

State of Georgia

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2012

CN3217600E
0599978-01B

This document printed in July, 2012 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): No. 0599978-01

POLICYHOLDER: Trustee of the Cigna Dental Care/Options Trust

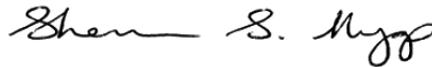
GROUP POLICY(S) — Dental Insurance

EMPLOYER: State of Georgia

Employer Account No. 3217600

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.



Shermona Mapp, Corporate Secretary

Explanation of Terms

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

Unless the context dictates otherwise, use of the male pronoun in this document will be deemed to include the female.

Notice Regarding Provider Directories and Provider Networks

This plan utilizes a network of dental care providers. You can access the list of providers who participate in the network by:

- visiting **www.cigna.com** or **www.mycigna.com**; or
- calling the following toll-free telephone number: **1-800-642-5810**

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by, or contracted with, CIGNA HealthCare or CIGNA Dental Health.

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.

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for (or change) coverage only during each Annual Enrollment Period. However, with the consent of your Employer, exceptions are allowed when you meet the criteria shown in the following Sections B through F.

B. Change of Status

If you choose single coverage upon your eligibility date, you may change to family coverage upon acquisition of a newly eligible Dependent (e.g., marriage, birth, adoption) within thirty (30) days of the event. The effective date of coverage for the Dependent(s) shall be the first of the month following the request date.

If you lose all eligible Dependents (e.g., death, divorce, child exceeding eligible age), you may change from family to single coverage within thirty (30) days of the event. If no change request is filed within the thirty days, a change will not be permitted until the next Annual Enrollment Period.

If you or your Dependent(s) lose dental coverage because the employment status of your spouse changes (e.g., due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence [including leaves that qualify under the Family and Medical Leave Act (FMLA)], or change in worksite), you may enroll in single or family coverage or change from single to family coverage within thirty (30) days of the event.

If your spouse gains coverage through a change of employment, you may change from family to single coverage, or discontinue family or single coverage within thirty (30) days following the event.

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 child cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

You must make your request for a change in your

coverage within thirty (30) days of such change in family status. If no change request is filed within thirty days, a change will not be permitted until the next Annual Enrollment Period.

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 child: (a) incurs a change, such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order, or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or Annual Enrollment Periods.

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Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee. You will be required to pay the cost of the insurance for yourself and your eligible Dependents.

Eligibility for Employee Insurance

You will become eligible for insurance on the date you complete the waiting period, if you are in a Class of Eligible Employees as follows:

- you are a full-time Employee of the State of Georgia (or of a State agency) working at least 30 hours per week on a continuous basis, and your employment is expected to last at least nine (9) months; or
- you are a public school teacher who is employed in a professionally certificated capacity, working 17.5 hours or more per week; or
- you are the Employee of a local school system, holding a non-certificated position, eligible to participate in the Teachers Retirement System, and working either: (a) at least

20 hours a week; or (b) 60% of the time necessary to carry out the duties of the position, if that is more than 20 hours per week; or

- you are an Employee who is eligible to participate in the Public School Employee Retiree System, and who works at least: (a) 15 hours per week; or (b) 60% of the time necessary to carry out the duties of the position, if that is more than 15 hours per week; or
- you are an Employee of a county or regional library working 17.5 hours or more per week; and
- you are otherwise deemed eligible by Federal or Georgia Law.

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

Initial Employee Group: You are in the Initial Employee Group if you are in the employ of an Employer on the Participation Date of the Employer.

New Employee Group: You are in the New Employee Group if your employment with an Employer starts after the Participation Date of that Employer.

Eligibility for Dependent Insurance

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

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

Waiting Period

A period of time ending on the first of the month following one full month of employment.

Classes of Eligible Employees

Each employee represents a class as they are reported to Cigna.

Coverage Effective Date - Employee

If you meet the conditions of insurability, your coverage under the policy shall become effective on the later of:

- The date you become eligible, provided you are Actively at Work. If you are not Actively at Work on that day, the coverage will begin on:
 - the date that you return to work; or
 - the date you become eligible, if it is your scheduled day off and you were Actively at Work on the preceding scheduled work day; or
- First day of the Plan Year following the initial Annual Enrollment Period, provided you are Actively at Work; or

- First day of the Plan Year following any Annual Enrollment Period subsequent to the initial Annual Enrollment Period, provided you are Actively at Work;
- For new hires, on the first day of the calendar month following one full month of employment.

Coverage Effective Date - Dependent

If you enroll for family coverage on your eligibility date, insurance for all your eligible Dependents shall be effective on the same date as your insurance. However, if any of your Dependents are confined in a Hospital or facility providing care or treatment for physical or mental infirmities on that date, insurance for such Dependent(s) shall become effective on the date following discharge or dismissal from the Hospital or facility.

If you do not enroll for family coverage on your eligibility date, you will be required to wait until the next Annual Enrollment Period to become covered [unless you qualify under the section of this document entitled, "Effect of Section 125 Tax Regulations on This Plan"]. Insurance for your eligible Dependents shall be effective on the first day of the Plan Year that next follows the end of the Annual Enrollment Period in which you elect it.

All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Annual Enrollment Period

The term Annual Enrollment Period means a defined period of time in each calendar year, as designated by the State of Georgia, during which you have an opportunity to change your benefit elections.

Plan Year

The term Plan Year (also referred to as Contract Year) refers to the period of time beginning each January 1st and ending on the following December 31st.

Choice of Dental Office

When you elect Employee Insurance, you may select a Dental Office from the list provided by CDH. If your first choice of a Dental Office is not available, you will be notified by CDH of your designated Dental Office, based on your alternate selection. You and each of your insured Dependents may select your own designated Dental Office. No Dental Benefits are covered unless the Dental Service is received from your designated Dental Office, referred by a Network General Dentist at that facility to a specialist approved by CDH, or otherwise authorized by CDH, except for Emergency Dental Treatment. A transfer from one Dental Office to another Dental Office may be requested by you through CDH. Any such transfer will take effect on the first day of the month after it is authorized by CDH. A transfer will not be authorized if

you or your Dependent has an outstanding balance at the Dental Office.

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Dental Benefits – CIGNA Dental Care

Your CIGNA Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you.

Member Services

If you have any questions or concerns about the Dental Plan, Member Services Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Member Services from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

Other Charges – Patient Charges

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change. CIGNA Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

Choice Of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise CIGNA Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in

the case of an emergency or when CIGNA Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Member Services at 1-800-Cigna24 for a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. Your Network General Dentist will provide care for children 7 years and older. If your child continues to visit the Pediatric Dentist after his/her 7th birthday, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, CIGNA Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at 1-800-Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Member Services.

Your Payment Responsibility (General Care)

For Covered Services provided by your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, CIGNA Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. CIGNA Dental will pay the non-Network Dentist the difference, if any, between his or her usual fee and the applicable Patient Charge.

See the *Specialty Referrals* section regarding payment responsibility for specialty care.

All contracts between CIGNA Dental and Network Dentists state that you will not be liable to the network dentist for any sums owed to the Network Dentist by CIGNA Dental.

Emergency Dental Care – Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive

bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

- **Emergency Care Away From Home**

If you have an emergency while you are out of your Service Area or unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. CIGNA Dental will reimburse you the difference, if any, between the dentist's usual fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to CIGNA Dental at the address listed for your state on the front of this booklet.

- **Emergency Care After Hours**

There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

Limitations On Covered Services

Listed below are limitations on services covered by your Dental Plan:

- **Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Specialty Care** – Except for Pediatric Dentistry and Endodontics, payment authorization is required for coverage of services performed by a Network Specialty Dentist.
- **Pediatric Dentistry** – Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 7th birthday.
- **Oral Surgery** – The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** - Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

General Limitations - Dental Benefits

No payment will be made for expenses incurred or services received:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without CIGNA Dental's prior approval (except in emergencies).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless the service is specifically listed on your Patient Charge Schedule (PCS). If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and

provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

- prescription drugs.
- procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. diagnose or treat conditions or disorders of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or if your Patient Charge Schedule ends in "-04" or higher; or c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or d. restore the occlusion.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- services associated with the placement, repair, removal, or prosthodontic restoration of a dental implant or any other services related to implants.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.
- the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.

- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- infection control and/or sterilization. CIGNA Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- services to correct congenital malformations, including the replacement of congenitally missing teeth
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.

In addition to the above, if your Patient Charge Schedule number ends in "-04" or a higher number, there is no coverage for the following:

- crowns and bridges used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered in your Patient Charge Schedule.

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

Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent break an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the

processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

Specialty Care

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the CIGNA Dental Network includes the following types of specialty dentists:

- Pediatric Dentists – children's dentistry.
- Endodontists – root canal treatment.
- Periodontists – treatment of gums and bone.
- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

Specialty Referrals

In General

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to CIGNA Dental for payment authorization, except for Pediatric Dentistry and Endodontics, for which prior authorization is not required. You should verify with the Network Specialist that your treatment plan has been authorized for payment by CIGNA Dental before treatment begins.

When CIGNA Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in the Orthodontics section. Treatment by the Network Specialist must begin within 90 days from the date of CIGNA Dental's authorization. If you are unable to obtain treatment within the 90-day period, please call Member Services to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if CIGNA Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Member Services.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a

Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialist is not available, as determined by CIGNA Dental, CIGNA Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. CIGNA Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

Orthodontics - (This section is only applicable if Orthodontia is listed on your Patient Charge Schedule.)

Definitions –

- **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.
- **Interceptive Orthodontic Treatment** – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- **Retention (Post Treatment Stabilization)** – the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

Patient Charges

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if banding/appliance insertion does not occur within 90 days of such visit; your treatment plan changes; or there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a prorated basis.

Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

- incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- orthognathic surgery and associated incremental costs;
- appliances to guide minor tooth movement;
- appliances to correct harmful habits; and
- services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Member Services at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown and bridge charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

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Coordination of Benefits

*Note: Under this plan, Coordination of Benefits provisions apply **only** to specialty care.*

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

Definitions

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

Plan

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

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

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

A Plan that determines its benefits after the benefits provided or paid by the Primary Plan (and that may reduce its benefits accordingly). A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If a person is covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If a person is covered by one Plan that provides services or supplies on the basis of reasonable and customary fees, and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If benefits for a person are reduced under the Primary Plan (through the imposition of a higher coinsurance percentage, a deductible, and/or a penalty) because he did not comply with Plan provisions, or because he did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and pre-authorization of services, as required.

Claim Determination Period

A plan year, but does not include any part of such a year during which a person is not covered under this policy (or any date before this section or any similar provision takes effect).

Reasonable Cash Value

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

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If a Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation will be utilized:

- The Plan that covers a person as an enrollee or an Employee shall be the Primary Plan, and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- For a Dependent child whose parents are not divorced, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or Employee;
- For the Dependent child of divorced or separated parents, benefits shall be determined in the following order:

- first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
- then, the Plan of the parent with custody of the child;
- then, the Plan of the spouse of the parent with custody of the child;
- then, the Plan of the parent not having custody of the child, and
- finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers a person as an active Employee (or as a Dependent thereof) shall be the Primary Plan, and the Plan that covers that person as laid-off or as a retired Employee (or as a Dependent thereof) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers a person under a right of continuation which is provided by federal or state law shall be the Secondary Plan, and the Plan that covers that person as an active or retired Employee (or as a Dependent thereof) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers an insured is governed by the laws of the state whose laws govern this Plan and that Plan determines the order of benefits based upon the gender of a parent and, as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

Effect on the Benefits of This Plan

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

Recovery of Excess Benefits

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

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any

insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

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

HC-COB58

04-10
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Expenses for Which a Third Party May Be Responsible

This Policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury, Sickness or condition. If you incur a Covered Dental Expense for which, in the opinion of Cigna, another party may be liable:

- (1) Cigna shall, to the extent permitted by law, be subrogated to all rights, claims, or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party, to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure Cigna's subrogation rights.
- (2) Alternatively, Cigna may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to Cigna the lesser of:
 - (a) the amount actually paid for such Covered Dental Expenses by Cigna; or
 - (b) the amount you actually receive from the third party for such Covered Dental Expenses;

at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award, or otherwise.

HC-SUB32

04-10
VI M

Facility of Payment

To Whom Payable

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

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

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

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

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

Recovery of Overpayment

When an overpayment has been made by CIGNA, CIGNA will have the right: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. Recovery of overpayment is limited to 18 months from the date the claim was paid. However, this 18 month time limit will not apply if the insured does not provide complete information, was not eligible for coverage or if material misstatements or fraud have occurred.

HC-POB41

04-10
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Miscellaneous

Certain Dental Offices may provide discounts on services not listed on the Patient Charge Schedule, including a 10% discount on bleaching services. You should contact your participating Dental Office to determine if such discounts are offered.

If you are a Cigna Dental plan member you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

HC-POB27

04-10
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Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or otherwise cease to qualify for the insurance.
- the last day of the calendar month following the month for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.
- the date you relocate to an area where the Dental plan is not offered.
- the date, as determined by Cigna, of a continuing lack of participating Dental Office in your area.
- the date upon a determination of fraud or misuse of dental services and/or dental facilities.

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

Temporary Layoff or Leave of Absence

Your insurance will cease on the date you are no longer Actively at Work, except that:

- while you are sick or injured, and in an approved, leave-without-pay period, your employment will be deemed to continue for up to 12 months from the date your disability began, as long as premium payments continue to be made on your behalf; and

- while you are on an approved leave of absence (except a leave of absence to enter military or naval service), your employment will be deemed to continue, as long as premium payments continue to be made on your behalf, for up to 12 months, unless your Employer cancels your insurance before the end of that time.

Injury or Sickness

If you are no longer Actively at Work 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, the insurance will not continue past the date your Employer stops paying premiums or the premium for you or otherwise cancels the insurance or premium payments.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the earlier of:

- the date you disenroll;
- your death;
- the date your annuity is insufficient to cover the required premium;
- the date on which your Employer cancels the insurance.

Dependents

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

- the date your insurance ceases, except when you die.
- the date you cease to be eligible for Dependent Insurance.
- the last day of the calendar month following the month for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.
- the date of a continuing lack of Participating Dental Facilities in your area (as determined by CG).

Insurance for any one of your Dependents will cease on:

- the date he or she no longer qualifies as a Dependent.
- the date of any determination of fraud or misuse, on your Dependent's part, of dental services and/or dental facilities.

Retiree and Surviving Dependents Continuation of Coverage

Employees who are eligible to participate and were enrolled in the dental option at the time of retirement on or after April 1, 1997, may be eligible for continuing their dental coverage through their retirement annuity.

The term *Retired Employee* means an Employee who:

- (1) was enrolled under the Flexible Benefits Program dental plan with continuous coverage on or after April 1, 1997; and
- (2) is eligible to receive an immediate and sufficient monthly benefit from the Employees' Retirement System, Legislative Retirement System, Teachers Retirement System, Public School Employees' Retirement System, Superior Court Judges Retirement System, or District Attorney's Retirement System; and
- (3) elects to participate in the Flexible Benefits Program dental plan as a retiree under one of the above retirement systems.

The term *Surviving Dependent* means a person who:

- (1) was covered as a Dependent spouse or child by an active or Retired Employee under the Flexible Benefits Program dental plan; and
- (2) is eligible as a beneficiary of the active or Retired Employee for an immediate and sufficient monthly benefit from the Employees' Retirement System, Legislative Retirement System, Teachers Retirement System, Public School Employees' Retirement System, Superior Court Judges Retirement System, or District Attorney's Retirement System; and
- (3) elects to participate in the Flexible Benefits Program dental plan as a Surviving Spouse/Dependent under one of the above retirement systems; and
- (4) is not otherwise eligible to participate in the Flexible Benefits Program dental plan as an active Employee, or as a Dependent Child covered under another active Employee.

Eligibility

To be eligible to enroll in the dental plan as a Retired Employee or Surviving Dependent, you must meet the definition above of a Retired Employee or Surviving Dependent, and have been continuously covered (with no lapse in coverage) under the Flexible Benefits Program dental plan. Upon the initial enrollment as a Retired Employee or Surviving Spouse/Dependent, the following changes are allowed:

Change of Dental Option. A change of dental option means a transfer to or from: (a) the dental Preferred Provider Organization (PPO); (b) the regular dental option; or (c) the dental HMO.

- At the time of enrollment, a transfer may be made to any option. To enroll in the PPO option, a person must live in the metropolitan Atlanta, Augusta, Macon, Savannah, or Valdosta areas, or have a PPO available in their area. To

enroll in the dental HMO option, a person must live in the metropolitan Atlanta area.

- If a person relocates from a PPO or dental HMO service area, a change from the PPO or dental HMO option to the regular dental insurance option is permitted. However, once a change is made, re-enrollment in the PPO or dental HMO option is not permitted.

Change of Dental Coverage Type. A change of dental coverage type means a change between single and family coverage. The following changes are allowed:

- A change from family to single dental coverage is allowed, upon request.
- retirees are allowed to change from single to family dental coverage upon acquisition of a Dependent by marriage, birth, adoption, or for certain other changes in family status, provided the request is within 30 days following the event. Surviving Dependents cannot change from single to family dental coverage.

A surviving spouse of a deceased Employee enrolled in the dental plan may elect dental coverage as a surviving Dependent spouse; or, if the spouse is an active Employee, through payroll reduction. The surviving Dependent spouse cannot elect dual coverage under this plan.

Upon death of an active or retired Employee, an eligible surviving Dependent child who was insured under the family dental plan and is the principal beneficiary under one of the retirement systems may continue coverage, until such time as he or she no longer meets the eligibility requirements.

The Dependent child may *not* be insured under the retiree dental provision if he or she is: (a) insured as a Dependent child under another active or retired Employee; or (b) eligible as an active Employee.

A surviving Dependent will be eligible for dental deductions **only** if he or she is receiving an immediate and sufficient benefit from an eligible retirement system. If the annuity is insufficient, the surviving Dependent will be eligible for continuing coverage under the "Temporary Coverage Continuation."

HC-TRM72

04-10
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Dental Benefits Extension

A Dental Service that is completed after a person's benefits cease will be deemed to be completed while he is insured, if:

- for fixed bridgework and full or partial dentures, the final impressions are taken and/or abutment teeth fully prepared

while he is insured, and the prosthesis inserted 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.
- for orthodontic services, the treatment commences while the person is insured, and the expenses are incurred within 60 days after his insurance ceases.

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

This extension of benefits does not apply if insurance ceases due to nonpayment of premiums.

HC-BEX38

04-10

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Dental Conversion Privilege

Any Employee or Dependent whose Dental Insurance ceases for a reason other than failure to pay any required contribution or cancellation of the policy may be eligible for coverage under another Dental Insurance Policy underwritten by Cigna; provided that: he applies in writing and pays the first premium to Cigna within 31 days after his insurance ceases; and he is not considered to be overinsured.

CDH or Cigna, as the case may be, or the Policyholder will give the Employee, on request, further details of the Converted Policy.

Conversion is not available if your insurance ceased due to:

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

HC-CNV2

04-10

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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 document, the provision which results in the richer benefit will apply.

HC-FED1

10-10 /M

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with CIGNA HealthCare or CIGNA Dental Health.

HC-FED2

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.

You must notify your Employer and elect coverage for that child (and yourself, if you are not already enrolled) within 30 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree, 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 health benefit coverage to such child, 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, 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 M

Eligibility for Coverage for Adopted Children

Any child under the age of 26 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance 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-FED8

10-10 M

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 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 Dental Insurance During Leave

Your dental 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 dental insurance during such leave must be paid, whether entirely by your Employer; in part by you and your Employer; or entirely by you.

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 dental insurance 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 it 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-FED17

10-10 M

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.

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 Pre-Existing Condition Limitation (PCL) or 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.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

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

Continuation Rights Under Federal Law (COBRA)

For You and Your Dependents

You will receive this notice because you have recently become covered under the Dental HMO Plan for the State of Georgia Flexible Benefits Program (the Plan). This notice contains important information about your right under federal mandate to a temporary extension of coverage under the Plan. The right to continuation coverage was created by a federal law called the "Consolidated Omnibus Budget Reconciliation

Act of 1985" (and referred to as "COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are insured under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under COBRA, you should contact your Flexible Benefits Program Administrator ("Program Administrator").

The Program Administrator's address is:

State of Georgia
P.O. Box 0549
Carol Stream, IL 60132-0549

The Program Administrator is responsible for administering COBRA continuation coverage.

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, same sex spouses, 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.

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for Trade Adjustment Assistance (TAA) and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (referred to herein as “eligible individuals”). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for Trade Adjustment Assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” provisions above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Interaction With Other Continuation Benefits

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

HC-FED37

04-12 M

Notice of an Appeal or a Grievance

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

HC-SPP4

04-10

V1 M

The Following Will Apply To Residents of Georgia:

When You Have A Complaint Or An Appeal

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

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

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free telephone number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call us (or write to us) at the following:

Customer Services Toll-Free telephone number (or address that appears on your benefit identification card, explanation of benefits [EOB], or claim form)

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

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

Appeals Procedure

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

Level-One Appeal

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

For level-one appeals, we will respond, in writing, with a decision within 30 calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the determination, we will

notify you, in writing, to request an extension of up to 15 calendar days, and to specify any additional information needed to complete the review.

Level Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To start a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decisions may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will include at least one Dentist reviewer in the same (or a similar) specialty as the care under consideration, as determined by CG's Dentist reviewer, and will include one Dentist other than CG's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals, we will acknowledge, in writing, that we have received your request, and schedule a Committee review. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you, in writing, to request an extension of up to 15 calendar days, and to specify any additional information needed by the Committee to complete the review. You will be notified, in writing, of the Committee's decision within five (5) working days after the Committee meeting; and within the Committee review time frames above, if the Committee does not approve the requested coverage.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The request for independent review may be submitted only by an insured, the parent or guardian of an insured who is a minor, or a legal guardian or representative of an insured who is incapacitated. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

In order to request a referral to an Independent Review Organization, certain conditions apply: the cost of the service must be \$500 or more; you must have exhausted the above Appeals procedures and remain dissatisfied; the reason for the

denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna; the proposed treatment is excluded as experimental, and you have a terminal condition with a substantial probability of causing death within two years or impairing your ability to regain or maintain maximum function; the standard treatments have been exhausted and the treating Physician certifies that there is no standard treatment available under this certificate more beneficial than the proposed treatment; the treating Physician has certified in writing the treatment is likely to be more beneficial than any available standard treatment; and the treating Physician has certified in writing that scientifically valid studies demonstrate that the proposed treatment is likely to be more beneficial to you than available standard treatment. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must complete the written request form and forward it to the Georgia state planning agency. The planning agency will select an independent review organization to review the issue and the Independent Review Organization will make a determination that is binding upon Cigna.

The Independent Review Organization will render an opinion within 15 working days following receipt of necessary information. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Dentist reviewer, the review shall be completed within 72 hours of receipt of all necessary information.

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

Appeal to the State of Georgia

You have the right to contact the Department of Insurance or the Department of Human Resources for assistance at any time.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided, in writing or electronically, and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) 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; (4) a statement describing any voluntary appeal procedures offered by the plan; (5) 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 (6) an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment, or other similar exclusion or limit.

You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to determine what options may be available to you is to contact your local U.S. Department of Labor office, or your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

"Relevant Information" refers to any document, record, or other information which: (a) was relied upon in making the benefit determination; (b) 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; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) 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

In most instances, you may not initiate a legal action against CG in federal court 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-APL52

04-10
VI

Definitions

Active Service

You will be considered in Active Service if:

- you are able to do the normal tasks of your job on a full-time basis for a full work day on the date your insurance is scheduled to become effective; and
- you are able to do such tasks at one of your Employer's normal places of business, or at a location to which you must travel to do your job; and
- you are not absent from work due to Sickness, disability, or temporary lay-off.

HC-DFS1

04-10
VI

Adverse Determination

An Adverse Determination is a decision made by Cigna Dental that it will not authorize payment for certain limited

specialty care procedures. Any such decision will be based on the necessity or appropriateness of the care in question. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and must meet the following requirements. It must:

- be consistent with the symptoms, diagnosis or treatment of the condition present;
- conform to commonly accepted standards of treatment;
- not be used primarily for the convenience of the member or provider of care; and
- not exceed the scope, duration or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the member at the dentist's Usual Fees.

HC-DFS350 04-10
V1

**Cigna Dental Health
(herein referred to as CDH)**

CDH is a wholly-owned subsidiary of Cigna Corporation that, on behalf of Cigna, contracts with Participating General Dentists for the provision of dental care. CDH also provides management and information services to Policyholders and Participating Dental Facilities.

HC-DFS352 04-10
V1

Contract Fees

Contract Fees are the fees contained in the Network Specialty Dentist agreement with Cigna Dental which represent a discount from the provider's Usual Fees.

HC-DFS353 04-10
V1

Covered Services

Covered Services are the dental procedures listed in your Patient Charge Schedule.

HC-DFS354 04-10
V1

Dental Office

Dental Office means the office of the Network General Dentist(s) that you select as your provider.

HC-DFS355 04-10
V1

Dental Plan

The term Dental Plan means the managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

HC-DFS356 04-10
V2

Dentist

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

HC-DFS125 04-10
V1

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
 - less than 26 years old;
 - 26 years old or older, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 30 days after the date the child ceases to qualify above. During the next two years, CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

The term "child" includes a legally adopted child from the first day of placement in your home, regardless of whether the adoption has become final. It also includes a foster child or stepchild who lives with you.

Benefits for a Dependent child will continue until the end month in which the birthday occurs.

HC-DFS201 04-10
V1 M

Employee

The term Employee means a person who:

- is a full-time employee of the State of Georgia, or a State Agency. "Full-time" means someone who works at least 30 hours a week, on a continuous basis, and whose employment is expected to last at least nine (9) months. [The following are certain categories of employees specifically excluded: student, seasonal, part-time, short-term and sheltered workshop]; or
- is a public school teacher who is employed in a professionally certificated capacity working 17.5 hours or more per week.
- is an employee of a local school system who holds a non-certificated position and who is eligible to participate in the Teachers Retirement System or its equivalent and working at least 20 hours a week (or 60% of the time necessary to carry out the duties of the position if that's more than 20 hours); or
- is an employee who is eligible to participate in the Public School Employee Retirement System as defined by 20 of Section 47-4-2 of the Official Code of Georgia, Annotated and who works at least 15 hours a week (or 60% of the time necessary to carry out the duties of the position); or
- is an employee of a county or regional library and working at least 17.5 hours or more; or
- is deemed eligible by Federal or Georgia state law.

HC-DFS7 04-10
V3 M

Employer

The terms Employer and Participating Employer refer to any Employer who has signed a Request for Participation in the Tennessee CIGNA Dental Care/Options Trust and whose request has been approved by the Insurance Company. These terms also include Affiliated Employers. "Affiliated Employers" are those Employers specified as affiliated employers in the Participating Employer's Request for Participation, in accordance with its terms.

HC-DFS8 04-10
V1 M

Group

The term Group means the Employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

HC-DFS357 04-10
V1

Medicaid

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

HC-DFS16 04-10
V1 M

Medicare

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

HC-DFS17 04-10
V1

Network General Dentist

A Network General Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide general dental care services to plan members.

HC-DFS358 04-10
V1

Network Specialty Dentist

A Network Specialty Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide specialized dental care services to plan members.

HC-DFS359 04-10
V1

Participation Date

The term Participation Date means the later of:

- the Effective Date of the policy; or

- the date on which your Employer becomes a participant in the plan of insurance authorized by the agreement of Trust.

HC-DFS18 04-10
V1

Patient Charge Schedule

The Patient Charge Schedule, provided by CDH, is a separate list of covered services and amounts payable by you.

HC-DFS360 04-10
V1 M

Service Area

The Service Area is the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

HC-DFS361 04-10
V1

Specialist

The term Specialist means any person or organization licensed as necessary: who delivers or furnishes specialized dental care services; and who provides such services upon approved referral to persons insured for these benefits.

HC-DFS362 04-10
V1

Subscriber

The subscriber is the enrolled employee or member of the Group.

HC-DFS363 04-10
V1

Usual Fee

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

HC-DFS138 04-10
V1