GLOBAL DENTAL

TRADITIONAL DENTAL COVERAGE

EFFECTIVE DATE: January 1, 2025

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05180A
409541

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your employer. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your employer or Cigna.

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Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

Cigna Health and Life Insurance Company

a CIGNA company (called CIGNA) certifies that it, provides coverage for certain Employees for the benefits provided by the following plan(s):

GROUP PLAN(S) — COVERAGE
05180A TRADITIONAL DENTAL COVERAGE

EFFECTIVE DATE: January 1, 2023

This certificate describes the main features of the coverage.
This certificate takes the place of any other issued to you on a prior date which described the coverage.

Shermona Mapp, Corporate Secretary

GM6000 C2 **CER7V23**

IMPORTANT INFORMATION

THE BENEFITS PROVIDED UNDER (THE "PLAN") ARE PROVIDED BY (THE "COMPANY") AND ARE PAID FROM THE GENERAL ASSETS OF THE COMPANY. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES, ONLY TO THE PLAN, CIGNA DOES NOT COVER THE BENEFITS DESCRIBED HEREIN.

THE COMPANY RESERVES THE RIGHT AT ANY TIME AND FOR ANY REASON TO TERMINATE, SUSPEND, WITHDRAW, AMEND OR MODIFY THE PLAN OR ANY OF ITS PROVISIONS. IF ANY MATERIAL CHANGES ARE MADE IN THE FUTURE, YOU WILL BE NOTIFIED.

PLEASE BE AWARE THAT THE COVERAGE HEREUNDER MAY BE PROHIBITED OR UNADVISABLE IN CERTAIN COUNTRIES. THE COMPANY MAY BE ABLE TO PROVIDE INFORMATION OR ASSISTANCE IN THIS REGARD, BUT THE COMPANY IS NOT IN A POSITION TO PROVIDE LEGAL ADVICE TO EMPLOYERS OR EMPLOYEES IN SUCH COUNTRIES.

Explanation of Terms

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

The Schedule

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

How To File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim form at www.cignaenvoy.com or from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing Cigna Service Center.

Depending on your Group Coverage benefits, file your claim forms as described below.

Dental Expenses

The first Dental Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS:

- BE SURE TO USE YOUR EMPLOYEE ID WHEN YOU FILE CIGNA CLAIM FORMS, OR WHEN YOU CALL THE CIGNA SERVICE CENTER.
- YOUR EMPLOYEE ID AND ACCOUNT NUMBER ARE BOTH SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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CLA3V15

Claims Provisions

Claims

Notice of Claim

Written notice of claim must be given to CIGNA within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CIGNA receives the notice of claim, it will give to the claimant, or to the Company for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CIGNA receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CIGNA within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CIGNA, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

Where CIGNA has followed the terms of the Plan, no action at law or in equity will be brought to recover on the Plan until at least 60 days after proof of loss has been filed with CIGNA. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

GM6000 CLA43V6

Eligibility - Effective Date

Eligibility for Employee Coverage

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

- you are an active, full-time employee (as defined by your Employer) earning wages from an Employer that offers Plan coverage to one or more Classes of Eligible Employees.
- you normally work at least 20 hours a week.

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

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

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

Eligibility for Dependent Coverage

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

- the day you become eligible for yourself; or

- the day you acquire your first Dependent.

Waiting Period
As determined by your Employer.

Classes of Eligible Employees

The following Classes of Employees are eligible for this coverage:

All full-time U.S. Expatriate and Retirees as identified by the company.

"Expatriate" means an Employee who is working outside his country of citizenship.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this plan.

GM6000 EL 2V-31
ELI5

Employee Coverage

This Plan is offered to you as an Employee. To be covered, you will have to pay part of the cost.

Effective Date of Your Coverage

You will become covered on the date you elect the coverage by signing an approved enrollment form, but no earlier than the date you become eligible.

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

GM6000 EF 1
ELI7V82

Dependent Coverage

For your Dependents to be covered, you will have to pay part of the cost of Dependent Coverage.

Effective Date of Dependent Coverage

Coverage for your Dependents will become effective on the date you elect it by signing an approved enrollment form, but no earlier than the day you become eligible for Dependent Coverage. All of your Dependents as defined will be included.

Covered Dental Expense

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

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

GM6000 DEN160

Alternate Benefit Provision

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

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

Predetermination of Benefits

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

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

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

Review of proposed treatment is advised whenever extensive dental work is recommended that exceeds $500 in charges.

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

GM6000 DEN161

Missing Teeth Limitation

The amount payable for the replacement of teeth that are missing when a person first becomes covered is 50% of the

amount payable for the replacement of teeth that are extracted after a person has dental coverage.

This payment limitation no longer applies after 24 months of continuous coverage.

GM6000 DEN165

Covered Services

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

Payment for a covered service is the Maximum Reimbursable Charge times the benefit percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the balance of the provider's actual charge.

GM6000 DES425

Class I Services – Diagnostic And Preventive

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

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

Bitewing X-rays – Only 1 charge per person per calendar year.

Prophylaxis (Cleaning) – Only 2 per person per calendar year.

Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.

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

Topical application of sealant, per tooth, on a posterior tooth – Only one treatment per person per 3 calendar years through the age of 14.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

GM6000 DES297V5

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

Amalgam Filling

Composite/Resin Filling

X-rays – Complete series – Only one per person per 5 calendar years.

Panoramic (Panorex) X-ray – Only one per person per 5 calendar years.

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

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

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

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

Recement Bridge

Routine Extractions

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

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

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

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

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

GM6000 DES298V7

Class III Services - Major Restorations, Dentures and Bridgework

High Noble Metal (gold) or Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Crowns

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Fixed or Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

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

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

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

GM6000 DES302V5

Dental Expenses Not Covered

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

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

GM6000 DEN183

- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- services for which benefits are not payable according to the "General Limitations" section.

GM6000 DEN186

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one plan and determines how benefits payable from all such plans will be coordinated. For claims incurred within the United States, you should file all claims under each plan. For claims incurred outside the United States, if you file claims with more than one plan, you must indicate, at the time of filing a claim under this Plan, that you also have or will be filing your claim under another 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:

(1) Group coverage whether insured or self-insured which neither can be purchased by the general public, nor is

individually underwritten, including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.

(3) 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 provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

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

Secondary Plan

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

GM6000 COB11

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles or coinsurance 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 you are confined to a private Hospital room and no Plan provides coverage for more than a semi-private room, the difference in cost between a private and semi-private room is not an Allowable Expense;
- if you are covered by two or more plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense;
- if you are covered by one plan that provides services or supplies on the basis of reasonable and customary fees and one plan that provides services and supplies on the basis of negotiated fees, the Primary plan's fee arrangement shall be the Allowable Expense;
- if your benefits are reduced under the Primary plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

GM6000 COB12

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

(1) The Plan that covers you as an enrollee or an employee shall be the Primary plan and the Plan that covers you as a Dependent shall be the Secondary plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) 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;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the Spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the

child; and

(e) finally, the Plan of the Spouse of the parent not having custody of the child.

GM6000 COB13

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary plan. If the other plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply;

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply;

(6) If one of the plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

When coordinating benefits with Medicare, this Plan will be the Secondary plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

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.

GM6000 COB14

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.

GM6000 COB15

Expenses For Which A Third Party May Be Liable

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered 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 Expenses by CIGNA; or
    b. the amount you actually receive from the third

party for such Covered Expenses;

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

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CCL7

Payment of Benefits – Dental Benefits

To Whom Payable

All Dental Benefits are payable to you. However, at the option of CIGNA and with the consent of the Company, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

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.

If you die while any of these benefits remain unpaid, CIGNA may choose to make direct payment to any of your following living relatives: Spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

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

Time of Payment

Benefits will be paid by CIGNA when it receives due proof of loss.

Recovery of Overpayment

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

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Termination of Coverage

Employees

Your coverage will end if any one of these things happens:

- You no longer work as an active, full-time employee for the Employer that offers Plan coverage.
- You retire and your Employer does not offer Plan coverage to its retirees.
- The Company or your Employer stops offering the Plan.
- Required contributions are not paid when due. Your Employee coverage will not end just because You do not pay contributions for Dependents coverage.
- You are eligible for Medicare and Medicare pays first before this Plan pays. See the "Coordination of Benefits" section.

If You are no longer an active full-time employee, check with your Employer at once to find out if You can continue your Plan coverage.

Dependents

Your dependents will lose coverage if any one of these things happens:

- You lose your Coverage for any reason except that You became eligible for Medicare coverage.
- Your Spouse or Child is no longer an Eligible Dependent.
- The Company or your Employer stops offering the Plan.
- Your Employer stops offering coverage to dependents.
- Required contributions are not paid when due.
- Your Spouse or Child becomes eligible for Medicare and Medicare pays first.

If your dependents lose coverage for any reason, call your Employer at once to find out if they can continue coverage.

A. Important Notice Requirement

You must report changes to coverage eligibility for You and your Covered Dependents immediately. Failure to report could be interpreted as fraud or intentional misrepresentation as provided by the federal healthcare reform law known as the Affordable Care Act (ACA). Policies and procedures have been adopted incorporating ACA guidance. You may make unnecessary contribution payments that may not be refundable in accordance with those policies and procedures, and your coverage may be subject to rescission.

B. Continued Coverage for Covered Dependents after Your Death

If You die while covered under the Plan, your Covered Dependents may continue their Plan coverage. This continued coverage will end when any one of these things happens:

Your dependent is no longer an Eligible Dependent.

Your dependent becomes eligible for benefits under any other group medical plan.

The Plan stops offering Dependents Coverage.

Your Employer or the Plan stops offering group medical plans.

Required contributions are not paid when due.

Your Spouse or Child becomes covered under Medicare and Medicare pays first.

C. Continuation Coverage for You and Your Covered Dependents

Some Employers allow You and your Covered Dependents to continue Plan coverage after it would otherwise end. This applies only if the following are true:

- Your Employer elects to offer Continuation Coverage.
- Your Employer continues to offer Plan coverage to its employees.
- You were not fired for gross misconduct, as determined by your Employer.
    - The maximum length of Continuation Coverage is:
    - 18 months for You and your Covered Dependents if the loss of Plan coverage is because You either lost your job or You work fewer than the hours required for active, full-time employment.
    - 36 months for your Spouse or Covered Dependent Child if the loss of Plan coverage is due to You and your Spouse's divorce or legal separation, or your Covered Dependent Child is no longer an Eligible Dependent.

Enrollment for Continuation Coverage. If You want Continuation Coverage, You or your Covered Dependents must:

- Get an application and other information about this coverage from your Employer.
- Apply for Continuation Coverage within 60 days after the date Plan coverage would otherwise end.

Adding Eligible Dependents to your Continuation Coverage. You may add a newborn or an adopted Child to your Continuation Coverage within 60 days after birth, adoption or placement in your home. Also, if You get married, You may add your new Spouse and any new Eligible Dependents to your Continuation Coverage within 60 days after your marriage.

You must act promptly. If You do not, You and your dependents will not be eligible for this Continuation Coverage.

Charges for Continuation Coverage. The monthly charge for Continuation Coverage will be up to 102% of the full cost of each Covered Person's Plan coverage. Your Employer is responsible for collecting monthly charges. **You must pay these costs of coverage when due, or your Continuation Coverage will end.**

Early termination of Continuation Coverage. Continuation Coverage will end sooner than the 18 or 36 months if:

- Costs of coverage are not paid when due.
- The Covered Person becomes covered under other group medical coverage, either as an employee or dependent.
- The Covered Person becomes eligible for Medicare.
- The Plan is no longer offered.

Dental Benefits Extension

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

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

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

Federal Requirements

The following pages explain your rights and responsibilities under this Plan of benefits pursuant to United States federal laws and regulations. Some states may have similar requirements. If a similar applicable provision appears elsewhere in this booklet, the provision which provides the better benefit will apply. Generally speaking, the following mandates are only applicable if you are a United States citizen or permanent U.S. resident. They generally and/or specifically may not apply to non-U.S. citizens or residents, nonresident aliens, nonresident aliens with no U.S. sourced income, or other foreign nationals.

FDRL1

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

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

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled.

B. Qualified Medical Child Support Order Defined

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

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. 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;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. 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 plan to provide coverage for any type or form of benefit or option not otherwise provided under the plan, except that an order may require a plan to comply with State laws regarding such coverage.

C. Payment of Benefits

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

FDRL2

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

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

A. 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 contributions 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 Plan cancels.

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

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.

B. 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 re-employed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

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

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

FDRL58

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; and "Physician reviewers" are licensed Physicians or licensed Dentists depending on the care, treatment or service under review.

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 number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please write to us at the following address:

Cigna
ATTN: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

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 our toll-free number or write to us at the address above.

GM6000 APL330

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 fifteen calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. CIGNA's Dentist reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

GM6000 APL758

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 decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by CIGNA'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 required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice 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 working days after the Committee

meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

GM6000 APL759

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 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 reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CIGNA. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CIGNA's level-two appeal review denial. CIGNA will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CIGNA's Physician or Dentist reviewer, the review shall be completed within 3 days.

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

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 and the claimant's right to bring an action under ERISA section 502(a); (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 an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

Relevant Information

Relevant Information is 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

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

GM6000 APL334

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business

or at some location to which you are required to travel for your Employer's business.

- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1

Coinsurance

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

DFS17

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 Plan.

DFS24

Dependent

Dependents are:

- your Spouse of the opposite sex to whom you were married in a civil or religious ceremony as defined in this plan booklet and
- any child of yours
  - through the end of the month in which they reach age 26.
  - age 26 or over and 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 CIGNA within 31 days after the date the child ceases to qualify above. During the next two years CIGNA may, from time to time, require proof of the continuation of such condition and dependence. After that, CIGNA may require proof no more than once a year.
- Your child means:
  - Your or your Spouse's natural (biological) child.
  - Your or your Spouse's legally adopted child or a child placed in your home for adoption.
  - Your or your Spouse's stepchild or foster child.
  - Your or your Spouse's grandchild who is dependent on you for support and maintenance.
  - A child for whom you or your Spouse must provide health care by court order or order of a state agency authorized to issue National Support Notices under federal law.
  - A child for whom you or your spouse are legal guardian or managing conservator

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

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

Employee

The term Employee means a full-time employee as defined by the employer of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

DFS1427

Employer

The term Employer means the entity you work for or which sponsors you and that makes this Plan available to you.

DFS212

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Injury

The term Injury means an accidental bodily injury.

DFS147

Maximum Reimbursable Charge

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

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

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

The Maximum Reimbursable Charge is subject to all other

benefit limitations and applicable coding and payment methodologies determined by CIGNA. Additional information about how CIGNA determines the Maximum Reimbursable Charge is available upon request.

DFS1997

Review Organization

The term Review Organization refers to an affiliate of CIGNA or another entity to which CIGNA has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

DFS1688

Spouse.

A person of the opposite sex to whom you are married at the relevant time by a religious or civil ceremony effective under the laws of the state in which the marriage was contracted.