IAFF Local 587 Health Insurance Trust Fund

CIGNA DENTAL PREFERRED
PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2024

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This document printed in May, 2024 takes the place of any documents previously issued to You which described Your benefits.

Printed in U.S.A.

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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

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 شمارەگیری کنید).

HC-NOT97 07-17

How To File A Claim

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

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

Cigna's Toll-Free Number(s):

1-(800) CIGNA24 (1-800-244-6224)

CLAIM REMINDERS

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

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

Timely Filing Of Claims

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

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

after services are rendered. If services are rendered on consecutive days, the limit will be counted from the last date of service. If claims are not submitted to Us within the timeframe shown above, the claim will not be considered valid and will be denied. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

NOTE: Cigna considers one month to equal 30 days regardless of the number of days within a Calendar month.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person: files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of

misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HCDFB-CLM59 06-21

Eligibility - Effective Date

Eligible Class

Each Employee as reported to Us by Your Employer.

Eligibility for Dental Insurance

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

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

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group 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.

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

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

Provided that contributions are received by the Trust on their behalf, the following persons will be eligible for benefits:

- IAFF Local 587/City of Miami bargaining unit employees on whose behalf the City is making a contribution, who are on and have been on the City's Fire Department payroll for at least ninety (90) days (""covered employees"") and their dependents.
- Covered employees who retired under the City of Miami Fire Fighters' and Police Officers' Retirement Trust, who were on the City of Miami's medical and dental benefit plan as of December 31, 2018 and their dependents.
- Covered employees who retire under the City of Miami Fire Fighters' and Police Officers' Retirement Trust after the date the Plan goes into effect and who were continuously a ""covered person"" for the lesser of the time since plan inception or forty-eight (48) months immediately before retiring or separating from employment and who were continuously a member of IAFF Local 587 during that time and their dependents, provided that the retiree enrolls at the time of their retirement. The "48 month covered person" rule may be satisfied by payment of premiums, in the amount determined by the trustees, so that the combined total of participation months and premium payments equals the lesser of 48 or the number of months since plan inception. The incarceration of a retiree shall not disqualify the member for benefits, if otherwise eligible; provided however that benefits for the retiree member shall be suspended during the period of incarceration.
- Non-bargaining unit employees who meet the following conditions:
  - Must be on the Fire Department Payroll for at least ninety days at the time of enrollment;
  - Must be an IAFF Local 587 member for two years (or length of time in Department if less than two years) prior to enrollment, and must maintain membership throughout the period of coverage; and
  - Must make the election within the later of plan inception or thirty (30) days after appointment out of the bargaining unit.
- Other employees on whose behalf the Trustees agree by rule to accept contributions.

Participants

Each participant becomes eligible for coverage on the later of:

- the effective date of this Plan; or
- the day following the date the participant completes ninety (90) days of continuous employment with the City of Miami.

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

90 days from date of hire.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

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

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.

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

Each dependent of a covered Participant becomes eligible for coverage on the latest of the following dates:

- the effective date of this Plan; or
- birth or placement for adoption; or
- marriage; or
- legal guardianship; or
- court or administrative order; or
- the date the Participant is eligibile for individual coverage; or
- the date the Participant first acquires a dependent; or
- the date the dependent loses alternative coverage through a qualifying event.

Participants must notify the City and the Health Trust within 31 days of their acquiring a dependent or any other change affecting dependent status. The notice shall be in writing and shall further provide proof of such changes as may be required by the Board, (for example: divorce decrees, birth certificates, marriage licenses, etc.) If the participant's coverage status is already under family coverage at the time of acquiring an additional dependent, then the dependent(s) will become covered on the date that they meet the definition of an eligible dependent as described in the plan document and provide notice to the health trust. In such case, the Board of Trustees may waive the 31-day notice requirement.

If the birth of the newborn results in a status change of coverage from single coverage to family coverage, then newborn children must be enrolled in the Plan within thirty (30) days of birth. Failure to notify the plan within thirty (30) days of birth may result in the Participant being charged an additional premium. If the participants coverage status is already under family coverage at the time of birth, then eligible dependent(s) will become eligible on the date that they meet the definition of an eligible dependent as described in this Article.

Coverage of a newborn of a dependent as described above shall terminate eighteen (18) months after the birth of the newborn child.

Eligibility for Coverage for Adopted Children

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

Exception for Newborns

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

Foster Children, Adoptive Children and Children in Custodial Care

Benefits applicable to children of the insured employee also apply to adoptive children, foster children and children in custodial care. Coverage begins from birth or from the moment of placement in the home. Except in the case of foster children, coverage may not exclude any preexisting condition of the child.

In the case of a newborn adoptive child, coverage begins from the moment of birth if there is a written agreement to adopt the child, whether or not the agreement is enforceable.

Coverage does not extend to an adoptive child who is not ultimately placed in the home of the insured employee.

If notice of the birth or placement of an adopted child is given to the company within 30 days there is no premium charge for the initial 30 day period. If timely notice is not given, the insurer may charge additional premium from the time of birth or placement.

If notice is given within 60 days of the birth or placement of an adopted child, the insurer may not deny coverage for the child due to the failure of the insured to timely notify the insurer of the birth or placement of the child.

If any family member of the insured employee is covered as a dependent, then benefits applicable to children are covered with respect to a foster child or other child in court-ordered temporary custody or other custody of the insured employee.

Newborn Children

Coverage for newborn children of an insured employee or the employee's covered family member begins from the moment of birth.

Coverage for a newborn child of a covered family member terminates when the child is 18 months old.

If notice of birth is given to the company within 30 days there is no premium charge for the initial 30 day period. If timely

notice is not given, the insurer may charge additional premium from the time of birth.

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

This policy covers newborn children for the necessary dental care or dental treatment of congenital defects or birth abnormalities of the teeth or gums.

Dual Eligibility

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

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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.

HCDFB-LEL23 06-21

Covered Dental Expenses

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

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

Alternate Benefit Provision

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

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

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required. The treatment plan should include supporting pre-operative radiographic images and other diagnostic materials as requested by Our dental consultant. If there is a change in the treatment plan, a revised plan should be submitted. We will determine Covered Dental Expenses for the proposed treatment plan. If there is no Predetermination of Benefits, We will determine Covered Dental Expenses when We receive a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $200. Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

The following section lists Covered Dental Services. We 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 Us.

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Payment Option

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

Dental PPO - Participating and Non-Participating Provider Payment

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

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

HCDFB-DEN133 06-21

Missing Tooth Limitation

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

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

HCDFB-MTL21 06-21

Cigna Dental Preferred Provider Insurance

The Schedule

Benefits For You and Your Dependents

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

Emergency Services

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

Participating Provider Payment

Services are paid based on the Contracted Fee that is agreed to by the provider and Us. Based on the provider's Contracted Fee, a higher level of plan payment (shown below as "The Percentage of Covered Expenses the Plan Pays") may be made to a Participating Provider resulting in a lower payment responsibility for You. To determine how Your Participating Provider compares refer to Your provider directory.
Provider information may change annually; refer to Your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.com.

Non-Participating Provider Payment

Benefit Payment

Services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile. See definition section for further explanation of Maximum Reimbursable Charge.

BENEFIT MAXIMUMS AND DEDUCTIBLES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III Combined Calendar Year Maximum	$2,000	
Class IV Lifetime Maximum	$2,500	$2,500
Class IX Lifetime Maximum	$2,000	$2,000
Benefits Paid for Participating and Non-Participating Provider Services will be applied toward both the Participating and Non-Participating maximum shown in the Schedule.		

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Class I	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Preventive Care	100%	100%

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Class II	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Basic Restorative	100%	100%
Class III	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Major Restorative	100%	100%
Class IV	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Orthodontia	100%	100%
Class IX	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Implants	100%	100%

Covered Dental Services

Teledentistry services are covered only when administered in conjunction with procedures and services which are covered under this plan. Covered Dental Services delivered through teledentistry are covered to the same extent We cover services rendered through in-person contact including the same cost-share, frequency limitations or any applicable benefit maximums or lack thereof.

Class I Services – Diagnostic and Preventive

Clinical oral evaluation – limited to 2 per person per Calendar Year. All oral cleaning services cross accumulate for frequency limit.

Palliative treatment of dental pain, per visit - unlimited. Covered as a separate benefit and administrated at the In-Network coinsurance percentage only if no other services, other than exam and radiographic images, were performed during the visit.

Full mouth or panoramic radiographic images – Complete series or Panoramic (Panorex) – limited to 1 per person, including panoramic images, in any 36 consecutive months.

Bitewing radiographic images – limited to 2 sets per person per Calendar Year.

Extraoral posterior radiographic images – limited to 1 image in any Calendar Year.

Prophylaxis (Cleaning) – limited to 2 per person per Calendar Year. Oral cleaning services include prophylaxis, periodontal maintenance, or scaling in the presence of gingival inflammation; all oral cleaning services cross accumulate for frequency limit.

Periodontal maintenance procedures (following active therapy) – limited to 2 per person per Calendar Year. Oral cleaning services include prophylaxis, periodontal maintenance, and scaling in the presence of gingival inflammation; all oral cleaning services cross accumulate for frequency limit.

Topical application of fluoride (excluding prophylaxis) – for a person less than 19 years old. Limited to 1 per person per Calendar Year.

Sealant, per tooth, on an unrestored primary and permanent bicuspid or molar tooth only for a person less than 14 years old - limited to 1 treatment per tooth in any 36 consecutive months.

Caries medicament application – limited to 2 per tooth in any 1 Calendar Year.

Space Maintainers - limited to non-Orthodontic Treatment for prematurely removed or missing teeth for a person less than 19 years old.

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

Amalgam restorations – unlimited. Multiple restorations on one surface will be treated as a single restoration. The replacement of any amalgam restoration involving the same surface(s) on the same tooth, by the same Dentist or a different Dentist in the same office, within a 12 consecutive month period is considered as part of the charges for the initial placement.

Resin-based composite restoration – unlimited. Multiple restorations on one surface will be treated as a single restoration. The replacement of any amalgam restoration involving the same surface(s) on the same tooth, by the same Dentist or a different Dentist in the same office, within a 12 consecutive month period is considered as part of the charges for the initial placement.

Pin Retention - Covered only in conjunction with amalgam or resin-based composite restoration. Payable one time per restoration regardless of the number of pins used.

Root canal therapy - any radiographic images, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Covered Dental Service.

Root canal therapy, retreatment - unlimited - covered only if more than 6 consecutive months have passed since the original endodontic therapy and only if necessity is confirmed by professional review.

Gingivectomy or gingivoplasty - unlimited.

Gingival flap procedure - including root planing - unlimited.

Clinical crown lengthening - hard tissue - unlimited.

Osseous surgery - flap entry and closure is part of the allowance for osseous surgery and not a separate Covered Dental Service - unlimited.

Bone replacement graft - unlimited.

Guided tissue regeneration - per site, per natural tooth – unlimited.

Pedicle soft tissue graft - unlimited.

Mesial/Distal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) - unlimited.

Free soft tissue graft (including recipient and donor surgical sites) - unlimited.

Autogenous connective tissue graft procedure (including donor and recipient surgical site surgery) - unlimited.

Non-autogenous connective tissue graft (including recipient site and donor material) - unlimited.

Removal of non-resorbable barrier - unlimited. Removal of a non-resorbable barrier is considered inclusive to guided tissue regenerative services, unless performed by a Dentist other than the Dentist who installed it.

Periodontal scaling and root planing - full mouth - unlimited.

Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation. Limited to 2 per Calendar Year. Oral cleaning services include prophylaxis, periodontal maintenance, and scaling in the presence of gingival inflammation; all oral cleaning services cross accumulate for frequency limit.

Full Mouth Debridement - limited to one per lifetime.

Adjustments to complete and partial dentures within 6 months of its installation is part of the allowance for adjustments and is not a separate Covered Dental Service.

Repairs to complete and partial dentures within 6 months of its installation is part of the allowance for repairs and is not a separate Covered Dental Service.

Rebasing dentures - limited to rebasing done more than 6 months after the initial insertion, and then not more than one time in any 36 month period.

Relining dentures - limited to relining done more than 6 months after the initial insertion, and then not more than one time in any 36 month period.

Soft Liner - Complete or Partial Removable Dentures - limited to services done more than 6 months after the initial insertion, and then not more than one time in any 36 month period.

Tissue conditioning - maxillary or mandibular.

Re-cement or re-bond crown, inlays, onlays, veneer or partial coverage restoration, indirectly fabricated or prefabricated post and core. Limited to repairs performed more than 6 consecutive months after the initial insertion.

Crown repair and fixed partial dental repair. Limited to repairs performed more than 6 consecutive months after the initial insertion.

Re-cement fixed partial denture/bridge - limited to repairs done more than 6 months after the initial insertion.

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, partially bony, completely bony.

Removal of residual tooth roots - 1 per tooth per lifetime.

Coronectomy - 1 per lifetime.

Biopsy of oral tissue.

Brush biopsy.

Alveoloplasty.

Vestibuloplasty.

Excision of benign cysts/lesions.

Removal of exostosis (maxilla or mandible).

Removal of torus services.

Incision and drainage.

Frenectomy/Frenuloplasty.

Excision of hyperplastic tissue - per arch or pericoronal gingiva.

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

General anesthesia - Paid as a separate benefit only when Medically Necessary and/or Dentally Necessary, in accordance with Our clinical guidelines, and only when administered in conjunction with procedures which are covered under this plan.

I. V. Sedation - Paid as a separate benefit only when Medically Necessary and/or Dentally Necessary, in accordance with Our clinical guidelines, and only when administered in conjunction with procedures which are covered under this plan.

Consultation – diagnostic service provided by Dentist or physician other than the requesting Dentist or physician.

Periodontics: bite registrations

Class III Services - Major Restorations, Dentures and Bridgework

Crowns - Initial placement of a crown is covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration due to major decay or fracture. Replacement of a crown within 5 Calendar Years after the date it was originally installed is not covered.

Stainless Steel Crowns, Resin Crowns - covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration.

Inlays - covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration due to major decay or fracture.

Onlays - covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration due to major decay or fracture.

Core buildup, including any pins.

Post/post and core - covered only for endodontically treated teeth when there is insufficient tooth structure to retain the final restoration.

Complete dentures - limited to 1 complete denture per arch within 5 Calendar Years.

Partial Dentures - limited to 1 partial denture per arch within 5 Calendar Years.

Overdentures - complete and partial - limited to 1 denture per arch per 5 Calendar Years.

Fixed partial dentures/bridges, inlays and onlays (pontics and retainer crowns) - replacement is limited to 1 service per tooth per 5 Calendar Years if the previous fixed partial denture/bridges is not serviceable and cannot be repaired.

Prosthesis Over Implant - A prosthetic device, supported by an implant or implant abutment is a Covered Dental 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 5 Calendar Years old, is not serviceable and cannot be repaired.

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Class IV Services - Orthodontics

The total amount payable for all expenses incurred for orthodontics during a Covered Person's lifetime will not be more than the orthodontia maximum shown in The Schedule. Benefits are payable under this plan only for active Orthodontic Treatment and for the orthodontic services listed below on the date the Orthodontic Treatment is started.

No benefits are payable for retention in the absence of full active Orthodontic Treatment.

Charges will be considered, subject to other plan conditions, as follows:

- 25% of the total case fee will be considered as being incurred on the date the initial active appliance is placed; and
- the remainder of the total case fee will be divided by the number of months for the total treatment plan and the resulting portion will be considered to be incurred on a monthly basis until the plan maximum is paid, treatment is completed or eligibility ends. Payments will be made quarterly.

Covered Orthodontic Treatment includes:

- Pre-Orthodontic Treatment examination to monitor growth and development;
- Orthodontic work-up including:
  - intraoral complete series of radiographic images or panoramic radiographic images taken in conjunction with an Orthodontic Treatment plan (if needed);
  - cephalometric radiographic image (if needed);
  - radiographs (if needed);
  - diagnostic casts (i.e., study models) for orthodontic evaluation (if needed);
  - treatment plan (if needed);
- Fixed or removable orthodontic appliances for limited tooth movement and/or limited tooth guidance;
- Comprehensive Orthodontic Treatment adult and child;
- Periodic Orthodontic Treatment visit;
- Placement of device to facilitate eruption of impacted tooth;
- Transseptal fiberotomy/supra crestal fiberotomy, by report;
- Harmful habits treatment.

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Class IX Services – Implants

Covered Dental Expenses include: the surgical placement of the dental implant body; the surgical implant index or surgical template guide used for implant surgery; implant abutment(s) and/or connecting bar(s); periodontal/peri-implant and/or maintenance services specifically related to a dental implant; and/or removal of an existing implant(s). 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.

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General Limitations and Expenses Not Covered

General Limitations

For limitations on specific Covered Dental Services, please see the Covered Dental Services.

- any treatment received outside of the United States is not covered unless the treatment is a Covered Dental Service under the plan. Any benefits for services received outside of the United States will be subject to the limitations, if any, stated under the Covered Dental Services and paid based on the Out-of-Network reimbursement shown in The Schedule;
- fixed bridge, any prosthesis over implant, or the addition of teeth is not covered, unless the replacement is needed due to a Medically Necessary and/or Dentally Necessary extraction of an additional Functioning Natural Tooth while the person is covered under this plan;
- replacement of a crown, bridge, onlay, post/post and core, or other laboratory prepared or CAD/CAM prepared restoration, within the frequency limitation stated under the Covered Dental Services is not covered unless:
  - the replacement is made necessary by the placement of an original opposing complete denture or the Medically Necessary and/or Dentally Necessary extraction of a Functioning Natural Tooth; or
  - the crown, bridge, onlay, post/post and core, other laboratory prepared or CAD/CAM prepared restoration, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- replacement of any amalgam or resin-based composite restoration involving the same surface(s) on the same tooth by the same Dentist or a different Dentist in the same office within the frequency limitation stated under the Covered Dental Services is not covered;
- a combination of radiographic images (such as ten or more periapical radiographic images; or a panoramic radiographic image with bite-wing radiographic images) completed on the same date of service will not be covered when the allowance meets or exceeds the allowance for an intraoral complete series of radiographic images. Plan reimbursement will be based on an intraoral complete series;
- localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth. Allowable only on teeth with both periodontal pocket depths of 5 mm or greater and a prior history of periodontal therapy. Not allowable when more than eight (8) of these procedures are reported on the same date of service;
- tissue preparation such as gingivectomy/gingivoplasty or crown lengthening as a separate allowance on the same date as a restoration on the same tooth;
- when covered by Your plan, any prosthesis over an implant is subject to the same exclusions, limitations, frequency limitations as standard traditional restorative, fixed and removable prosthetics;
- Covered Dental Services to the extent that billed charges exceed the rate of reimbursement as described in The Schedule;
- any replacement of a crown, bridge, which is or can be made usable according to commonly accepted dental standards;
- crowns, inlays, cast restorations, or other laboratory prepared or CAD/CAM prepared restorations on teeth unless the tooth cannot be restored with an amalgam or resin-based composite restoration due to major decay or fracture;

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

Expenses Not Covered

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

- any services not stated under Covered Dental Services and The Schedule;
- procedures that are deemed to be medical services or are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- any charges, including ancillary charges, for services and supplies received from a hospital, outpatient facility, ambulatory surgical center or similar facility;
- charges incurred due to injuries which are intentionally self-inflicted;
- charges for or in connection with an injury or illness arising out of, or in the course of any employment for wage or profit;
- charges for or in connection with an injury or illness which is covered under any workers' compensation or similar law;
- charges made by a hospital owned or operated by or which provides care or performs services for, the United States

Government, if such charges are directly related to a military-service-connected condition;

- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- consultations and/or evaluations associated with services that are not covered;
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) which may include but is not limited to the following: bleaching (tooth whitening), in office and/or at home, enamel microabrasion, odontoplasty, facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth will always be considered cosmetic;
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances, if orthodontics is covered) that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
- procedures, services, supplies, restorations, or appliances (except complete dentures), whose sole or primary purpose is to change or maintain vertical dimension;
- procedures, services, supplies, restorations or appliances whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint;
- the restoration of teeth which have been damaged by erosion, attrition, abfraction or abrasion;
- bite registration or bite analysis;
- any procedure, service, supply or appliance used primarily for the purpose of splinting;
- services to correct congenital malformations, including the replacement of congenitally missing teeth;
- procedures, restorations, appliances or services to stabilize periodontally involved teeth;
- myofunctional therapy;
- prescription drugs;
- treatment of jaw fractures and/or orthognathic surgery;
- the treatment of cleft lip and cleft palate;
- charges for sterilization of equipment, infection control processes and procedures, disposal of medical waste or other requirements mandated or recommended by the Centers for Disease Control and Prevention (CDC), OSHA or other regulatory agencies; We consider these to be incidental to and part of the charges for services provided and not separately chargeable;
- charges for travel time; transportation costs;
- personal supplies, including but not limited to toothbrushes, rotary toothbrushes, floss holders, and water irrigation devices;
- instructions, tobacco counseling, substance use counseling, and nutritional counseling;
- charges for broken appointments; completion of claim forms; duplication of radiographic images and/or exams required by a third party;
- charges for treatment or surgery that does not meet plan guidelines;
- general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management;
- indirect pulp capping on the same date of service as a permanent restoration, We consider this to be incidental to and part of the charges for services provided and not separately chargeable;
- additional/incremental costs associated with optional/elective orthodontic materials including but not limited to: ceramic, clear, or lingual brackets, or other cosmetic appliances including clear aligners; orthognathic surgery and associated incremental costs; appliances to guide minor tooth movement; and services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis. This exclusion applies when orthodontics is covered under Your plan;
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis;
- intentional root canal treatment in the absence of injury or disease solely to facilitate a restorative procedure;
- services to the extent You or Your enrolled Dependent(s) are compensated under any group medical plan;
- house/extended care facility calls; hospital calls; office visits for observation (during regularly scheduled hours) when no other services are performed; office visits after regularly scheduled hours; and case presentations;
- procedures performed by a Dentist who is a member of the Covered Person's family except in the case of a dental emergency when no other Dentist is available. (Covered Person's family is limited to a Spouse, siblings, parents, children, grandparents, and the Spouse's siblings and parents);
- dental services that do not meet commonly accepted dental standards;
- replacement of teeth beyond the normal adult dentition of thirty-two (32) teeth;
- services not included in The Schedule, unless We agree to accept such expense as a Covered Dental Expense, in which case payment will be made consistent with similar services

which would provide the least expensive professionally satisfactory result;

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

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

Coordination of Benefits

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

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

Definitions

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

A. **Plan.** A Plan is any of the following that provides benefits or services for medical or dental care or treatment. Plan includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or non-group type coverage (whether insured or uninsured); and medical or dental benefits under group or individual automobile contracts; Medicare, Medicaid or any other federal governmental plan, as permitted by law.

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

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

C. **Primary Plan.** The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan. A Plan that does not contain a coordination of benefits provision that is consistent with this section is always primary.

D. **Secondary Plan.** A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to You.

E. **Allowable Expenses.** The amount of charges considered for payment under the Plan for a Covered Dental Service

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

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If You are covered by two or more Plans that provide services or supplies on the basis of Reasonable and Customary fees, any amount in excess of the highest Reasonable and Customary fee is not an Allowable Expense.
- If You are covered by one Plan that provides services or supplies on the basis of Reasonable and Customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If Your benefits are reduced under the Primary Plan (through the imposition of a higher Coinsurance percentage, a Deductible, and/or a penalty) because You did not comply with Plan provisions or because You did not use a Participating Provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of services.

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

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

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

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan.

If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- **Employee:** The Plan that covers a person as an Employee shall be the Primary Plan and the Plan that covers a person as a Dependent shall be the Secondary Plan.
- **Dependent:** For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the Calendar Year.
- For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the Spouse of the parent with custody of the child;
  - then, the Plan of the noncustodial parent of the child; and
  - finally, the Plan of the Spouse of the parent not having custody of the child.
- **Employee in Active Service or laid-off Employee or Retiree:** The Plan that covers You as an Employee in Active Service and Your Dependent shall be the Primary Plan and the Plan that covers You as a laid-off Employee or Retiree and Your Dependent shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- **COBRA or State Continuation of Coverage:** The Plan that covers You under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers You as an Employee in Active Service or Retiree or Your Dependent shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers You is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.
- **Longer or Shorter Length of Coverage:** The Plan that covers a person for a longer period of time is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.

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

Effect on the Benefits of This Plan

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

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

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

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

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

Recovery of Excess Benefits

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

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

Right to Receive and Release Information

We, without consent or notice to You, may obtain information from and release information to any other Plan with respect to You in order to coordinate Your benefits pursuant to this section. You must provide Us with any information We request in order to coordinate Your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, You will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

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Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

Right of Reimbursement

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

Lien of the Plan

By accepting benefits under this plan, a Covered Person:

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

Additional Terms

- No adult Covered Person may assign any rights that the Covered Person may have to recover dental expenses from any third party or other person or entity to any Dependent child without Our prior express written consent. Our right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Covered Person shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- Our right of recovery shall be a prior lien against any proceeds recovered by the Covered Person. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat Our recovery rights by allocating the proceeds exclusively to non-dental expense damages.
- No Covered Person shall incur any expenses on behalf of the plan in pursuit of the plan's rights. Specifically; no court costs, attorneys' fees, or other representatives' fees may be deducted from the plan's recovery without Our prior express written consent. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- We shall recover the full amount of benefits provided under the plan without regard to any claim of fault on the part of any Covered Person, whether under comparative negligence or otherwise.
- We hereby disavow all equitable defenses in the pursuit of Our right of recovery. Our recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Covered Person fails or refuses to honor his obligations under the plan, We shall be entitled to recover any costs incurred in enforcing the terms of the Policy including, but not limited to, attorney's fees, litigation, court costs, and other expenses. We shall also be entitled to offset the reimbursement obligation against any entitlement to future dental benefits under the Covered Person has fully complied with his reimbursement obligations, regardless of how those future dental benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Covered Person agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, We shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Covered Persons must assist Us in pursuing any recovery rights by providing requested information.

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Payment of Benefits

Assignment and Payment of Benefits

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

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

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

Initial Determination

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

If We require an extension, You will be notified in writing before the end of the initial 30 day period. The notice of extension will explain the reasons for the extension and will state when a determination will be made. If an extension is

required because We require additional information from You, the time from the date of Our notice requesting further information and the time We receive the necessary information does not count toward the time period We are allowed to notify You of the claim determination. You will have 45 days from the date You receive the request for additional information to provide the requested information.

Claim Denial

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

To Whom Payable

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

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

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

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

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

Recovery of Overpayment

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

HCDFB-POB65 06-21

Termination of Insurance

Termination of Your Insurance

Your insurance will cease on the earliest date below:

- the date You cease to be in an Eligible Class or cease to qualify for the insurance.
- the last day for which You have made any required contribution for the insurance.
- the date the Policy is canceled or lapses due to a nonpayment of premium.
- the last day of the calendar month in which Your Active Service ends, except as described below.
- the last date of the month Cigna receives written notice from IAFF 587 Health Insurance Trust Fund to end your coverage, or the date requested in the notice, if later.

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 as determined by your Employer.

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 cancels Your insurance.

Retirement

If Your Active Service ends because You retire, Your insurance will be continued until the date on which Your Employer cancels Your insurance.

Termination of Insurance - Dependents

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

- the date Your insurance ceases; or

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

HCDFB-TRM86M 06-21

Dental Benefits Extension

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

- for root canal therapy, the pulp chamber of the tooth is opened while You are insured and the treatment is completed within 3 calendar month(s) after Your insurance ceases.

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

Dental Benefits Extension – For Total Disability Upon Policy Discontinuation

An expense incurred in connection with a Covered Dental Service that is completed after Your benefits cease, for any reason other than the person's failure to pay premiums, will be deemed to be incurred while You are insured if:

- the course of treatment was recommended in writing by the physician and began while the person was insured for dental benefits; and
- the Covered Dental Service is performed within 90 days after his insurance ceases.

The terms of this Dental Benefits Extension will not apply to a person who becomes insured under another group policy for similar dental benefits.

HCDFB-BEX13 06-21

Miscellaneous

Notice Regarding Provider Directory

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

Additional Programs

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

Oral Health Integration Program

As a Cigna Covered Person, You may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for Covered Dental Services may be relaxed for You if You have certain conditions, including but not limited to, pregnancy, diabetes or cardiac disease. Please review Your plan enrollment materials for details. You may contact Customer Service at 1-(800) CIGNA24 (1-800-244-6224) for additional information.

Impossibility of Performance

Neither Employer nor Cigna shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of unforeseeable events beyond the control of either party. Such events are limited to include natural disaster, war, riot, acts of terrorism (domestic and/or foreign), epidemic, pandemic, cyber events (including breakdown of communication facilities, web hosting and internet services) or any other emergency or similar event not within either party’s control which may result in facilities, personnel, or financial resources being unavailable to provide or arrange for the provision of services in accordance with this Policy. Timelines for performance shall be extended to the extent necessary and agreed upon by both parties, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay and the impacted party makes good faith effort to provide or arrange for the provision of service, taking into account the severity of the event.

Administrative Policies Relating to this Contract

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

Assignability

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

Clerical Error

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

Entire Contract

The entire Contract will be made up of the Policy; the Certificate; the application of the Employer, a copy of which

is attached to the Policy; any riders and amendments to the Policy or Certificate; and any enrollment forms.

Conformity with State and Federal Statutes

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

Statements not Warranties

All statements made by the Employer or any person covered under the Certificate will, in the absence of fraud, be deemed representations and not warranties. No statement made by You or the Employer to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and signed by You or the Employer and a copy is sent to the Employer, You and/or Your beneficiary.

Time Limit on Certain Defenses

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

Your Dental Records

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

HCDFB-MISC47 06-21

Definitions

Active Service

You will be considered in Active Service:

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

HCDFB-DFS391 06-21

Amount Eligible for Coverage by Your Plan

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

HCDFB-DFS392 06-21

Balance Billing

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

HCDFB-DFS394 06-21

Calendar Year

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

HCDFB-DFS395 06-21

Calendar Year Maximum

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

HCDFB-DFS396 06-21

Certificate

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

HCDFB-DFS403 01-19

Chewing Injury

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

HCDFB-DFS404 01-18

Coinsurance

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

HCDFB-DFS405 06-21

Contract

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

HCDFB-DFS406 06-21

Contracted Fee

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

HCDFB-DFS408 06-21

Covered Dental Expenses

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

- It is Medically Necessary and/or Dentally Necessary;
- Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- Your Deductible, if any, has been met;
- The maximum benefit in The Schedule has not been exceeded;
- The charge does not exceed the amount allowed under the Alternate Benefit Provision; and
- It is not excluded as described in the section entitled General Limitations and Expenses Not Covered.

HCDFB-DFS409 06-21

Covered Dental Service

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

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

HCDFB-DFS410 06-21

Covered Person

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

HCDFB-DFS411 01-18

Deductible

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

HCDFB-DFS412 01-18

Dentist

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

HCDFB-DFS414 06-21

Dependent

The term Dependent means:

- Your lawful Spouse; or
- Your Domestic Partner; and

- any unmarried child of Yours who is:
  - less than 30 years old.
  - 30 or more years old and primarily supported by You and incapable of self-sustaining employment by reason of intellectual or physical disabilities. Proof of the child's condition and dependence may be required to be submitted to Us as a condition of coverage after the date the child ceases to qualify above. However, if a claim is denied, proof must be submitted by the Employee that the child is and has continued to be intellectually or physically disabled..

The term child means a child born to You or a child legally adopted by You, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

- a stepchild who lives with You;
- a child born to an uninsured Dependent child of yours until such child is 18 months old who lives with You, or a child supported pursuant to a court order imposed on You (including a Qualified Medical Child Support Order).

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

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

A child under age 30 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee. A covered Employee who participates as a dependent of another covered Employee or retiree may revert to a primary covered Employee status upon the occurrence of a qualifying event.

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

HCDFB-DFS415 M 06-21

Domestic Partner

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

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

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

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

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

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

HCDFB-DFS419 06-21

Effective Date

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

HCDFB-DFS420 01-18

Eligibility Waiting Period

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

HCDFB-DFS421 06-21

Eligible Class

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

HCDFB-DFS422 06-21

Eligible Employee

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

HCDFB-DFS423 06-21

Eligible Person

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

HCDFB-DFS425 01-18

Emergency Services

The term Emergency Services means a service required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

HCDFB-DFS426 01-18

Employee

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

HCDFB-DFS427 06-21

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HCDFB-DFS428 06-21

Full-Time

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

HCDFB-DFS430 06-21

Functioning Natural Tooth

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

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

HCDFB-DFS431 06-21

Fund

The term Fund means the Policyholder and all Affiliated Employers. The term Employer means an Employer participating in the Fund which is established under the agreement of Trust for the purpose of providing insurance.

HCDFB-DFS432 06-21

Handicapping Malocclusion

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

HCDFB-DFS433 01-18

Late Entrant

The term Late Entrant means a person who elects the insurance under this Policy more than 30 days after becoming eligible or a person who again elects the insurance under the Policy after cancelling or terminating premium payments, if required.

HCDFB-DFS435 06-21

Maximum Benefit Amount

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

HCDFB-DFS438 06-21

Maximum Reimbursable Charge (MRC)

The Maximum Reimbursable Charge (MRC) for Covered Dental Services is determined based on the lesser of:

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

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

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

HCDFB-DFS439 06-21

Medicaid

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

HCDFB-DFS440 01-18

Medically Necessary and/or Dentally Necessary

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

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

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

HCDFB-DFS441 06-21

Medicare

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

HCDFB-DFS442 01-18

Non-Participating Provider

The term Non-Participating Provider means a Dentist, or a professional corporation, professional association, partnership, or other entity that has not entered into a Contract with Us to

provide dental services. Services received from Non-Participating Providers are considered out-of-network ("Out-of-Network").

HCDFB-DFS445 06-21

Orthodontic Treatment

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

HCDFB-DFS446 06-21

Participating Provider

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

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

HCDFB-DFS448 06-21

Policy

The term Policy means a written agreement between the Policyholder and Us outlining the terms and conditions under which We agree to insure certain Employees and pay benefits.

HCDFB-DFS454 06-21

Policyholder

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

HCDFB-DFS455 06-21

Qualified Medical Child Support Order

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

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

HCDFB-DFS457 01-19

Retiree

The term Retiree means a former Employee of the Employer:

- who has attained the Normal Retirement Age;

Normal Retirement Age, as used above, shall mean the age determined by the Employer in their established guidelines.

HCDFB-DFS458 06-21

Specialist

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

HCDFB-DFS459 01-18

Spouse

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

HCDFB-DFS460 06-21

Usual Fee

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

HCDFB-DFS461 01-18

We, Us and Our

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

HCDFB-DFS462 01-18

You, Your, Yourself

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

HCDFB-DFS463 01-18

Federal Requirements

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

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

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

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

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

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

HC-FED4 10-10

Effect of Section 125 Tax Regulations on This Plan

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

A. Coverage elections

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

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

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution. When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

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

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

HC-FED112 01-23

Eligibility for Coverage for Adopted Children

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

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

HC-FED67V1 09-14

Group Plan Coverage Instead of Medicaid

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

HC-FED13 10-10

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

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified

by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

HC-FED93 10-17

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

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

Continuation of Coverage

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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

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

HC-FED18 10-10

Claim Determination Procedures

Procedures Regarding Medical Necessity Determinations

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

You or your authorized representative (typically, your health care professional) must request Medical Necessity determinations according to the procedures described below, in the booklet, 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 booklet, 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

Appointment of Authorized Representative

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

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

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

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

HC-FED88 01-17

Dental - When You Have a Complaint or an Appeal

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

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

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

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

Level-One Appeal

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

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

You or your authorized representative may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

Cigna's reviewer, in consultation with the treating health care provider, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

Level-Two Appeal

If you are dissatisfied with Cigna's level-one appeal decision, you have the right to request a level-two appeal from the Board of Trustees of the IAFF Local 587 Health Insurance Trust Fund within sixty (60) days from receipt of the level-one appeal determination. To initiate a level-two appeal, you or your authorized representative must submit a request in writing to the IAFF Local 587 Health Insurance Fund at 2980 NW South River Drive, Miami, FL 33125.

Cigna will forward the entire file regarding the level-one appeal to counsel for the Board of Trustees of the IAFF Local 587 Health Insurance Trust Fund.

You or your authorized representative may review the pertinent documents related to your claim and/or appeals, and may submit any additional relevant information and/or comments in writing. The Board of Trustees of the IAFF Local 587 Health Insurance Trust Fund shall issue a full and fair decision reaffirming, modifying or setting aside the level-one appeal. The decision on review shall be in writing and shall include specific reasons for the decision.

With respect to appeals of urgent care claims, the Board of Trustees of the IAFF Local 587 Health Insurance Trust Fund shall issue a full and fair written decision within 72 hours from the time the claim is made.

With respect to appeals for pre-service claims involving access to medical care or facilities, the Board of Trustees of the IAFF Local 587 Health Insurance Trust Fund shall issue a full and fair written decision within 30 days of the appeal request of an adverse benefit determination.

Independent Review Procedure

If, after exhausting your internal appeals, you are not fully satisfied with the decision made by the IAFF Local 587 Health Insurance Trust Fund and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare, or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. Cigna and the IAFF Local 587 Health Insurance Trust Fund will abide by the decision of the Independent Review Organization.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of the IAFF Local 587 Health Insurance Trust Fund level-two appeal review decision. Cigna will then forward the file, including documents related to both the level-one and level-two appeals, to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours

Notice of Benefit Determination on Appeal

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

Necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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 for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services.

HC-FED84 M 01-11

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.