

HBC

CIGNA DENTAL PREFERRED
PROVIDER INSURANCE
Core Plan

EFFECTIVE DATE: January 1, 2019

CN028
3339027

This document printed in November, 2018 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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

POLICYHOLDER: HBC

GROUP POLICY(S) — COVERAGE

3339027 - DPPO2 CIGNA DENTAL PREFERRED PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2019

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

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


Anna Krishdul, Corporate Secretary

Explanation of Terms

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

The Schedule

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

Important Notices

Discrimination is Against the Law

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

Cigna:

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

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

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

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

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

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

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

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki deyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de

Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

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

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

Japanese –

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

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

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

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

HC-NOT97

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Health Care Services

A denial of claim or a clinical decision regarding health care services will be made by qualified clinical personnel. Notice of denial or determination will include information regarding the basis for denial or determination and any further appeal rights.

Authorization

No authorization will be required prior to receiving Emergency Services.

Non-English Assistance

For non-English assistance in speaking to Member Services, please use the translation service provided by AT+T. For a translated document, please contact Customer Service at the toll-free telephone number shown on your ID card.

New York Disclosure and Synopsis Statement

The accident and health insurance evidenced by this certificate provides dental insurance only.

This Schedule highlights the benefits of the plan. The benefits shown may not always be payable because the plan contains certain limitations and exclusions. Dental Expense Benefits, for instance, are not payable for such things as work-related injuries or unnecessary care or orthodontia. These limitations and others can be found in their entirety on subsequent pages of the certificate.

HC-IMP68

04-10

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How To File Your Claim

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

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

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on

consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied.

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

HC-CLM1

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Eligibility - Effective Date

Who is Covered Under this Certificate

You, the Employee to whom this Certificate is issued, are covered under this Certificate.

Members of your family may also be covered depending on the type of coverage you selected.

Types of Coverage

Cigna offers the following types of coverage:

- **Individual.** If you selected individual coverage, then you are covered.
- **Individual and Spouse.** If you selected individual and spouse coverage, then you and your spouse are covered.
- **Parent and Child/Children.** If you selected parent and child/children coverage, then you and your Dependent child or children, as described below, are covered.
- **Family.** If you selected family coverage, then you and your spouse and your Dependent child or children, as described below, are covered.

Children Covered Under this Certificate

If you selected parent and child/children or family coverage, children covered under this Certificate include your natural children, legally adopted children, stepchildren, and children for whom you are the proposed adoptive parent without regard to financial dependence, residency with you, student status or employment. A proposed adopted child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption. Coverage lasts until the end of the month in which the child turns 26 years of age. Coverage also includes children for whom you are a permanent legal guardian if the children are chiefly dependent upon you for support and you have been appointed the legal guardian by a court order.

Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the child's coverage would otherwise terminate and who is chiefly dependent upon you for support and maintenance, will remain covered while your insurance remains in force and your child remains in such condition. You have 31 days from the date of your child's attainment of the termination age to submit an application to request that the child be included in your coverage and proof of the child's incapacity. We have the right to check whether a child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Employee and all other prospective or covered insured persons in relation to eligibility for coverage under this Certificate at any time.

When Coverage Begins

Coverage under this Certificate will begin as follows:

- If you, the Employee, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date you become eligible, or on the date determined by your Employer Group. Groups cannot impose waiting periods that exceed 90 days. Employees must:
 - be in a Class of Eligible Employees; and
 - be an eligible, full-time Employee; and
 - normally work at least 30 hours a week; and
 - pay any required contribution.
- If you, the Employee, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, you must wait until the Group's next open enrollment period to enroll, except as provided below.
- If you, the Employee, marry while covered, and Cigna receives notice of such marriage within 30 days thereafter, coverage for your spouse starts on the first day of the month following such marriage. If Cigna does not receive notice within 30 days of the marriage, you must wait until the Group's next open enrollment period to add your spouse.
- If you, the Employee, have a newborn or adopted newborn child and Cigna receives notice of such birth within 31 days thereafter, coverage for your newborn starts at the moment of birth; otherwise, coverage begins on the date on which Cigna receives notice. Your adopted newborn child will be covered from the moment of birth if you take physical custody of the infant as soon as the infant is released from the Hospital after birth and you file a petition pursuant to

Section 115-c of the New York Domestic Relations Law within 31 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If you have individual or individual and spouse coverage, you must also notify us of your desire to switch to parent and child/children or family coverage and pay any additional premium, if required, within 31 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which Cigna receives notice and the premium payment, if such payment is required. If a premium payment is not received as required, no benefits for expenses incurred for the newborn or adopted newborn child after the 31st day will be payable.

Special Enrollment Periods

You, your spouse or child can also enroll for coverage within 30 days of the loss of coverage in another group health plan if coverage was terminated because you, your spouse or child are no longer eligible for coverage under the other group health plan due to:

- termination of employment;
- termination of the other group health plan;
- death of the spouse;
- legal separation, divorce or annulment;
- reduction of hours of employment;
- employer contributions toward the group health plan were terminated; or
- a child no longer qualifies for coverage as a child under the other group health plan.

You, your spouse or child can also enroll 30 days from exhaustion of your COBRA or continuation coverage.

We must receive notice and premium payment within 30 days of the loss of coverage. The effective date of your coverage will depend on when we receive your application. If your application is received between the first and fifteenth day of the month, your coverage will begin on the first day of the following month. If your application is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month.

In addition, you, your spouse or child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

- you or your spouse or child loses eligibility for Medicaid or a state child health plan; or
- you or your spouse or child becomes eligible for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of one of these events. The effective date of your coverage will depend on when we receive your application. If your application is received between the first and fifteenth day of the month, your coverage will begin on the first day of the following month. If your application is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month.

HC-ELG135

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Important Information about Your Dental Plan

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

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

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

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

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

Change in Option Elected

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

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

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

Effective Date of Change

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

HC-IMP2

04-10

HC-IMP74

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Cigna Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes two options. When you select a Participating Provider, this plan pays a greater share of the cost than if you were to select a non-Participating Provider.

Emergency Services

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

Deductibles

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

Participating Provider Payment

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

Provider information may change annually; refer to your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.com.

Non-Participating Provider Payment

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 90th percentile of all provider charges in the geographic area.

Simultaneous Accumulation of Amounts

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

Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III Combined Calendar Year Maximum	\$1,500	
Calendar Year Deductible		
Individual	\$50 per person	\$150 per person
	Not Applicable to Class I	Not Applicable to Class I
Family Maximum	\$150 per family	\$450 per family

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	Not Applicable to Class I	Not Applicable to Class I
Class I Preventive Care	100%	80%
Class II Basic Restorative	80% after plan deductible	60% after plan deductible
Class III Major Restorative	50% after plan deductible	50% after plan deductible

Covered Dental Expense

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

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

Alternate Benefit Provision

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

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

You have the right to appeal the denial of the requested procedure.

Predetermination of Benefits

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

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

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

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

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

Covered Services

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

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Dental PPO – Participating and Non-Participating Providers

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

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

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

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

HC-DEN2

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Class I Services – Diagnostic and Preventive

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

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

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

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

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

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

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

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN3

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

Amalgam Filling

Composite/Resin Filling

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

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

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

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

Recement Bridge

Routine Extractions

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

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

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

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

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

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Class III Services - Major Restorations, Dentures and Bridgework

Crowns

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

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

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

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

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense.

Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

HC-DEN5

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HC-DEN164V1

Expenses Not Covered

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

- services performed solely for cosmetic reasons; unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the utilization review process in the utilization review and external appeals sections of this certificate unless medical information is submitted.
- replacement of a lost or stolen appliance.
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion.
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
- bite registrations; precision or semiprecision attachments; or splinting.
- instruction for plaque control, oral hygiene and diet.
- dental services that do not meet common dental standards.
- dental service, procedure, treatment, test or device that we determine is not Medically Necessary. If an External Appeal Agent certified by the state overturns our denial, however, we will cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise covered under the terms of this certificate.
- services and supplies received from a Hospital.
- services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

- orthodontic treatment.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- services for which benefits are not payable according to the “General Limitations” section.

HC-DEX45

07-14

V1

General Limitations

Dental Benefits

No coverage is available under this certificate for the following:

- for services if benefits for such services are provided under any state or federal Workers’ Compensation, employers’ liability or occupational disease law.
- for care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.
- for an illness, treatment or medical condition due to war, declared or undeclared; services for which no charge is normally made.
- for health care service, procedure, treatment, or device that is experimental or investigational. However, we will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial, when our denial of services is overturned by an External Appeal Agent certified by the state. However, for clinical trials, we will not cover the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the certificate for non-investigational treatments. See the utilization review and external appeal sections of this certificate for a further explanation of your appeal rights.
- for any illness, treatment or medical condition due to your participation in a felony, riot or insurrection.
- for an illness, treatment or medical condition due to service in the armed forces or auxiliary units.
- for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

- any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.

HC-DEX45

07-14

V2

Coordination of Benefits

This section applies when you or any one of your Dependents also have group dental coverage with another plan. When you or any one of your Dependents receives a covered service, Cigna will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

Definitions

“Allowable expense” is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

“Plan” is other group dental coverage with which Cigna will coordinate benefits. The term “plan” includes:

- Group dental benefits and group blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
- Dental benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
- Dental benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

“Primary plan” is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: the plan has no order of benefits rules or its rules differ from those required by regulation; or all plans which cover the person use the order of benefits rules required by regulation and under those rules the

plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

“Secondary plan” is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Rules to Determine Order of Payment

The first of the rules listed below in the following six paragraphs that applies will determine which plan will be primary:

- If the other plan does not have a provision similar to this one, then the other plan will be primary.
- If the person receiving benefits is the subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
- If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
- If a child is covered by both parents’ plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child’s dental care expenses:
 - The plan of the parent who has custody will be primary.
 - If the parent with custody has remarried, and the child is also covered as a child under the step-parent’s plan, the plan of the parent with custody will pay first, the step-parent’s plan will pay second, and the plan of the parent without custody will pay third.
 - If a court decree between the parents says which parent is responsible for the child’s dental care expenses, then that parent’s plan will be primary if that plan has actual knowledge of the decree.
 - If the person receiving services is covered under one plan as an active Employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active Employee, and is also covered under another plan as a laid-off or retired Employee or as the spouse or child of such a laid-off or retired Employee, the plan that covers such person as an active Employee or spouse or child of an active Employee will be primary. If the other plan does

not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

- If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed the maximum available benefit for each covered service. Also, the amount will not be more than the amount it would pay if it were primary. As each claim is submitted, we will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Necessary Information

Cigna may release or receive information that it needs to coordinate benefits. Cigna does not need to tell anyone or receive consent to do this. Cigna is not responsible to anyone for releasing or obtaining this information. You or your covered Dependents must give Cigna any needed information for coordination purposes, in the time frame requested.

Our Right to Recover Overpayment

If Cigna made a payment as a primary plan, you agree to pay Cigna any amount by which Cigna should have reduced its payment. Also, Cigna may recover any overpayment from the primary plan or the Provider receiving payment and you agree to sign all documents necessary to help recover any overpayment.

Coordination with “Always Excess,” “Always Secondary,” or “Non-Complying” Plans

Cigna will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

- If this Certificate is primary, as defined in this section, Cigna will pay benefits first.
- If this Certificate is secondary, as defined in this section, Cigna will pay only the amount it would pay as the secondary insurer.

If Cigna requests information from a non-complying plan and does not receive it within 30 days, Cigna will calculate the amount it should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, Cigna will make any necessary adjustments.

HC-COB123

07-14
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Payment of Benefits

To Whom Payable

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

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

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

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

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

Recovery of Overpayment

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

HC-POB42

04-10
V1

Miscellaneous

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

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

For members with diabetes, cerebrovascular or cardiovascular disease:

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

For members who are pregnant:

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

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

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

Please refer to the plan enrollment materials for further details.

HC-POB8

04-10
V1

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.

- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day through end of the pay period in which your Active Service ends except as described below.

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

Injury or Sickness

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

Dependents

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

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

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

HC-TRM3

04-10
V1 M

Dental Benefits Extension

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

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

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

HC-BEX3

04-10

V1

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 H and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

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

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

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

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

HC-FED95

04-17

Eligibility for Coverage for Adopted Children

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

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

HC-FED67V1

09-14

Group Plan Coverage Instead of Medicaid

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

HC-FED13

10-10

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

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

HC-FED93

10-17

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

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

Continuation of Coverage

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

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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

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

HC-FED18

10-10

Claim Determination Procedures under ERISA

Procedures Regarding Medical Necessity Determinations

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

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

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Postservice Determinations

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

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

Notice of Adverse Determination

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

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.

ERISA Required Information

The name of the Plan is:

HBC U.S. Health and Welfare Plan

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

Lord & Taylor Acquisition Inc.
225 Liberty Street
Floor 31
New York, NY 10281
646-802-7087

Employer Identification
Number (EIN):

990372181

Plan Number:

501

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

Employer named above

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

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

The Plan’s fiscal year ends on 12/31.

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

Plan Trustees

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

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Discretionary Authority

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

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

Plan Modification, Amendment and Termination

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

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

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

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

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

Statement of Rights

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

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union

halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.

- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in

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

Assistance with Your Questions

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

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Notice of an Appeal or a Grievance

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

HC-SPP4

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Grievance Procedures

Grievances

Cigna Dental's grievance procedure applies to any issue not relating to Medical Necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding Cigna Dental's administrative policies or access to Dentists.

Filing a Grievance

You can contact Cigna Dental by phone at 1.800.Cigna24 or in writing to the address that appears on your explanation of benefits to file a grievance. You may submit an oral grievance

in connection with a denial of a referral or a covered benefit determination. We may require that you sign a written acknowledgement of your oral grievance, prepared by us. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

When we receive your grievance, we will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry.

Grievance Determination

Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify you within the following timeframes:

Expedited/Urgent Grievances:

By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of your grievance. Written notice will be provided within 72 hours of receipt of your grievance.

Pre-Service Grievances:

(A request for a service or treatment that has not yet been provided.)

In writing, within 15 calendar days of receipt of your grievance.

Post-Service Grievances:

(A claim for a service or a treatment that has already been provided.)

In writing, within 30 calendar days of receipt of your grievance.

All Other Grievances:

(That are not in relation to a claim or request for a service.)

In writing, within 45 calendar days of receipt of all necessary information.

Grievance Appeals

If you are not satisfied with the resolution of your grievance, you or your designee may file an appeal by phone at 1.800.Cigna24 or in writing. You have up to 60 business days from receipt of the grievance determination to file an appeal.

When we receive your appeal, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and

telephone number of the person handling your appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the appeal and notify you in writing within the following timeframes:

Expedited/Urgent Grievances: The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of your appeal.

Pre-Service Grievances: 15 calendar days of receipt of your appeal.
(A request for a service or treatment that has not yet been provided.)

Post-Service Grievances: 30 calendar days of receipt of your appeal.
(A claim for a service or a treatment that has already been provided.)

All Other Grievances: 30 business days of receipt of all necessary information to make a determination.
(That are not in relation to a claim or a request for a service.)

Assistance

If you remain dissatisfied with our appeal determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If you need assistance filing a grievance or appeal, you may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
www.communityhealthadvocates.org

External Appeal

Your Right to an External Appeal

In some cases, you have a right to an external appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that a service does not meet our requirements for Medical Necessity (including appropriateness, health care

setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the state to conduct these appeals.

In order for you to be eligible for an external appeal you must meet the following two requirements:

- the service, procedure, or treatment must otherwise be a Covered Service under the certificate; and
- in general, you must have received a final adverse determination through the first level of our internal appeal process. But, you can file an external appeal even though you have not received a final adverse determination through the first level of our internal appeal process if:
 - we agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal; or
 - you file an external appeal at the same time as you apply for an expedited internal appeal; or
 - we fail to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

Your Right to Appeal a Determination that a Service is not Medically Necessary

If we have denied coverage on the basis that the service does not meet our requirements for Medical Necessity, you may appeal to an External Appeal Agent if you meet the requirements for an external appeal in the paragraph “Your Right to an External Appeal” above.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If we have denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the two requirements for an external appeal in the paragraph “Your Right to an External Appeal” above and your attending Physician must certify that your condition is one for which:

- standard health services are ineffective or medically inappropriate;
- there does not exist a more beneficial standard service or procedure covered by us; or
- there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – your attending Physician should contact the state for current information as to what documents will be considered or acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be your treating Physician.

Your Right to Appeal a Determination That a Service Is Out-of-Network

If we have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, you may appeal to an External Appeal Agent if you meet the two requirements for an external appeal in paragraph “Your Right to an External Appeal” above, and you have requested preauthorization for the out-of-network treatment.

In addition, your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat you for the health service.

You do not have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a

health care provider is available in-network to provide the particular health service requested by you.

The External Appeal Process

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on our failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of our internal appeal process or our written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1.800.400.8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the state will forward the request to a certified External Appeal Agent.

You can submit additional documentation with your external appeal request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which we based our denial, the External Appeal Agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited external appeal (described below), we do not have a right to reconsider our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your Physician, or us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending Physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must notify you and us by telephone or facsimile of that decision.

The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, we will provide coverage subject to the other terms and conditions of this certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the cost of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under this certificate for non-experimental or non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both you and us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge you a fee of \$25 for each external appeal, not to exceed \$75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if we determine that paying the fee would be a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to you.

Your Responsibilities. It is your responsibility to start the external appeal process

You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Notice of Benefit Determination on Grievance or Appeal

Every notice of a determination on grievance or appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination including clinical rationale; 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: the procedures to initiate the next level of appeal; 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.

In addition, every notice of a utilization review final adverse determination must include: a clear statement describing the basis and clinical rationale for the denial as applicable to the insured; a clear statement that the notice constitutes the final adverse determination; Cigna's contact person and his or her telephone number; the insured's coverage type; the name and full address of Cigna's utilization review agent, if any; the utilization review agent's contact person and his or her telephone number; a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or Dentist proposed to provide the treatment and the developer/manufacture of the health care service; a statement that the insured may be eligible for an external appeal and the time frames for requesting an appeal; and a clear statement written in bolded text that the four month time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing the request a second level internal appeal, the time may expire for the insured to request an external appeal.

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

Relevant Information

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

advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

HC-APL250

07-14

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Definitions

Accidental Injury

An accidental injury means an injury that is caused by biting on a foreign object not expected to be a normal constituent of food, or by biting down on an item such as a pencil, eyeglass frame, or dislodged or loose dental prosthesis.

HC-DFS497

04-10

V1

Active Service

You will be considered in Active Service:

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

HC-DFS1

04-10

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Coinurance

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

HC-DFS122

04-10

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Contracted Fee

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

HC-DFS123

04-10

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Dentist

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

HC-DFS125

04-10

V3

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
 - less than 26 years old.
 - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

A child includes any natural, adopted or step-children, unmarried disabled children, newborn children, or any other children as described in the Eligibility and Effective Date, Who is Covered section of this Certificate. If your Domestic Partner has a child, that child will also be included as a Dependent.

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

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

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

HC-DFS780

07-14

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Domestic Partner

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

- Has a registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
- For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
 - The affidavit must be notarized and must contain the following:
 - the partners are both eighteen years of age or older and are mentally competent to consent to contract;
 - the partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
 - the partners have been living together on a continuous basis prior to the date of the application; and
 - neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
 - Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
 - Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
 - a joint bank account;
 - a joint credit card or charge card;
 - joint obligation on a loan;
 - status as an authorized signatory on the partner's bank account, credit card or charge card;
 - joint ownership of holdings or investments;
 - joint ownership of residence;
 - joint ownership of real estate other than residence;
 - listing of both partners as tenants on the lease of the shared residence;
 - shared rental payments of residence (this need not be shared 50/50);
 - listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
 - a common household and shared household expenses, e.g. grocery bills, utility bills, telephone bills, etc. (this need not be shared 50/50);
 - shared household budget for purposes of receiving government benefits;

- status of one as representative payee for the other's government benefits;
- joint ownership of major items of personal property, e.g. appliances, furniture;
- joint ownership of a motor vehicle;
- joint responsibility for child care, e.g. school documents, guardianship;
- shared child-care expenses, e.g. babysitting, day care, school bills (this need not be shared 50/50);
- execution of wills naming each other as executor and/or beneficiary;
- designation as beneficiary under the other's life insurance policy;
- designation as beneficiary under the other's retirement benefits account;
- mutual grant of durable power of attorney;
- mutual grant of authority to make health care decisions, e.g. health care power of attorney;
- affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

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

HC-DFS778

07-14
V1

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7

04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8

04-10
V1

External Appeal Agent

The term External Appeal Agent means an entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

HC-DFS776

07-14
V1

Hospital

The term Hospital means:

A short term, acute, general Hospital, which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or Dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

HC-DFS775

07-14
V1

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 policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

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

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

HC-DFS421

04-10
V1

Medicaid

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

HC-DFS16

04-10
V1

Medicare

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

HC-DFS17

04-10
V1

Participating Provider

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

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

HC-DFS136

04-10
V1

Physician or Physician Services

The term Physician or Physician Services means health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

HC-DFS777

07-14
V1

