DENTAL PLAN

People's United Bank offers three dental coverage options to help you and your family cover the cost of dental care.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This document is a Summary Plan Description (SPD) of the health and welfare benefit plans sponsored by People's United Bank, N.A. The company reserves the right to change, amend, or discontinue any plan or program described in this document. This document is intended for informational purposes only and does not constitute an employment agreement for any recipient. If there is a conflict between this SPD and the insurance contract or governing plan document, the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

TABLE OF CONTENTS

This section, combined with the Participating in the People's United Bank Group Benefits Plan and Rules, Regulations and Plan Administration sections, make up the Summary Plan Description for the Dental Plan.

Type of Plan Administration and Funding

The Dental Plan's Basic and Enhanced Options are not insured benefits. The benefits described in this Summary Plan Description (SPD) are self-insured by People's United which is responsible for their payment. Cigna Health and Life Insurance Company (Cigna) provides claims administration services to the Plan, but Cigna does not insure the benefits described. People's United Bank is ultimately responsible for providing plan benefits, and not Cigna. Benefits are paid in part by People's United Bank out of its general assets, and in part by employees' pre-tax payroll deductions. There is no special fund or trust or insurance from which benefits are paid.

The Cigna Dental Care® DHMO Option is an insured benefit. Employees electing the DHMO Option should refer to the separate Benefit Summary/Patient Charge Schedule and Plan Certificate which detail insured benefits provided under the option. The DHMO benefit is listed in the *Schedule of Dental Benefits* for comparison purposes only.

Your Dental Plan Options

You have a choice of three Cigna dental coverage options — the Basic Option, the Enhanced Option, and the Cigna Dental Care® Dental Health Maintenance Organization (DHMO).

- The Basic Option provides low-cost diagnostic and preventive care, basic restorations, periodontics and endodontics. It gives you the flexibility to receive services from in-network and out-of-network providers. Orthodontic and major services are not covered under the Basic Option.

- The Enhanced Option covers diagnostic and preventive care, basic restorations, periodontics and endodontics, major restorations, dentures and bridgework, oral surgery, prosthodontic maintenance and child orthodontia. It gives you the flexibility to receive services from in-network and out-of-network providers.

- The DHMO Option covers diagnostic and preventive care, basic restorations, periodontics and endodontics, major restorations, dentures and bridgework, oral surgery, prosthodontic maintenance and adult and child orthodontia. You must receive care from a DHMO provider to receive benefits. Under the DHMO, you must choose a primary care dentist and obtain referrals for all specialty care, except orthodontia services. Each covered dependent can choose his or her own primary care dentist. **See the DHMO Benefit Summary/Patient Charge Schedule and Plan Certificate for more information.**

How the Dental Plan Works

When you receive services from a Participating Provider, the plan pays a greater share of the cost than if you were to receive care from a non-Participating Provider.

Provider information may change annually; refer to your provider directory prior to receiving a service. To find out if your provider is an in-network, Participating Provider, visit www.myCigna.com. The Basic and Enhanced Options use the Total Cigna DPPO network. The DHMO Option uses the Cigna Dental Care network.

Participating Provider Payment

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

Non-Participating Provider Payment

Plan payment for a covered service delivered by a non- Participating Provider is the Maximum Reimbursable Charge for that procedure, times the benefit percentage that applies to the class of service, as specified in the *Schedule of Dental*

Benefits. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

The covered person is responsible for the balance of the non-Participating Provider's actual charge.

Simultaneous Accumulation of Amounts

Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the *Schedule of Dental Benefits*.

How to File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out- of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

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

Claim Reminders:

- Be sure to use your member ID and account/group number when you file Cigna's claim forms, or when you call the Cigna claim office.
- Your Member ID and account/group number are located on your ID Card.
- Be sure to follow the instructions listed on the back of the claim form carefully when submitting a claim to Cigna.

Timely Filing of Out-of-Network Claims

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

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.

Covered Dental Expense

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

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

Alternative Benefit Provision

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

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

Predetermination of Benefits

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

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

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.
Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $200.

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

Emergency Services

The Benefit Percentage for Emergency Services incurred for charges made by a non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

Missing Teeth Limitation

The amount payable for the replacement of teeth that are missing when a person first becomes insured is 50% of the amount payable for the replacement of teeth that are extracted after a person has dental coverage. This payment limitation no longer applies after 24 months of continuous coverage.

Schedule of Dental Benefits

The following tables show a summary of the plan feature details for your Dental Plan options.

Features/Services	Basic Option		Enhanced Option		DHMO
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*	*In-Network Only (where available)*
Annual Deductible[1] (Individual /Family)	None	$50 / $150	None	$50 / $150	None
Maximum Annual Benefit per Member	$1,000		$1,500		Unlimited
Class I - Diagnostic and Preventive Services Oral exams, bitewing and full mouth X-rays and fluoride; age and frequency limits apply	Plan pays 100%, deductible waived (does not count towards maximum annual benefit per Member)				
Class II Services – Basic Services Silver fillings, composite fillings on anterior teeth, endodontics, routine extractions and non-major periodontics, root canals (non-molar teeth) and emergency services	Plan pays 70%, Member pays 30%	Plan pays 70%, Member pays 30% after deductible	Plan pays 80%, Member pays 20%	Plan pays 80%, Member pays 20% after deductible	Plan pays 100%
Class III - Major Services Crowns (all materials), full and partial dentures, inlays, onlays, osseous surgery, oral surgery and root canals (molar teeth)	Not Covered		Plan pays 50%, Member pays 50%	Plan pays 50%, Member pays 50% after deductible	Plan pays 60%; Member pays 40%[2]
Class IV - Orthodontia Partial and Comprehensive Treatment	Not Covered		Plan pays 50%, Member pays 50%, deductible waived (applies only to a Dependent Child less than 19 years of age)		Plan pays 50%, Member pays 50%
Orthodontia Lifetime Maximum Plan Benefit per Member	N/A		$1,650		None

[1] Does not apply to preventive services

[2] Under the DHMO, surgical removal of an erupted tooth is covered at no cost to you; you pay 40% for all other oral surgery.

Covered Services

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

Class I Services – Diagnostic and Preventive

- Clinical oral examination – Only 2 per person per calendar year.
- X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.
- Bitewing x-rays – Only 2 charges per person per calendar year.
- Prophylaxis (Cleaning), including Periodontal maintenance (following active therapy) – Only 2 per person per calendar year.
- Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.
- Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any 3 calendar years.
- Space Maintainers, fixed unilateral – Limited to non-orthodontic treatment.

Class II Services – Basic Restorations, Periodontics, Endodontics

- Amalgam Filling
- Composite/Resin Filling
- Root Canal Therapy (non-molar teeth) – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.
- Routine Extractions
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)
- Periodontal Scaling and Root Planing – Entire Mouth

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

- Crowns

  Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
  - Porcelain Fused to High Noble Metal
  - Full Cast, High Noble Metal
  - Three-Fourths Cast, Metallic
- Removable Appliances
  - Complete (Full) Dentures, Upper or Lower
  - Partial Dentures
  - Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
  - Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)
- Fixed Appliances
  - Bridge Pontics - Cast High Noble Metal
  - Bridge Pontics - Porcelain Fused to High Noble Metal
  - Bridge Pontics - Resin with High Noble Metal
  - Retainer Crowns - Resin with High Noble Metal
  - Retainer Crowns - Porcelain Fused to High Noble Metal
  - Retainer Crowns - Full Cast High Noble Metal

- Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.
- Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth
  - Removal of Impacted Tooth, Soft Tissue
  - Removal of Impacted Tooth, Partially Bony
  - Removal of Impacted Tooth, Completely Bony
- General Anesthesia – Paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- I.V. Sedation – Paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this Plan.
- Adjustments – Complete Denture
  - Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.
- Recement Bridge
- Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.
- Periodontal Scaling and Root Planing – Entire Mouth
- Root Canal Therapy (molar teeth) – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.
- Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

The total amount payable for all expenses incurred for orthodontics during a Dependent child's lifetime will not be more than the orthodontia maximum shown in the *Schedule of Dental Benefits*.

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

Expenses Not Covered

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

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 8 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;

- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

Dental Benefits

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

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the *Schedule of Dental Benefits*) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. 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;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the *Schedule of Dental Benefits*;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

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:

Plan

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

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

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

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 if rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area where the health care service was delivered.

Order of Benefit Determination Rules

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

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

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;

- then, the Plan of the spouse of the parent with custody of the child;
- then, the Plan of the noncustodial parent of the child; and
- finally, the Plan of the spouse of the parent not having custody of the child.

- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, the benefits that would be payable under this Plan in the absence of Coordination will be reduced by the benefits payable under all other Plans for the expense covered under this Plan.

When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an expense incurred and a benefit payable.

Recovery of Excess Benefits

If Cigna pays charges for services and supplies that should have been paid by the Primary Plan, Cigna will have the right to recover such payments.

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

Right to Receive and Release Information

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

Expenses for Which a Third Party May be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile

medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this Plan is secondary to any automobile no-fault or similar coverage.

Right of Reimbursement

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

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

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

- Participants must assist the plan in pursuing any recovery rights by providing requested information.

Payment of Benefits

To Whom Payable

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.
Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

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

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

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

Recovery of Overpayment

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

Definitions

Coinsurance

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

Contracted Fee

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

Dentist

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

Maximum Reimbursable Charge - Dental

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

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

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

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.

Medicare

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

Participating Provider

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

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers is available on www.mycigna.com.

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your active service ends except as described in the *Rules, Regulations and Plan Administration* section.

Dependents

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

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

The insurance for any one of your Dependents will cease on the last day of the month in which that Dependent no longer qualifies as a Dependent.