

SERFF Tracking Number: CCGH-126836862 State: Arkansas
 Filing Company: CIGNA Health and Life Insurance Company State Tracking Number: 47047
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Managed Dental Benefits
 Project Name/Number: CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC/

Filing at a Glance

Company: CIGNA Health and Life Insurance Company

Product Name: Group Managed Dental Benefits SERFF Tr Num: CCGH-126836862 State: Arkansas

TOI: H10G Group Health - Dental SERFF Status: Closed-Approved- State Tr Num: 47047
 Closed

Sub-TOI: H10G.000 Health - Dental Co Tr Num: State Status: Approved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Kathryn Graywacz, Debbie Kingsley, Dewey Post
 Disposition Date: 11/08/2010

Date Submitted: 10/14/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Employer, Association, Trust

Filing Status Changed: 11/08/2010

Explanation for Other Group Market Type:

State Status Changed: 11/08/2010

Deemer Date:

Created By: Dewey Post

Submitted By: Dewey Post

Corresponding Filing Tracking Number:

Filing Description:

We are submitting for your review and approval, new Dental Master Policy and Master Certificate form series for use with CIGNA Health and Life Insurance Company.

The proposed Master Policy documents (the HP form series) and Master Certificate documents (the HC form series) are presented to you as an insert page matrix of forms.

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These forms do not replace any forms currently on file with your department.

Company and Contact

Filing Contact Information

Dewey Post, dewey.post@cigna.com
 900 Cottage Grove Road 860-226-6258 [Phone]
 B6LPA 860-226-5400 [FAX]
 Hartford, CT 06152

Filing Company Information

CIGNA Health and Life Insurance Company	CoCode: 67369	State of Domicile: Connecticut
900 Cottage Grove Road	Group Code: 901	Company Type: LAH
Bloomfield, CT 06002	Group Name:	State ID Number:
(860) 226-6000 ext. [Phone]	FEIN Number: 59-1031071	

Filing Fees

Fee Required? Yes
 Fee Amount: \$2,400.00
 Retaliatory? Yes
 Fee Explanation: 48 forms X \$50 each = \$2,400.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
CIGNA Health and Life Insurance Company	\$2,400.00	10/14/2010	40716773

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/08/2010	11/08/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	11/01/2010	11/01/2010	Dewey Post	11/05/2010	11/05/2010

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Disposition

Disposition Date: 11/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document (revised)	Forms Listing	Approved-Closed	Yes
Supporting Document	Forms Listing	Replaced	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Policy	Approved-Closed	Yes
Form	Policy Application	Approved-Closed	Yes
Form	Policy Amendment – General Use	Approved-Closed	Yes
Form	HC-RDR1	Approved-Closed	Yes
Form	Table of Contents	Approved-Closed	Yes
Form	Certification	Approved-Closed	Yes
Form	Special Plan Provisions Appeals	Approved-Closed	Yes
Form	Important Notices	Approved-Closed	Yes
Form	Eligibility – Effective Date	Approved-Closed	Yes
Form	Important Information About your Dental Plan – CDO/FlexAdvantageExtra	Approved-Closed	Yes
Form	Dental Covered Services Payment Formula	Approved-Closed	Yes
Form	Dental Covered Services Class I (Preventive & Diagnosis)	Approved-Closed	Yes
Form	Dental Covered ServicesDental Covered Services Class II (Basic Restorative Services)	Approved-Closed	Yes
Form	Dental Covered Services Class III(Major Restorative Services)	Approved-Closed	Yes
Form	Dental Covered Services Class IV (Orthodontia)	Approved-Closed	Yes
Form	Dental Conversion Privilege	Approved-Closed	Yes
Form	Coordination of Benefits	Approved-Closed	Yes
Form	Conditional Claim Payment	Approved-Closed	Yes
Form	Payment of Benefits	Approved-Closed	Yes
Form	Payment of Benefits Dental Misc. & OHIP	Approved-Closed	Yes
Form	Termination of Insurance	Approved-Closed	Yes
Form	Dental Benefits Extension	Approved-Closed	Yes
Form	When You Have a Complaint or Appeal	Approved-Closed	Yes
Form	Active Service	Approved-Closed	Yes

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 Project Name/Number: CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC/

Form	Adverse Determination	Approved-Closed	Yes
Form	CIGNA Dental Health	Approved-Closed	Yes
Form	Contract Fees	Approved-Closed	Yes
Form	Covered Services	Approved-Closed	Yes
Form	Dental Office	Approved-Closed	Yes
Form	Dental Plan	Approved-Closed	Yes
Form	Dentist	Approved-Closed	Yes
Form (revised)	Dependent	Approved-Closed	Yes
Form	Dependent	Approved-Closed	Yes
Form	Domestic Partner	Approved-Closed	Yes
Form	Employee	Approved-Closed	Yes
Form	Employer	Approved-Closed	Yes
Form	Employer Trustee	Approved-Closed	Yes
Form	Group	Approved-Closed	Yes
Form	Maximum Reimbursable Charge	Approved-Closed	Yes
Form	Medicaid	Approved-Closed	Yes
Form	Medicare	Approved-Closed	Yes
Form	Network General Dentist	Approved-Closed	Yes
Form	Network Specialty Dentist	Approved-Closed	Yes
Form	Participation Date (Trustee)	Approved-Closed	Yes
Form	Patient Charge Schedule	Approved-Closed	Yes
Form	Service Area	Approved-Closed	Yes
Form	Specialist	Approved-Closed	Yes
Form	Subscriber	Approved-Closed	Yes
Form	Usual Fee	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/01/2010

Submitted Date 11/01/2010

Respond By Date

Dear Dewey Post,

This will acknowledge receipt of the captioned filing.

Objection 1

- Dependent, HC-DFS126 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 11/05/2010
 Submitted Date 11/05/2010

Dear Rosalind Minor,

Comments:

Thank you for your comment dated 11/1/2010, I have responded below.

Response 1

Comments: Please note the new definition HC- DFS392 replaces the existing HC-DFS126, I have deleted the reference to time limits for proof of incapacity per your request. I have also recorded this change in the new attached forms list.

Related Objection 1

Applies To:

- Dependent, HC-DFS126 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Forms Listing

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Dependent	HC-DFS392		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		50.350	HC-DFS392.pdf

Previous Version

<i>SERFF Tracking Number:</i>	<i>CCGH-126836862</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Managed Dental Benefits</i>		
<i>Project Name/Number:</i>	<i>CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC/</i>		
<i>Dependent</i>	<i>HC-DFS126</i>	<i>Certificate Amendment, Initial Insert Page, Endorsement or Rider</i>	<i>50.350 HC-DFS126.pdf</i>

No Rate/Rule Schedule items changed.

Thank you for your time with this submission.

Sincerely,
 Debbie Kingsley, Dewey Post, Kathryn Graywacz

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/08/2010	HP-POL120	Policy/Cont ract/Fratern al Certificate	Policy	Initial		50.350	POL120 AR-CDC.pdf
Approved-Closed 11/08/2010	HP-APP-1	Application/ Enrollment Form	Policy Application	Initial		50.350	HP-APP-1 cat # 831494 (Generic).pdf
Approved-Closed 11/08/2010	HP-AMD1	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Policy Amendment – General Use	Initial		50.350	HP-AMD1 _General Amendment for Policy Revisions_.pdf
Approved-Closed 11/08/2010	HC-RDR1	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	HC-RDR1	Initial		50.350	HC-RDR1.pdf
Approved-Closed 11/08/2010	HC-TOC6	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Table of Contents	Initial		50.350	HC-TOC6.pdf
Approved-Closed 11/08/2010	HC-CER18	Certificate Amendmen t, Insert	Certification	Initial		50.350	HC-CER18.pdf

<i>SERFF Tracking Number:</i>	<i>CCGH-126836862</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Managed Dental Benefits</i>		
<i>Project Name/Number:</i>	<i>CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC/</i>		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-SPP4	Certificate Special Plan	Initial	50.350
Closed	Amendmen Provisions Appeals		
11/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-IMP70	Certificate Important Notices	Initial	50.350
Closed	Amendmen		
11/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-ELG4	Certificate Eligibility – Effective	Initial	50.350
Closed	Amendmen Date		
11/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-IMP74	Certificate Important Information	Initial	50.350
Closed	Amendmen About your Dental		
11/08/2010	t, Insert Plan –		
	Page, CDO/FlexAdvantage		
	Endorseme Extra		
	nt or Rider		
Approved- HC-DEN26	Certificate Dental Covered	Initial	50.350
Closed	Amendmen Services Payment		
11/08/2010	t, Insert Formula		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-DEN27	Certificate Dental Covered	Initial	50.350
Closed	Amendmen Services Class I		
11/08/2010	t, Insert (Preventive &		
	Page, Diagnosis)		
	Endorseme		

SERFF Tracking Number:	CCGH-126836862	State:	Arkansas
Filing Company:	CIGNA Health and Life Insurance Company	State Tracking Number:	47047
Company Tracking Number:			
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	Group Managed Dental Benefits		
Project Name/Number:	CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC/ Closed Amendmen 11/08/2010 t, Insert Page, Endorseme nt or Rider		
Approved- Closed 11/08/2010	HC-POB27 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Payment of Benefits Initial Dental Misc. & OHIP	50.350 HC- POB27.pdf
Approved- Closed 11/08/2010	HC-TRM72 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Termination of Insurance Initial	50.350 HC- TRM72.pdf
Approved- Closed 11/08/2010	HC-BEX38 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Dental Benefits Extension Initial	50.350 HC- BEX38.pdf
Approved- Closed 11/08/2010	HC-APL94 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	When You Have a Complaint or Appeal Initial	50.350 HC- APL94.pdf
Approved- Closed 11/08/2010	HC-DFS1 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Active Service Initial	50.350 HC-DFS1.pdf
Approved- Closed 11/08/2010	HC-DFS350 Certificate Amendmen t, Insert	Adverse Determination Initial	50.350 HC- DFS350.pdf

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<i>Filing Company:</i>	CIGNA Health and Life Insurance Company	<i>State Tracking Number:</i>	47047
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<i>TOI:</i>	H10G Group Health - Dental	<i>Sub-TOI:</i>	H10G.000 Health - Dental
<i>Product Name:</i>	Group Managed Dental Benefits		
<i>Project Name/Number:</i>	CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC/		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate CIGNA Dental Health	Initial	50.350
Closed DFS352	Amendmen		
11/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Contract Fees	Initial	50.350
Closed DFS353	Amendmen		
11/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Covered Services	Initial	50.350
Closed DFS354	Amendmen		
11/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Dental Office	Initial	50.350
Closed DFS355	Amendmen		
11/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Dental Plan	Initial	50.350
Closed DFS356	Amendmen		
11/08/2010	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- HC-	Certificate Dentist	Initial	50.350
Closed DFS125	Amendmen		
11/08/2010	t, Insert		
	Page,		
	Endorseme		

<i>SERFF Tracking Number:</i>	<i>CCGH-126836862</i>	<i>State:</i>	<i>Arkansas</i>		
<i>Filing Company:</i>	<i>CIGNA Health and Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47047</i>		
<i>Company Tracking Number:</i>					
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>		
<i>Product Name:</i>	<i>Group Managed Dental Benefits</i>				
<i>Project Name/Number:</i>	<i>CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC/</i>				
Closed	DFS130	Amendmen Reimbursable		DFS130.pdf	
11/08/2010		t, Insert Charge Page, Endorseme nt or Rider			
Approved- Closed	HC-DFS16	Certificate Medicaid Amendmen	Initial	50.350	HC- DFS16.pdf
11/08/2010		t, Insert Page, Endorseme nt or Rider			
Approved- Closed	HC-DFS17	Certificate Medicare Amendmen	Initial	50.350	HC- DFS17.pdf
11/08/2010		t, Insert Page, Endorseme nt or Rider			
Approved- Closed	HC- DFS358	Certificate Network General Amendmen Dentist	Initial	50.350	HC- DFS358.pdf
11/08/2010		t, Insert Page, Endorseme nt or Rider			
Approved- Closed	HC- DFS359	Certificate Network Specialty Amendmen Dentist	Initial	50.350	HC- DFS359.pdf
11/08/2010		t, Insert Page, Endorseme nt or Rider			
Approved- Closed	HC-DFS18	Certificate Participation Date Amendmen (Trustee)	Initial	50.350	HC- DFS18.pdf
11/08/2010		t, Insert Page, Endorseme nt or Rider			
Approved- Closed	HC- DFS360	Certificate Patient Charge Amendmen Schedule	Initial	50.350	HC- DFS360.pdf
11/08/2010		t, Insert			

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

POLICYHOLDER: [Insert Policyholder Name]

ADDRESS: [Insert Policyholder Address]

ACCOUNT NUMBER: [Insert Account Number]

Group Insurance
Policy and Policy Number

Effective
Date

Anniversary
Date

CIGNA DENTAL INSURANCE

[Insert Effective
Date]

[Insert
Anniversary
Date]

[Insert if list continues on next page]

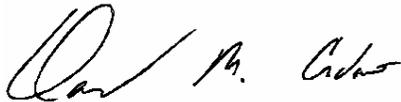
[(This listing of the Group Insurance Policies is continued on the next page.)]

These Policies contain the terms under which the Insurance Company agrees to insure certain Employees and pay benefits.

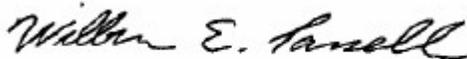
The Insurance Company and the Policyholder have agreed to all of the terms of these policies.



Shermona Mapp, Corporate Secretary



David M. Cordani, President



Wilbur E. Parsell, Registrar

(Continued)

POLICYHOLDER: *[Insert Policyholder Name]*

<u>Group Insurance Policy and Policy Number</u>	<u>Effective Date</u>	<u>Anniversary Date</u>
<i>[Insert Additional Policies]</i>	<i>[Insert Effective Date]</i>	<i>[Insert Anniversary Date]</i>
<i>[Insert Additional Policies]</i>	<i>[Insert Effective Date]</i>	<i>[Insert Anniversary Date]</i>
<i>[Insert Additional Policies]</i>	<i>[Insert Effective Date]</i>	<i>[Insert Anniversary Date]</i>

These policies are issued in Arkansas and shall be governed by its laws.

Arkansas state law requires insurers to deliver the following notice to policyholders.

**ARKANSAS LIFE AND DISABILITY INSURANCE
GUARANTY ASSOCIATION NOTICE**

Residents of this state who purchase life insurance or disability insurance or annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Disability Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

The Arkansas Life and Disability Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the Insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.

If you have additional questions, you should first contact your insurer or agent and then may contact:

**Arkansas Life and Health
Insurance Guaranty Association
C/O The Liquidation Division
1023 W Capital Avenue
Little Rock, Arkansas 72201**

OR

**Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904**

The state law that provides for this safety-net coverage is called the Arkansas Life and Disability Insurance Guaranty Association Act. Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or disability insurance contract, or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state. (This may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends and voting rights and experience rating credits;
- credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation (FPBC) (whether the FPBC is yet liable or not);
- portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than the insurance company would owe under a policy or contract. Also, for any one insured's life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

CONTENTS

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[THE SCHEDULE	
THE INSURANCE SCHEDULE.....	4
ALL OTHER SCHEDULE SECTIONS	Certificate
DEFINITIONS.....	Certificate
ELIGIBILITY	Certificate
EFFECTIVE DATE	Certificate
BENEFITS	
Dental Insurance	Certificate
GENERAL LIMITATIONS	Certificate
[MEDICARE ELIGIBLES.....	Certificate]
COORDINATION OF BENEFITS	Certificate
PAYMENT OF BENEFITS.....	Certificate
TERMINATION OF INSURANCE.....	Certificate
PREMIUMS.....	7
CANCELLATION OF POLICY	9
MISCELLANEOUS PROVISIONS.....	10 and Certificate]

THE INSURANCE SCHEDULE

The terms set forth herein and in the Certificate(s) listed below describe the insurance underwritten by the Insurance Company. These Certificates are included in and made a part of the policy(ies). Each Certificate is identified by a Certificate Number (CN).

Any reference in the certificate to "you" or "yours" refers to the Employee.

An Employee in any of the classes shown below may be insured but only for the policy(ies) listed for his Employee Class. The Effective Date shown below is the date on which a policy becomes effective for an Employee Class.

An Employee will become eligible and insured in accordance with the terms of the "Eligibility" and "Effective Date" sections of the Certificate.

<u>GROUP POLICY(IES)</u>		<u>EMPLOYEE CLASS</u>	
<u>Certificate Number</u>	<u>Policy(ies)</u>	<u>Eligible Employees</u>	<u>Effective Date</u>
[<i>Insert Certificate number</i>]	Dental Insurance	[Each Employee as reported to the insurance company by the Employer]	[<i>Insert Effective Date</i>]

THE INSURANCE SCHEDULE (Continued)

The Certificate may include Certificate Riders which are identified by Rider Numbers. These Certificate Riders are listed below.

Certificate Rider Number

[Insert Rider number]

Certificate Number

[Insert Certificate number]

AFFILIATED EMPLOYERS

ELIGIBILITY FOR EMPLOYEE INSURANCE

Each Employee in one of the Classes of Eligible Employees shown below will become eligible for Employee Insurance according to the provisions set forth in the ELIGIBILITY - EFFECTIVE DATE section of the Employee Certificate.

AFFILIATED EMPLOYERS

[Insert Affiliated Employer Name]

WAITING PERIOD

[Insert applicable waiting period]

[None] [[1-90 days] after date of hire] [[1-90] days from the date of Active Service] [First of the month following [1-90] days from the date of Active Service] [The first day of the month following [1-90] days from date of hire]

CLASSES OF ELIGIBLE EMPLOYEES

[All Hourly Employees]

PREMIUMS

PREMIUM PAYMENT. The first premium will be due on the Effective Date. After that, premium will be due monthly unless the Policyholder and the Insurance Company agree on some other method of premium payment. The Policyholder and the Insurance Company may agree to change the method of premium payment from time to time. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

PREMIUM DUE DATE. After the Effective Date, the Premium Due Date will be the first of the month. The Anniversary Date will be the first of the month when the policy becomes effective. If the Policyholder and the Insurance Company agree that premiums will be paid on a quarterly, semiannual or annual basis, the Premium Due Date will be at the appropriate regular interval, quarterly, semiannually or annually. Premiums must be received at the Home Office or by an authorized agent of the Insurance Company on the Premium Due Date or the policy will be cancelled except as set forth in the Grace Period.

MONTHLY STATEMENT DATE. If premiums are to be paid monthly, the Monthly Statement Date will be the same as the Premium Due Date. If premiums are to be paid on a quarterly, semiannual or annual basis, the Monthly Statement Date will be the day in each month with the same number as the Premium Due Date.

MONTHLY PREMIUM STATEMENT. If premiums are due monthly, a Monthly Premium Statement will be prepared as of the Premium Due Date. This Monthly Premium Statement will show the premium due. If premiums are due quarterly, semiannually or annually, a Monthly Premium Statement will be prepared as of the Monthly Statement Date for the time from the Monthly Statement Date to the next Premium Due Date. This Monthly Statement will reflect any pro rata premium charges and credits due to changes in the number of insured persons and changes in insurance amounts that took place in the preceding month.

SIMPLIFIED ACCOUNTING. To simplify the accounting process, premium adjustments will be made on the Monthly Statement Date that is the same as or next follows the date that (1), (2) or (3) below takes place.

- (1) A person becomes insured.
- (2) The amount of insurance on a person changes, but not due to a revision of The Schedule.
- (3) A person ceases to be insured.

MONTHLY PREMIUM RATE FOR DENTAL INSURANCE. The monthly premium rate for Dental Insurance is as follows:

For Employee Insurance	For Dependent Insurance
\$!	\$!

DENTAL INSURANCE PREMIUM. The monthly premium for Dental Insurance will be calculated as follows:

- (1) Multiply the number of Employees insured on the Premium Due Date in each rate class by the premium rate in effect on that date for that class.
- (2) Add the results.

CHANGE IN METHOD OF PREMIUM PAYMENT. If premiums are to be paid other than monthly, the method of calculation is the same. However, the rate for each class is first changed to quarterly, semiannual or annual rates by multiplying them by 2.9852, 5.9557 or 11.8227, respectively. All results are taken to the nearer cent. If the Policyholder and the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, a pro rata adjustment will be made in the premium due.

[Insert if employee contributes toward the premium]

[EMPLOYEE CONTRIBUTIONS. If at any time the total of all Employee Contributions paid under the policy exceeds the total premiums paid under the policy, (after giving effect to any experience credits), the excess: (1) will be applied to the Policyholder; and (2) will benefit only the Employees. Any rate reduction or experience credit that the Insurance Company grants the Policyholder will release the Company of all liability for that reduction or credit.]

CHANGES IN PREMIUM RATES. Any premium rate may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No such change will be made until 12 months after the Effective Date. An increase will not be made more often than once in a 12-month period. If an increase in premium rates takes place on a date that is not a Premium Due Date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next Premium Due Date. If a decrease in premium rates takes place on a date that is not a Premium Due Date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next Premium Due Date.

[Insert percentage selected by Policyholder]

The Insurance Company may change rates immediately if, following the latter of the effective date or renewal date, the enrolled population either increases or decreases by [5-20]% or more.

As of any Anniversary Date after the policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine, based on experience. The experience under this policy may be combined with the experience under other contracts issued by the Insurance Company or its affiliates and covering the policyholder or its employees.

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by any change in state or federal law or by a revision in the insurance under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

CANCELLATION OF POLICY

The Policyholder may cancel the policy as of any Premium Due Date by giving written notice to the Insurance Company before the date.

The Insurance Company may cancel the policy due to the following reasons only:

with at least 90 days prior written notice, if the Insurance Company ceases to offer coverage of this type, in accordance with applicable state or federal law;

as of any Premium Due Date, if the premium is not received at the Home Office or by an authorized agent of the Insurance Company when due;

immediately, if the Employer has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact;

as of any Premium Due Date, if the number of insured Employees or if the number of insured Dependents fails to meet the minimum required per group participation rules; or for failure to comply with any other material plan provision relating to Employer contributions or group participation rules;

if the Insurance Company withdraws from the health insurance market with prior written notice and in accordance with applicable state or federal law;

in accordance with any applicable state law, if it is determined that the size of the Employer group has changed, making such group eligible for a guaranteed issued small group product;

in accordance with any applicable state or federal law, if prior notice is given to the Employer;

as to an Employer member of an association to which this policy is issued, when the Employer's membership in the association ceases, in accordance with applicable state or federal law.

Coverage will cease at midnight on the date on which termination occurs, unless otherwise stated above.

Uniform Modification of Coverage. At renewal, the provisions of this policy may be modified to reflect product revisions which have been uniformly made to this product.

GRACE PERIOD. If, before a Premium Due Date, the Policyholder has not given written notice to the Insurance Company that the policy is to be canceled, a Grace Period of 31 days will be granted for the payment of each premium after the initial premium. The policy will stay in effect during that time. If any premium is not received at the home office or by an authorized agent of the Insurance Company by the end of the Grace Period, the policy will automatically be canceled at the end of the Grace Period; except that, if the Policyholder has given written notice in advance of an earlier date of cancellation, the policy will be canceled as of the earlier date. The Policyholder will be liable to the Insurance Company for any unpaid premium for the time the policy was in force.

MISCELLANEOUS PROVISIONS

EXECUTION OF POLICY. The policy is executed at the Home Office of the Insurance Company. The Post Office address of the Insurance Company is Hartford, Connecticut.

CONSIDERATION. The policy is issued to the Policyholder in consideration of the application and payment of premiums.

INSURANCE DATA. The Policyholder will give the Insurance Company all of the data that it needs to calculate the premium and all other data that it may reasonably require. Failure of the Policyholder to give this data will not void or continue an Employee's insurance. The Insurance Company has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. It also has this right until all rights and obligations under the policy are finally determined.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

PROVISIONS

ENTIRE CONTRACT. The entire contract will be made up of the policy, the application of the Policyholder, a copy of which is attached to the policy and all subsequent versions of the policy, and the applications, if any, of the Employees.

POLICY CHANGES. Changes may be made in the policy only by amendment signed by the Policyholder and by the Insurance Company acting through its President, Vice President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the policy.

STATEMENTS NOT WARRANTIES. All statements made by the Policyholder or by an insured Employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the Employee and a copy is sent to the Policyholder, the Employee or his Beneficiary.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company 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 the Insurance Company receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to have met the proof of loss requirements 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 the Insurance Company 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 nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

PHYSICAL EXAMINATION. The Insurance Company, 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. No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with the Insurance Company. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required by the policy.

TIME LIMITATIONS. If any time limit set forth in the policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee lives when the policy is issued, then the time limit provided in the policy is extended to agree with the minimum permitted by the law of that state.

CERTIFICATES. The Insurance Company will issue to the Policyholder for delivery to each insured Employee an individual certificate. The Policyholder will be responsible for distributing the certificates to its Employees. The certificate will show the benefits provided under the policy. It will set forth any changes in benefits due to age and to whom benefits will be paid. Nothing in the certificate will change or void the terms of the policy.

NOTICE OF TERMINATION OF ELIGIBILITY. Written notice of the termination of eligibility of any Employee or Dependent must be given to the Insurance Company within (60) days of the loss of eligibility. If such notice is not received by the Insurance Company within (60) days of the date of loss of eligibility for an Employee or Dependent, then the Employer shall be responsible for all claims for that Employee or Dependent incurred through the (60th) day prior to the Insurance Company's receipt of notice of termination of eligibility for the Employee or Dependent.

Application

**Insured and/or Administered by
CIGNA Health and Life Insurance Company**
900 Cottage Grove Road
Hartford, CT 06152



1. Name of Applicant	2. Main Address																																																
3. Nature of Business																																																	
4. Classes and Locations of Individuals Eligible	5. Subsidiary and Affiliated Companies Included																																																
6. Total Number of Individuals Eligible	For Individual Benefits																																																
	For Dependent Benefits																																																
Have any of the classes of individuals eligible been covered under a group insurance policy or any other form of group plan within the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If so, please specify the benefits, the underwriting company or organization, and the dates these benefits were terminated.</i>																																																	
7. Group Insurance Applied For: <i>(Please check all that apply)</i> <table style="width:100%; border: none;"> <tr> <td style="width:15%;">Individual</td> <td style="width:15%;">Dependent</td> <td style="width:40%;"></td> <td style="width:15%;">Individual</td> <td style="width:15%;">Dependent</td> <td style="width:40%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Life Insurance</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Doctors Attendance Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Accidental Death & Dismemberment Insurance</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Laboratory and X-ray Examination Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td>—</td> <td>Short Term Disability Insurance</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Major Medical Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td>—</td> <td>Long Term Disability Insurance</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Comprehensive Medical Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hospital Benefits</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Dental Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Surgical Benefits</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Vision Care Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Individual	Dependent		Individual	Dependent		<input type="checkbox"/>	<input type="checkbox"/>	Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Doctors Attendance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Laboratory and X-ray Examination Benefits	<input type="checkbox"/>	—	Short Term Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Major Medical Benefits	<input type="checkbox"/>	—	Long Term Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Comprehensive Medical Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Hospital Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Dental Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Vision Care Benefits	<input type="checkbox"/>	<input type="checkbox"/>				
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8. Effective Date Requested: _____ Group Insurance at the Insurance Company's rates and under the terms of the policy(s) applied for will take effect on the Effective Date Requested if the Application is accepted at the Home Office of the Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of: the date the required number have enrolled, or on the Effective Date Requested. If this Application is not accepted, no insurance will become effective. Any premium advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.																																																	
9. THE APPLICANT DECLARES: that he has read the above statement and the answers to the above questions are complete and true. The Applicant agrees: (1) that this Application is offered as an inducement for the Group Insurance applied for; (2) that the terms and conditions of the Insurance Company's Proposal for the Group Insurance applied for forms a part of this Application and that this Application will form a part of any policy(s) issued; (3) that only the information on this Application will bind the Insurance Company; and (4) that no waiver or change will bind the Insurance Company unless signed by an Executive Officer of the Insurance Company. Group Insurance will only be provided for persons eligible under the policy(s) issued.																																																	
Dated at _____ on _____ Name of Applicant _____ By _____ Title _____ Witness _____ Soliciting Agent if other than Witness _____																																																	
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.																																																	
STATEMENT TO BE SIGNED BY APPLICANT UPON PAYMENT OF THE PREMIUM OR ANY PART THEREOF																																																	
I HEREBY DECLARE that I have paid to _____ Agent _____ Dollars for which I hold his receipt.																																																	
Date _____ Applicant _____ Agent _____ Agent's License No. _____																																																	

HP-APP-1

Cat. #831494 04-10

Conditional Receipt

**Insured and/or Administered by
CIGNA Health and Life Insurance Company**
900 Cottage Grove Road
Hartford, CT 06152



Received of _____ Dollars to be applied against the first premium on the proposed Group Insurance under this Application. This payment is made and accepted subject to the following conditions. Group Insurance at the Insurance Company's rates and under the terms of the policy(s) applied for will take effect as of the Effective Date Requested if the Application is accepted at the Home Office of the Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of: the date the required number have enrolled, or on the Effective Date Requested. If the Application is not accepted, no insurance will become effective. Any premium payment advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.

Date _____ Agent _____ Agent's License No. _____

DETACH THIS RECEIPT WHEN PAYMENT IS MADE

HP-APP-1

Cat. #831494 04-10

AMENDMENT

POLICYHOLDER: [Insert Policyholder Name]

POLICY NUMBER: [Insert Policy Number]

EFFECTIVE DATE OF THIS AMENDMENT: [Insert Effective Date]

[ISSUE DATE: [Insert Issue Date]

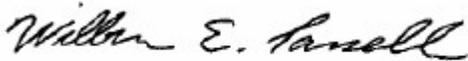
As of the Effective Date of this Amendment, the Policy specified above is amended by the provisions shown below:

[Insert specific amendatory text here.]

CIGNA HEALTH AND LIFE INSURANCE COMPANY



Shermona Mapp, Corporate Secretary



Wilbur E. Parsell, Registrar

ACCEPTED BY:

Policyholder Representative

Title

Date

**CIGNA HEALTH AND LIFE INSURANCE COMPANY
a CIGNA COMPANY (hereinafter called CIGNA)**

CERTIFICATE RIDER

No. CR [1]

[2]

Policyholder: [ABC Company]

Rider Eligibility: [All Insured Employees]

Policy No. or Nos. [A1234567]

[Certificate Rider issued to: [John Doe]]

Effective Date: [September 1, 2010] if you are in Active Service on that date; otherwise, on the date you return to Active Service. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

This certificate rider forms a part of the certificate issued to you by CIGNA describing the benefits provided under the policy(ies) specified above.

A handwritten signature in black ink, appearing to read "Shermona Mapp". The signature is fluid and cursive, with a large initial "S" and "M".

Shermona Mapp, Corporate Secretary

[Insert rider text here.]

Table of Contents

Certification	[1]
[Important Notices]	[1]
Eligibility – Effective Date	[1]
Waiting Period	[1]
Employee Insurance	[1]
[Dependent Insurance]	[1]
<i>Add the following Important Information item to this TOC when plan design is a CDO/CDO FlexAdvantage</i>	
[Important Information About Your Dental Plan]	[1]
Dental Benefits – CIGNA Dental Care	[1]
General Limitations	[1]
Dental Conversion Privilege	[1]
[Coordination of Benefits]	[1]
[Expenses For Which A Third Party May Be Responsible]	[1]
Payment of Benefits	[1]
Termination of Insurance	[1]
Employees	[1]
[Dependents]	[1]
Dental Benefits Extension	[1]
When You Have a Complaint or Appeal	[1]
Definitions	[1]

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):

POLICY HOLDER: [Insert Policyholder Name]

GROUP POLICY(S) DENTAL CARE INSURANCE

[Insert Account Number]

EFFECTIVE DATE: [Insert Effective Date]

[Insert Notice if Policyholder is Section 125]

[NOTICE

Any insurance benefits in this certificate will apply to an Employee only if: a) he has elected that benefit; and b) he has a "Final Confirmation Letter," with his name, which shows his election of that benefit.]

[OR Insert Notice if Policyholder election of process is a "Name" certificate]

[NOTICE

This certificate does not apply to any employees unless this space is covered by a sticker indicating the employee's name and the certificate date.]

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.

Coordination of Benefits Included — See Table of Contents for Location of Coordination of Benefits Section.



Shermona Mapp, Corporate Secretary

Special Plan Provisions

Notice of an Appeal or a Grievance

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

DISCLOSURE NOTICE [ET – AR PRODUCT RESTRICTIONS: MANDATE FREE BENEFIT PLAN. DISCLOSURE: CERTIFICATE DISCLOSURE]

NOTICE: AS PERMITTED BY §23-79-803, THE POLICYHOLDER HAS SELECTED THIS PLAN WHICH DOES NOT PROVIDE COVERAGE IN ACCORDANCE WITH ONE, SOME OR ALL OF THE REQUIREMENTS FOR ONE OR MORE BENEFITS MANDATED BY THE STATUTES OF THE STATE OF ARKANSAS

STATE MANDATED BENEFITS NOT COVERED IN WHOLE OR IN PART ARE AS FOLLOWS:

Note: Refer to your Policy or Certificate of Insurance for details about covered expenses, non-covered expenses and limited covered expenses. Inclusion on this Disclosure Notice list may not mean that the benefit or service is not covered, but only that coverage may differ in some respect from the statutory requirements:

[Arkansas Mental Health Parity Act, §23-99-501, et. Seq.

Prescription drug benefit, §23-79-149

Provisions generally, unlicensed professionals (“Freedom of Choice”) §23-79-114 and Bulletin 9-85]

You are urged to contact your health insurance agent or the Arkansas Insurance Department Consumer Affairs or Legal Division about questions or concerns related to the nature of the state mandated health benefit which is not provided in this health benefits plan.

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least [15-40] hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the [New Employee Group] Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within [30 days-one year] after your insurance ceased.

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

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

Initial Employee Group: [None] [[1-90] Days]

New Employee Group: [None] [[1-90 days] after date of hire] [[1-90] days from the date of Active Service] [First of the month following [1-90] days from the date of Active Service] [The first day of the month following [1-90] days from date of hire]

Classes of Eligible Employees

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

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible. If you are a Late Entrant, you may elect the insurance only during an Open Enrollment Period. Your insurance will become effective on the first day of the month after the end of that Open Enrollment Period in which you elect it.

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

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or

- you again elect it after you cancel your payroll deduction (if required) CIGNA may require evidence of good health to be provided at your expense if you are a Late Entrant.

Open Enrollment Period

Open Enrollment Period means a period in each calendar year as designated by your Employer.

[Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CIGNA agrees to insure that Dependent.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

CIGNA may require evidence of your Dependent's good health at your expense if you are a Late Entrant.]

[Do not include Choice of Dental Office if plan is a CDO Plan]

Choice of Dental Office

[Include one of the bracketed statements based on Policyholder election of process]

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][You and all of your insured Dependents must be treated at the same 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.

[Insert Important Information paragraph when plan has a CDO (Combined Dental Option) Plan or a CDO FlexAdvantage Plan]

[Insert appropriate text for CDO or CDO FlexAdvantage]

[Important Information about [the CignaFlex Advantage][Your] Dental Plan]

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

[Insert appropriate product names based on CDO Product selection]

- [CIGNA Dental Care;[or]
- [CIGNA Dental Preferred Provider; or]
- [CIGNA Traditional Dental]

[Insert appropriate option if CDO Certificate is combined or separate]

Details of the benefits under each of the options are described in [the following pages][separate certificates/booklets].

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

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

[Insert the following two paragraphs for a CDO Plan, do not use if CDO FlexAdvantage]

[Change in Option Elected]

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

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

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

Effective Date of Change

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

[Insert the following paragraph for a CDO FlexAdvantage Plan, do not use if plan is CDO]

[Change in Option Elected]

You may elect to change your CIGNA Flex Advantage dental option at any time. Requests received by the 15th day of the month will be processed for the first day of the following month. For plan information or to switch options, call CIGNA Dental at 1-800-481-1213.]

CIGNA Dental Care: Choice of Dental Office

[Include one of the bracketed statements based on Policyholder election of process]

If you elect CIGNA Dental Care you must select a Network General Dentist and an alternate provider from a list provided by CDH. CDH will notify you if your first choice of provider is not available and you will be assigned to the alternate provider. [Each insured family member may select their own Network General Dentist.][You and all of your insured Dependents must be treated at the same participating Dental Office.]

Dental coverage only applies if:

- the dental service is received from your Network General Dentist; or
- your Network General Dentist refers you to a specialist approved by CDH; or
- the service is otherwise authorized by CDH; or
- the service is Emergency Treatment as specified in your certificate.

A transfer to a different Network General Dentist takes effect on the first day of the month after it is authorized by CDH.

Dental Benefits – CIGNA Dental Care

[Use the following Text for CDC06 Plan]

[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.

1. 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.

2. 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:

- 1. Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- 2. Specialty Care** – Except for Pediatric Dentistry and Endodontics, payment authorization is required for coverage of services performed by a Network Specialty Dentist.
- 3. 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.
- 4. 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.

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:

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA Dental's prior approval (except in emergencies).
3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule.
7. 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.
8. prescription drugs.
9. 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 abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
10. replacement of fixed and/or removable appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. services associated with the placement or prosthodontic restoration of a dental implant.
12. services considered to be unnecessary or experimental in nature.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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.)
15. 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.
16. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage.

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:

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

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

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 a. banding/appliance insertion does not occur within 90 days of such visit; b. your treatment plan changes; or c. 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.

Dental Benefits – CIGNA Dental Care

[Use the following Text for CDC07 Plan]

[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.

1. 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.

2. 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:

- 1. Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- 2. Pediatric Dentistry** – Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
- 3. 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.
- 4. 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.
- 5. 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:

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA Dental's prior approval (except in emergencies).
3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. 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.
7. 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.
8. prescription drugs.
9. 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.
10. 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.
11. services associated with the placement, repair, removal, or prosthodontic restoration of a dental implant or any other services related to implants.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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.)
15. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage.
16. consultations and/or evaluations associated with services that are not covered.

17. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
18. 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.
19. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
20. services performed by a prosthodontist.
21. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
22. 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.
23. 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.
24. services to correct congenital malformations, including the replacement of congenitally missing teeth.
25. 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:

1. crowns and bridges used solely for splinting.
2. 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 a. banding/appliance insertion does not occur within 90 days of such visit; b. your treatment plan changes; or c. 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.

Dental Benefits – CIGNA Dental Care

[Use the following Text for Specialty Access Plan 06]

[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, 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.CIGNA.24]. 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 Network General Dentist. 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 by your Network General Dentist.

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.

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.CIGNA.24]. 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 by your Network General Dentist, 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 General Dentist. You will pay the non-Network General Dentist the applicable Patient Charge for Covered Services. CIGNA Dental will pay the non-Network General Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See the *Specialty Referrals* section regarding your 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.

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are 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.

2. 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:

- 1. Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- 2. Specialty Care** – Payment for care received from a Network Specialty Dentist is not provided by this Plan. You will be responsible for Contract Fees for care received from a Network Specialty Dentist.
- 3. Oral Surgery** – The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

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:

- 1.** services not listed on the Patient Charge Schedule.
- 2.** services provided by a non-Network Dentist without CIGNA Dental's prior approval, except in

emergencies.

3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
7. 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.
8. prescription drugs.
9. 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 abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or, c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
10. replacement of fixed and/or removable appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. services associated with the placement or prosthodontic restoration of a dental implant.
12. services considered to be unnecessary or experimental in nature.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network General 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.)
15. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage.
16. crowns and bridges used solely for splinting.
17. resin bonded retainers and associated pontics.

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

APPOINTMENTS

To make an appointment with your Network General 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 General 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 by the provider.

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.CIGNA.24]. 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.CIGNA.24].

Your transfer request will take about five 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. If you need specialty care, you may seek treatment from a Network Specialty Dentist at a discounted rate. 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.

Discounted rates are not available at prosthodontists or other specialty dentists not listed above.

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, you are entitled to receive a discount for services listed on your Patient Charge Schedule when rendered by a Network Specialty Dentist. If you see a Network Specialty Dentist, you will be responsible for paying total Contract Fees, which are a discount from the dentist's Usual Fees, to the Network Specialty Dentist. The dollar amounts listed on your Patient Charge Schedule are not applicable to treatment performed by Network Specialty Dentists. Under your plan, preauthorization from CIGNA Dental is not necessary for care received from a Network Specialty Dentist. CIGNA Dental will not make payments toward specialty care.

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

ORTHODONTICS – (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

Definitions – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:

- **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.

Payment

Your payment for your entire orthodontic case, including retention, will be based upon the Orthodontist's Contract Fee in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Contract Fee may apply.

Your 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 payment 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.

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 (plus any additional charge that may apply) 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.]

[Use the following Text for Specialty Access 07]

[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, 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.CIGNA.24]. 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 Network General Dentist. 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 by your Network General Dentist.

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.

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.CIGNA.24]. 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 by your Network General Dentist, 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 General Dentist. You will pay the non-Network General Dentist the applicable Patient Charge for Covered Services. CIGNA Dental will pay the non-Network General Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See the *Specialty Referrals* section regarding your 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.

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are 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.

2. 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:

- 1. Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- 2. Oral Surgery** – The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.
- 3. 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.

- 4. 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 run 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:

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA Dental's prior approval, except in emergencies.
3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. 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..
7. 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.
8. prescription drugs.
9. 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.
10. 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.
11. services associated with the placement, repair, removal, or prosthodontic restoration of a dental implant, or any other services related to implants.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network General 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.)
15. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage.
16. consultations and/or evaluations associated with services that are not covered.
17. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
18. 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.

19. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
20. services performed by a prosthodontist.
21. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
22. 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.
23. 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.
24. services to correct congenital malformations, including the replacement of congenitally missing teeth
25. 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:

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

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under 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 General 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 General 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 by the provider.

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.CIGNA.24]. 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.CIGNA.24].

Your transfer request will take about five 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. If you need specialty care, you may seek treatment from a Network Specialty Dentist at a discounted rate. 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.

Discounted rates are not available at prosthodontists or other specialty dentists not listed above.

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, you are entitled to receive a discount for services listed on your Patient Charge Schedule when rendered by a Network Specialty Dentist. If you see a Network Specialty Dentist, you will be responsible for paying total Contract Fees, which are a discount from the dentist's Usual Fees, to the Network Specialty Dentist. The dollar amounts listed on your Patient Charge Schedule are not applicable to treatment performed by Network Specialty Dentists. Under your plan, preauthorization from CIGNA Dental is not necessary for care received from a Network Specialty Dentist. CIGNA Dental will not make payments toward specialty care.

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

ORTHODONTICS – (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

Definitions – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:

- **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.

Payment

Your payment for your entire orthodontic case, including retention, will be based upon the Orthodontist's Contract Fee in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Contract Fee may apply.

Your 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 payment 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.

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 (plus any additional charge that may apply) 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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[Include or Exclude based on Policyholder election of process]

Alternate Benefit Provision

The following limiting provision applies to your dental plan.

If more than one service may be used to treat a dental condition, coverage will be limited to the less costly Covered Service provided it is: a professionally accepted; necessary; and appropriate method of treatment.

If treatment is provided by a Network Dentist, and the patient requests or accepts a more costly Covered Service, the specific Patient Charge for such service is equal to:

- A. the Patient Charge for the less costly service; plus
- B. the difference in cost between the Usual Fee for the more costly service and Usual Fee for the less costly service

[Use for CDC Standalone]

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: (a) he applies in writing and pays the first premium to CIGNA within 31 days after his insurance ceases; and (b) he is not considered to be overinsured.

CIGNA 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:

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

[Use with CDO or FlexAdvantage]

Dental Conversion Privilege For CIGNA Dental Care, CIGNA Dental Preferred Provider and CIGNA Traditional Dental

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 Group Dental Insurance Policy underwritten by CIGNA; provided that: (a) he applies in writing and pays the first premium to CIGNA within 31 days after his insurance ceases; and (b) 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.

COORDINATION OF BENEFITS

[Under this dental plan Coordination of Benefits rules apply to specialty care only.]

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

Definitions

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

Plan

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

- (1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- (2) [Coverage under Medicare and other] [G][g]overnmental benefits as permitted by law, excepting Medicaid[, Medicare] 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 medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

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.

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:

- (1) 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.
- (2) 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.
- (3) 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.
- (4) 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.

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.
- (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.

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

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

- (1) CIGNA's obligation to provide services and supplies under this policy;
- (2) whether a benefit reserve has been recorded for you; and
- (3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

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

Recovery of Excess Benefits

If 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.

[MEDICARE ELIGIBLES

CIGNA will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

- (a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
- (d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- (e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

- (f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

CIGNA will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan. Therefore, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CIGNA is the Secondary Plan.]

EXPENSES FOR WHICH A THIRD PARTY MAY BE RESPONSIBLE

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

RIGHT OF REIMBURSEMENT

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

LIEN OF THE PLAN

By accepting benefits under this plan, a Participant:

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

ADDITIONAL TERMS

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

[PAYMENT OF BENEFITS

To Whom Payable

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

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

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

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

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

Recovery of Overpayment

When an overpayment has been made by CIGNA, CIGNA will have the right at any time to: (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.

[Bracketed text will be included or deleted, based on Policyholder election.]

[Calculation of Covered Expenses

CIGNA, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.]]

[Insert Miscellaneous paragraph when Healthy Reward Program is included]

[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.

[Insert Miscellaneous paragraph when Oral Health Integration Program is elected. Bracketed text may be removed]

[Miscellaneous

If you are a CIGNA Dental plan member[as well as a member of a CIGNA medical plan,] 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.]

[Use for CDC Standalone]

TERMINATION OF INSURANCE – EMPLOYEES

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least two opportunities to transfer to another Dental Office.
- the date the policy is canceled.
- the date 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

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

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

[TERMINATION OF INSURANCE – DEPENDENTS

Your 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 for which you have made any required contribution for the insurance.
- with respect to your Dental benefits, the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least one opportunity to transfer to another participating Dental Office.
- the date Dependent Insurance is canceled.

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

[Dependent Dental Insurance After Your Death

If you are insured for Dental Insurance when you die, any of your Dependents who are then insured for such insurance will remain so insured without further payment of premiums for them. The insurance on any of those Dependents will remain in force until the earliest date below:

- the last day of the 24th month after your death;
- the date of remarriage of a surviving spouse, if any;
- the date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you.

The Dependent benefits payable after you die will be those in effect for your Dependents on the day prior to your death.]]

[Use with CDO or FlexAdvantage]

TERMINATION OF INSURANCE – EMPLOYEES

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

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

[Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.]

Injury or Sickness

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

[Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.]

Note:

When a person's Dental Insurance ceases, CIGNA does not offer any Converted Policy either on an individual or group basis. However, upon termination of insurance due to termination of employment in an eligible class or ceasing to qualify as a Dependent, you or any of your Dependents may apply to CIGNA Dental Health, Inc. for coverage under an individual dental plan.

Upon request, CIGNA Dental Health Inc. or your Employer will provide you with further details of the Converted Policy.

[TERMINATION OF INSURANCE – DEPENDENTS

Your 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 for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

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

[Dependent Dental Insurance After Your Death

If you are insured for Dental Insurance when you die, any of your Dependents who are then insured for such insurance will remain so insured without further payment of premiums for them. The insurance on any of those Dependents will remain in force until the earliest date below:

- the last day of the 24th month after your death;
- the date of remarriage of a surviving spouse, if any;
- the date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you.

The Dependent benefits payable after you die will be those in effect for your Dependents on the day prior to your death.]]

[Delete if Plan does not elect Benefits Extension]

[Delete bracketed bullet[s]t if service listed is not covered by the plan]

[Dental Benefits Extension

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

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

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

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

**The Following Will Apply To Residents of Arkansas
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 number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits 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 or write to us at the toll-free 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 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.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, CIGNA Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.]

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 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.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.]

[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 Dentist reviewer, the review shall be completed within three days.

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

Appeal to the State of Arkansas

You have the right to contact the Arkansas Insurance Department for assistance at any time. The Consumer Services Division may be contacted at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
501-371-2640
501-371-2749 Fax
or call: 1-800-852-5494

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.

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

Relevant Information

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.

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.]

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.

**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.

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.

Covered Services

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

Dental Office

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

Dental Plan

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

DEFINITIONS

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.

DEFINITIONS

Dependent

[Dependents are:

- your lawful spouse; *[Add bullet if Domestic Partners are covered]*[or
- your Domestic Partner; and]

[If Policyholder chooses to comply with PPACA for dependent coverage “unmarried” will be removed from the bullet below]

- any [unmarried] child of yours who is

[Revise age based on policyholder selection – standard is 19 for non-student and 23 for Students – age range is 19-99. If Policyholder chooses to comply with PPACA dependent age, the age under the first bullet will be age 26. If the policyholder choose to cover students beyond the PPACA Age of 26 the student bullet age will begin at age 26 and “unmarried” will be added to the student bullet.]

- [less than [19-99] years old.]
- [19-99] years but less than [23-99] years old, [unmarried], enrolled in school as a full-time student and primarily supported by you.]
- [19] or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to CIGNA after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, CIGNA may require proof of the continuation of such condition and dependence.

[Add bracketed text if Domestic Partners are covered]

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild who lives with you. [If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.]

[Add “or student” if separate student bullet is added above][Insert one of the three choices based on policyholder selection]

[Benefits for a Dependent child [or student] will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.][Benefits for a Dependent child [or student] will continue until the last day of the calendar month in which the limiting age is reached.][Benefits for a Dependent child [or student]will continue until the last day of the calendar year in which the limiting age is reached.]

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

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

DEFINITIONS

[Domestic Partner

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

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

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

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

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

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

DEFINITIONS

[Employee

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

DEFINITIONS

[Employer

The term Employer means the Policyholder and all Affiliated Employers.]

DEFINITIONS

[Employer

The term Employer means an employer participating in the fund which is established under the agreement of Trust for the purpose of providing insurance.]

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.

DEFINITIONS

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge is the lesser of:

1. the provider's normal charge for a similar service or supply; or
2. the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

CIGNA uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

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

Additional information about the Maximum Reimbursable Charge is available upon request.

DEFINITIONS

[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.]

DEFINITIONS

[Medicare

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

Definitions

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.

Definitions

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.

DEFINITIONS

[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.]

Definitions

Patient Charge Schedule

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

Definitions

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.

Definitions

Specialist

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

Definitions

Subscriber

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

DEFINITIONS

Usual Fee

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

SERFF Tracking Number: CCGH-126836862 State: Arkansas
 Filing Company: CIGNA Health and Life Insurance Company State Tracking Number: 47047
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Managed Dental Benefits
 Project Name/Number: CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	11/08/2010
Comments:		
Attachment: Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	11/08/2010
Comments: This application was filed and approved 8/13/2010, SERFF number CCGH-126664583.		
Attachment: HP-APP-1 cat # 831494 (Generic).pdf		

	Item Status:	Status Date:
Satisfied - Item: Forms Listing	Approved-Closed	11/08/2010
Comments:		
Attachment: CHLIC Forms Listing (Dental CDC)11-5-2010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability	Approved-Closed	11/08/2010
Comments:		
Attachment: SERFF - CHLIC (Dental) Statement of Variability -9.1.10.pdf		

CIGNA HEALTH AND LIFE INSURANCE COMPANY
Group Forms

This is to certify that the forms listed below are in compliance with state readability laws and regulations and the NAIC Life and Health Insurance Policy Language Simplification Model Act.

A. Option Selected

Certificate pages are scored as a group for the Flesch reading ease test.

Form and Form Numbers to Which Certification is Applicable:

<u>Form</u>	<u>Form Number</u>	<u>Flesch Score</u>
Group Dental Policy and Certificate	HP-POL et al.	50.35

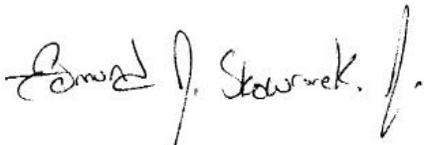
B. Test Option Selected

Test was applied to the certificate as a whole.

C. Standards for Certification

The following standards have been achieved:

1. The text achieved the minimum score of 50.35 on the Flesch reading ease test in accordance with section A above.
2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
3. The layout and spacing separate the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs, or constructions are not used.
6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
7. A table of contents or an index of the principal sections is included in the policy.
8. Any words which are defined in the policy(ies) and any medical terminology have been excluded from the Flesch test score.



Edmund J. Skowronek, Jr.

Director
Officer's Title

9/29/2010
Date

Application

Insured and/or Administered by
CIGNA Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152



1. Name of Applicant	2. Main Address																																																
3. Nature of Business																																																	
4. Classes and Locations of Individuals Eligible	5. Subsidiary and Affiliated Companies Included																																																
6. Total Number of Individuals Eligible	For Individual Benefits																																																
	For Dependent Benefits																																																
Have any of the classes of individuals eligible been covered under a group insurance policy or any other form of group plan within the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If so, please specify the benefits, the underwriting company or organization, and the dates these benefits were terminated.</i>																																																	
7. Group Insurance Applied For: <i>(Please check all that apply)</i>																																																	
<table style="width:100%; border: none;"> <tr> <th style="text-align: left;">Individual</th> <th style="text-align: left;">Dependent</th> <th style="width: 20%;"></th> <th style="text-align: left;">Individual</th> <th style="text-align: left;">Dependent</th> <th style="width: 20%;"></th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Life Insurance</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Doctors Attendance Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Accidental Death & Dismemberment Insurance</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Laboratory and X-ray Examination Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td>—</td> <td>Short Term Disability Insurance</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Major Medical Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td>—</td> <td>Long Term Disability Insurance</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Comprehensive Medical Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hospital Benefits</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Dental Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Surgical Benefits</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Vision Care Benefits</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Individual	Dependent		Individual	Dependent		<input type="checkbox"/>	<input type="checkbox"/>	Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Doctors Attendance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Laboratory and X-ray Examination Benefits	<input type="checkbox"/>	—	Short Term Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Major Medical Benefits	<input type="checkbox"/>	—	Long Term Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Comprehensive Medical Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Hospital Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Dental Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Benefits	<input type="checkbox"/>	<input type="checkbox"/>	Vision Care Benefits	<input type="checkbox"/>	<input type="checkbox"/>					
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8. Effective Date Requested: _____ Group Insurance at the Insurance Company's rates and under the terms of the policy(s) applied for will take effect on the Effective Date Requested if the Application is accepted at the Home Office of the Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of: the date the required number have enrolled, or on the Effective Date Requested. If this Application is not accepted, no insurance will become effective. Any premium advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.																																																	
9. THE APPLICANT DECLARES: that he has read the above statement and the answers to the above questions are complete and true. The Applicant agrees: (1) that this Application is offered as an inducement for the Group Insurance applied for; (2) that the terms and conditions of the Insurance Company's Proposal for the Group Insurance applied for forms a part of this Application and that this Application will form a part of any policy(s) issued; (3) that only the information on this Application will bind the Insurance Company; and (4) that no waiver or change will bind the Insurance Company unless signed by an Executive Officer of the Insurance Company. Group Insurance will only be provided for persons eligible under the policy(s) issued.																																																	
Dated at _____ on _____																																																	
Name of Applicant _____																																																	
By _____ Title _____																																																	
Witness _____ Soliciting Agent if other than Witness _____																																																	
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.																																																	
STATEMENT TO BE SIGNED BY APPLICANT UPON PAYMENT OF THE PREMIUM OR ANY PART THEREOF																																																	
I HEREBY DECLARE that I have paid to _____ Agent _____ Dollars for which I hold his receipt.																																																	
Date _____ Applicant _____																																																	
Agent _____ Agent's License No. _____																																																	

HP-APP-1

Cat. #831494 04-10

Conditional Receipt

Insured and/or Administered by
CIGNA Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152



Received of _____ Dollars
to be applied against the first premium on the proposed Group Insurance under this Application. This payment is made and accepted subject to the following conditions. Group Insurance at the Insurance Company's rates and under the terms of the policy(s) applied for will take effect as of the Effective Date Requested if the Application is accepted at the Home Office of the Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of: the date the required number have enrolled, or on the Effective Date Requested. If the Application is not accepted, no insurance will become effective. Any premium payment advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.

Date _____ Agent _____ Agent's License No. _____

DETACH THIS RECEIPT WHEN PAYMENT IS MADE

HP-APP-1

Cat. #831494 04-10

CIGNA Health & Life Insurance Company (CIGNA)
Dental Forms List – 04/10
ARKANSAS

Form Number	Form Description
HP-POL120	Policy
HP-APP-1	Policy Application
HP-AMD1	Policy Amendment – General Use
HC-TOC6	Table of Contents
HC-CER18	Certifying Page
HC-SPP4	Special Plan Provisions – Notice of an Appeal or a Grievance
HC-IM70 P	Important Notices
HC-ELG4	Eligibility – Effective Date
HC-IMP74	Important Information About your Dental Plan – CDO/ Flex Advantage
HC-DEN26	Dental Benefits Core Provisions CDC06
HC-DEN27	Dental Benefits Core Provisions CDC07
HC-DEN28	Dental Benefits Core Provisions SA06
HC-DEN29	Dental Benefits Core Provisions SA07
HC-DEN30	Alternate Benefit Provision
HC-CNV2	Conversion Provision
HC-COB58	Coordination of Benefits – Non-Dup
HC-SUB2	Expenses for Which a Third Party May be Liable
HC-POB4	Payment of Benefits
HC-POB27	Payment of Benefits Dental Misc. & OHIP
HC-TRM72	Termination
HC-BEX38	Dental Benefit Extension
HC-APL94	Appeals
HC-DFS1	Definition - Active Service
HC-DFS350	Definition – Adverse Determination
HC-DFS352	Definition – CIGNA Dental Health
HC-DFS353	Definition – Contract Fees
HC-DFS354	Definition – Covered Services
HC-DFS355	Definition – Dental Office
HC-DFS356	Definition – Dental Plan
HC-DFS125	Definition – Dentist
HC-DFS392	Definition – Dependent
HC-DFS47	Definition – Domestic Partner
HC-DFS7	Definition – Employee
HC-DFS8	Definition – Employer
HC-DFS9	Definition – Employer (Trustee)
HC-DFS357	Definition – Group
HC-DFS130	Definition – Maximum Reimbursable Charge
HC-DFS16	Definition – Medicaid
HC-DFS17	Definition – Medicare
HC-DFS358	Definition –Network General Dentist
HC-DFS359	Definition – Network Specialty Dentist
HC-DFS18	Definition – Participation Date (Trustee)
HC-DFS360	Definition – Patient Charge Schedule
HC-DFS361	Definition – Service Area
HC-DFS362	Definition – Specialist
HC-DFS363	Definition – Subscriber
HC-DFS138	Definition – Usual Fee
HC-RDR1	Certificate Rider – General Use

CIGNA Health & Life Insurance Company (CIGNA)
Dental Forms List – 04/10
[ARKANSAS](#)

CIGNA Health and Life Insurance Company

Statement of Variability Forms HP-POL et al. and HC-TOC et al.

General

1. To the extent that variable changes are made, they will not be ambiguous or deceptive.
2. Titles or names – such as the product name – may change, but their relation to the matter to which they pertain will not be ambiguous or deceptive.
3. Fill in text has been presented in “John Doe” format.
4. Connective words and phrases that only serve the grammatical purpose of meaningful continuity may vary as the sense demands.
5. Wording may vary in order to facilitate and/or to clarify the meaning of terms and benefits conveyed in the coverage. Examples of such changes include but are not limited to: benefit provisions may be rewritten at the request of a Policyholder to clarify the Policyholder’s understanding of benefits and/or administration.
6. Schedule items may be varied to reflect Policyholder election (e.g. a “copay” cost sharing option is elected for a coverage item rather than a “coinsurance” cost-sharing option). Possible numerical values available to Policyholder’s are expressed by a defined range in the Schedule (i.e., a copayment dollar amount range, a coinsurance percentage range, a day or visit maximum range or contract, calendar year or lifetime dollar maximum range). Policyholders may elect any numerical value within the identified range.
7. Proposed Exclusion text has been marked variable to allow a Policyholder to include all, or some, of the proposed exclusions.
8. Proposed Covered Expenses text has been marked variable to allow a Policyholder to include all, or some, of the proposed coverage items.
9. References to Consecutive Months may be changed to Calendar Year and vice versa, based on Policyholder election.

Specific Forms

Form HP-POLX: Policy

- Policyholder Name, Account Number, Policy Numbers, Amendment Numbers and Effective Date will be included.
- Table of Contents entries vary based on Policyholder coverage elections.
- Text may be varied to reflect the appropriate description of Class of Eligible Employee based on Policyholder specification (e.g. “All Hourly Employees”).
- Applicable time periods may vary within the range shown.
- The monthly premium rate will be included
- Include Employees Contribution Paragraph if employee pays part of the cost
- Include Change in Premium percentage selected by Policyholder

Form HP-APPX: Policy Application

- Fill in information entries will vary based on Policyholder information

Form HP-AMD1: Policy Amendments

- Fill in information entries will vary based on Policyholder information. Examples of entries include but are not limited to: benefit provisions may be rewritten at the request of a Policyholder to clarify the Policyholder's understanding of benefits and/or administration.

Form HC-TOC6: Table of Contents

- Table of Contents entries vary based on Policyholder coverage elections.

Form HC-CER17: Certification

- Policyholder Name, Account Number and Effective Date will be included.
- "Notice" language may be included for a Section 125 plan or when a Policyholder elects a "Name: certificate, as appropriate.

Form HC-ELG4: Eligibility – Effective Date

- Include text relating to Dependents, if coverage of Dependents is elected by the Policyholder.
- Text may be varied to reflect the appropriate description of Class of Eligible Employee based on Policyholder specification (e.g. "All Hourly Employees").
- Text regarding "Initial Employee Group" and "New Employee Group" will be removed for a renewed certificate.
- Applicable time periods may vary within the range shown.
- Text regarding the Participation Date of the Employer will be used for plans issued to a Trust.
- Choice of Dental Office :
 - will not be included if policy holder elects a CDO plan.
 - Text regarding designation of dentist will vary depending on what policy holder elects.

Form HC-DEN26 – HC-DEN29 – Covered Services and Services not Covered

- Include page if services elected by the Policyholder.
- Phone numbers may change

Form HC-DEN30: Alternate Benefit Provision

- Text may be included or excluded.

Form HC-COB57: Maintenance of Benefits

- Page will be included or excluded as elected by the Policyholder
- References to Medicare/Medicare Eligibles will be removed if Policyholder elects not to coordinate benefits with Medicare.

Form HC-COB58: Coordination of Benefits

- Page will be included or excluded as elected by the Policyholder
- References to Medicare/Medicare Eligibles will be removed if Policyholder elects not to coordinate benefits with Medicare.

Form HC-POB4: Payment of Benefits

- Bracketed text will be included or excluded based on Policyholder election.

Form HC-POB27: Miscellaneous Programs

- Health Rewards paragraph may be included or excluded based on Policyholder election.
- Oral Health Integration Program paragraph, bracketed text will be included or excluded based on Policyholder election.

Form HC-TRM72: Termination of Insurance

- Include provision regarding Temporary Layoff based on Policyholder election.
- Include Retirement provision if Policyholder elects coverage for retired employees.
- Include text relating to Dependents, if coverage of Dependents is elected by the Policyholder.

- Include Family Security Provision (Dependent Dental Insurance After your Death) if Policyholder elects to include Family Security Provision.

Form HC-BEX38: Dental Benefit Extension

- Include this section if elected by Policyholder.
- Not applicable if Policyholder elects Class I Services Only.
- Bullets may be deleted to appropriate reflect only those services covered under the plan.

Form HC-APLX: Dental Appeals

- Include Expedited Review text if elected to be included by Policyholder.
- Include Independent Review text if elected to be included by Policyholder.

Form HC-DFS1 et al.: Definitions

- Include definitions necessary to describe coverage based on Policyholder product election.
- **Dependent Definition** –
 - Insert appropriate dependent age within range shown as elected by the Policyholder
 - Add bracketed Domestic Partner references if Domestic Partners are covered as elected by Policyholder
 - If non-Students and Student are covered to the same age delete Student Bullet.
 - Include one of the three “coverage continued until” option.

SERFF Tracking Number: CCGH-126836862 State: Arkansas
 Filing Company: CIGNA Health and Life Insurance Company State Tracking Number: 47047
 Company Tracking Number:
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Managed Dental Benefits
 Project Name/Number: CIGNA Health and Life Insurance Company Policy and Certificate (LEA) Dental CDC/

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/12/2010		Supporting Forms Listing Document	11/05/2010	CHLIC Forms Listing (Dental CDC)10-11-2010.pdf (Superseded)
09/28/2010	Form	Dependent	11/05/2010	HC-DFS126.pdf (Superseded)

CIGNA Health & Life Insurance Company (CIGNA)
Dental Forms List – 04/10
ARKANSAS

Form Number	Form Description
HP-POL120	Policy
HP-APP-1	Policy Application
HP-AMD1	Policy Amendment – General Use
HC-TOC6	Table of Contents
HC-CER18	Certifying Page
HC-SPP4	Special Plan Provisions – Notice of an Appeal or a Grievance
HC-IM70 P	Important Notices
HC-ELG4	Eligibility – Effective Date
HC-IMP74	Important Information About your Dental Plan – CDO/ Flex Advantage
HC-DEN26	Dental Benefits Core Provisions CDC06
HC-DEN27	Dental Benefits Core Provisions CDC07
HC-DEN28	Dental Benefits Core Provisions SA06
HC-DEN29	Dental Benefits Core Provisions SA07
HC-DEN30	Alternate Benefit Provision
HC-CNV2	Conversion Provision
HC-COB58	Coordination of Benefits – Non-Dup
HC-SUB2	Expenses for Which a Third Party May be Liable
HC-POB4	Payment of Benefits
HC-POB27	Payment of Benefits Dental Misc. & OHIP
HC-TRM72	Termination
HC-BEX38	Dental Benefit Extension
HC-APL94	Appeals
HC-DFS1	Definition - Active Service
HC-DFS350	Definition – Adverse Determination
HC-DFS352	Definition – CIGNA Dental Health
HC-DFS353	Definition – Contract Fees
HC-DFS354	Definition – Covered Services
HC-DFS355	Definition – Dental Office
HC-DFS356	Definition – Dental Plan
HC-DFS125	Definition – Dentist
HC-DFS126	Definition – Dependent
HC-DFS47	Definition – Domestic Partner
HC-DFS7	Definition – Employee
HC-DFS8	Definition – Employer
HC-DFS9	Definition – Employer (Trustee)
HC-DFS357	Definition – Group
HC-DFS130	Definition – Maximum Reimbursable Charge
HC-DFS16	Definition – Medicaid
HC-DFS17	Definition – Medicare
HC-DFS358	Definition –Network General Dentist
HC-DFS359	Definition – Network Specialty Dentist
HC-DFS18	Definition – Participation Date (Trustee)
HC-DFS360	Definition – Patient Charge Schedule
HC-DFS361	Definition – Service Area
HC-DFS362	Definition – Specialist
HC-DFS363	Definition – Subscriber
HC-DFS138	Definition – Usual Fee
HC-RDR1	Certificate Rider – General Use

DEFINITIONS

Dependent

[Dependents are:

- your lawful spouse; *[Add bullet if Domestic Partners are covered]*[or
- your Domestic Partner; and]

[If Policyholder chooses to comply with PPACA for dependent coverage “unmarried” will be removed from the bullet below]

- any [unmarried] child of yours who is

[Revise age based on policyholder selection – standard is 19 for non-student and 23 for Students – age range is 19-99. If Policyholder chooses to comply with PPACA dependent age, the age under the first bullet will be age 26. If the policyholder choose to cover students beyond the PPACA Age of 26 the student bullet age will begin at age 26 and “unmarried” will be added to the student bullet.]

- [less than [19-99] years old.]
- [19-99] years but less than [23-99] years old, [unmarried], enrolled in school as a full-time student and primarily supported by you.]
- [19] or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to CIGNA within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, CIGNA may require proof of the continuation of such condition and dependence.

[Add bracketed text if Domestic Partners are covered]

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild who lives with you. [If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.]

[Add “or student” if separate student bullet is added above][Insert one of the three choices based on policyholder selection]

[Benefits for a Dependent child [or student] will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.][Benefits for a Dependent child [or student] will continue until the last day of the calendar month in which the limiting age is reached.][Benefits for a Dependent child [or student]will continue until the last day of the calendar year in which the limiting age is reached.]

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

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