductible

Missing Teeth Limitation

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

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

HC-MTL7 04-10
V1

Covered Dental Expense

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

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

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

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

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

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

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

Covered Services

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

HC-DEN1 04-10
V1

Texas Statutory Provision

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

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

HC-DEN310 08-20

Cigna Dental Choice

Plan payment for a covered service delivered by a Cigna DPPO Advantage Contracted Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the balance of the Contracted Fee.

Plan payment for a covered service delivered by a Cigna DPPO Contracted Provider is the lesser of the Contracted Fee or the Maximum Allowable Charge. The Maximum Allowable Charge is the fee for that procedure as listed on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, times the benefit

percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the Cigna DPPO Contracted Provider Contracted Fee minus what the plan pays.

Plan payment for a covered service delivered by a non-Contracted Provider is the lesser of the non-Participating Provider's actual charge or the Maximum Allowable Charge. The Maximum Allowable Charge is the fee for that procedure as listed on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, times the benefit percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the non-Contracted Provider's actual charge minus what the plan pays.

HC-DEN288 01-21

Class I Services – Diagnostic and Preventive

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

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

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

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

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

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

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN3 04-10
V5

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

Amalgam Filling

Composite/Resin Filling

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

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

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

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

Recement Bridge

Routine Extractions

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

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

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

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

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

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

HC-DEN163 04-10
V1

Class III Services - Major Restorations, Dentures and Bridgework

Crowns

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

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

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

HC-DEN172 07-14
V1

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

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

Continued active treatment after the first month.

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

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

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

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment.

Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

HC-DEN6 04-10
V3

Class IX Services – Implants

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

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

HC-DEN8 04-10
V1

Expenses Not Covered

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

- services performed solely for cosmetic reasons, except for the treatment of congenital defects in a newborn child.
- replacement of a lost or stolen appliance.
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion.
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
- bite registrations; precision or semiprecision attachments; or splinting.
- instruction for plaque control, oral hygiene and diet.

- dental services that do not meet common dental standards.
- services that are deemed to be medical services.
- services and supplies received from a hospital.
- services for which benefits are not payable according to the "General Limitations" section.

HC-DEX96 10-19
V1

General Limitations

Dental Benefits

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

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

HC-DEX1 04-10
V3

Coordination Of This Contract's Benefits With Other Benefits

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

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

Definitions

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

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

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with

activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

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

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

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

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

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

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

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

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

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

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

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

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the

absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order Of Benefit Determination Rules

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

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

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the

Dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

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

(I) the plan covering the custodial parent;

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

(III) the plan covering the noncustodial parent; then

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

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

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

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

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

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

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

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect On The Benefits Of This Plan

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

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

Compliance With Federal And State Laws Concerning Confidential Information

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

Facility Of Payment

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

Right Of Recovery

If the amount of the payments made by Cigna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

HC-COB121 09-14
V1

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

Right Of Reimbursement

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

Lien Of The Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called “Made-Whole Doctrine”, “Rimes Doctrine”, or any other such doctrine purporting to defeat the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof

including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

HC-SUB2 04-10
V1

Payment of Benefits

To Whom Payable

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

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

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

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

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment to the Dentist who provided the service.

HC-POB160 10-19

Miscellaneous

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

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

For members with diabetes, cerebrovascular or cardiovascular disease:

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

For members who are pregnant:

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

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

- topical application of fluoride
- topical fluoride varnish
- application of sealant

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

Please refer to the plan enrollment materials for further details.

HC-POB8 04-10
V1

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

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

Temporary Layoff or Leave of Absence

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

Injury or Sickness

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

Dependents

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

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

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

HC-TRM3 04-10
V1

Dental Benefits Extension

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

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

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

HC-BEX3 04-10
V1

Notice of an Appeal or a Grievance

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

HC-SPP4 04-10
V1

The Following Will Apply To Residents Of Texas

When You Have A Complaint Or An Adverse Determination Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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

When You Have a Complaint

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

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

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

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

Complaint Appeals Procedure

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

Your complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. You may present your situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received your request within five working days after the date we receive your request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

When You have an Adverse Determination Appeal

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

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

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

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

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

Retrospective Review Requirements

Notice of adverse determinations (denials only) of retrospective reviews must be made in writing to the patient

within a reasonable period, not to exceed 30 days from the date of receipt.

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

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Dentist may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter. Cigna must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

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

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

Appeal to the State of Texas

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

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

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the denial decision; reference to the specific plan provisions on which the decision is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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

Legal Action under Federal Law

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Complaint or Adverse Determination Appeal process. If your Complaint is expedited, there is no need to complete the Complaint Appeal process prior to bringing legal action.

HC-APL366 10-19

Definitions

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

Charges

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

HC-DFS225 04-10
V1

Coinsurance

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

HC-DFS122 04-10
V1

Contracted Dentist

The term Contracted Dentist means:

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

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

HC-DFS227 04-10
V1

Contracted Fee

The term Contracted Fee refers to:

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

HC-DFS226 04-10
V1

Dentist

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

HC-DFS125 04-10
V3

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. During the next two years Cigna may, from time to time, require proof of the continuation of such condition

and dependence. After that, Cigna may require proof no more than once a year.

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

Benefits for a Dependent child will continue until the last day of the calendar 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-DFS224 04-10

V1

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

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

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

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

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

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

HC-DFS47 04-10

V1

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-DFS1471 01-20

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10

V1

Maximum Allowable Charge (MAC)

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

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

HC-DFS1422 01-21

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

Federal Requirements

The following Federal Requirement section is not part of your group insurance certificate. The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in your group insurance certificate, the provision which provides the better benefit will apply.

HC-FED1 10-10
V1

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

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

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

HC-FED4 10-10

Effect of Section 125 Tax Regulations on This Plan

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

A. Coverage elections

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

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

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

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

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

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

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

HC-FED95 04-17

Eligibility for Coverage for Adopted Children

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

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

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67V1 09-14

Group Plan Coverage Instead of Medicaid

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

HC-FED13 10-10

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

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

HC-FED93 10-17

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

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

Continuation of Coverage

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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

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

HC-FED18 10-10

Claim Determination Procedures under ERISA

Procedures Regarding Medical Necessity Determinations

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

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

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your

provider's network participation documents as applicable, and in the determination notices.

Postservice Determinations

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

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED83 03-13

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

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

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

"Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

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

Disability Extension

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

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

Employer's Notification Requirements

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the

occurrence of a qualifying event, 44 days after the qualifying event occurs; or

- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

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

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer's Bankruptcy

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

Interaction With Other Continuation Benefits

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

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

Millennium Health, LLC Welfare Benefit Plan

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

Millennium Health, LLC
16981 Via Tazon
San Diego, CA 92127
858-451-3535

Employer Identification Number (EIN):	Plan Number:
261565558	501

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

Employer named above

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

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

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

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

Plan Trustees

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

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit

payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

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

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

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

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

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

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse

the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72 05-15