Community Action Team, Inc.

Dental PPO

TABLE OF CONTENTS

- **INTRODUCTION**
  - About This Plan 1
- **PPO DENTAL BENEFITS SCHEDULE** 2
- **ELIGIBILITY**
  - Eligible Employees 4
  - Eligible Dependents 4
- **WHEN COVERAGE BEGINS & ENDS**
  - When Will Coverage Begin? 6
  - What If I Don't Apply On Time? 6
  - Will My Coverage Change? 6
  - When Will My Coverage End? 6
  - Can Coverage Be Reinstated? 7
- **PPO DENTAL BENEFITS**
  - How Does the Dental Plan Work? 8
  - What's Covered? (Covered Expenses) 8
- **BENEFIT LIMITATIONS** 12
- **CLAIMS & LEGAL ACTION**
  - How To File Claims 14
  - Claim Determinations and Appeal Procedures 14
  - What If a Member Has Other Coverage? (Coordination of Benefits) 17
  - Expenses For Which A Third Party May Be Responsible 19
  - Right of Reimbursement 19
  - Lien of the Plan 19
  - Additional Terms 20
  - Payment of Benefits 20
  - Other Information a Member Needs to Know 21
- **GLOSSARY** 22
- **USERRA RIGHTS AND RESPONSIBILITIES** 24
- **CONTINUATION OF COVERAGE - FMLA** 25
- **CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA** 25
- **EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN** 29
- **ERISA GENERAL INFORMATION** 30
- **STATEMENT OF ERISA RIGHTS** 31

INTRODUCTION

■ About This Plan

Community Action Team, Inc. (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of July 1, 2016, the dental benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the dental benefit terms described in this booklet. The Plan may be amended from time to time.

This booklet takes the place of any other issued to you on a prior date.

The dental benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Cigna Health and Life Insurance Company (Cigna) processes claims and provides other services to the Employer related to the self-funded benefits. Cigna does not insure or guarantee the self-funded benefits.

Defined terms are capitalized and have specific meaning with respect to dental benefits, see GLOSSARY.

Discretionary Authority

The Plan Administrator has the discretionary authority to control and manage the operation and administration of the Employer's self-funded dental benefit Plan. The Plan Administrator in his or her discretionary authority, will determine benefit eligibility under such self-funded Plan, construe the terms of the self-funded Plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the self-funded Plan, including but not limited to eligibility for participation and claims for benefits.

For initial claim determination, the Plan Administrator has the discretionary authority to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated Cigna Health and Life Insurance Company as the appeals fiduciary. Cigna will have the discretionary authority to determine whether a claim should be paid or denied on appeal and according to the Plan provisions.

Plan Modification, Amendment and Termination

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

PPO DENTAL BENEFITS SCHEDULE

This Schedule provides a general description of dental benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

Dental Plan Deductible

This deductible is the amount of covered dental expenses that must be paid by you or your covered Dependent each calendar year before the Plan begins to pay benefits for covered services in the following Classes, and once the Dental Plan Deductible has been reached, you and your family need not satisfy any further Plan Deductible for the rest of that calendar year:

- Network and Non-network Class II.
- Network and Non-network Class III.

When both Network and Non-Network expenses in a Class or Classes are subject to the Dental Plan Deductible, then expenses for network services will apply to the non-network deductible and expenses for non-network services will apply to the network deductible.

The Dental Plan Deductible does not apply to covered services in the following Classes:

- Network and Non-network Class I.
- Network and Non-network Class IV.

Individual Calendar Year Dental Plan Deductible	
- Network	$50.00
- Non-Network	$50.00
Family Calendar Year Dental Plan Deductible	
- Network	$150.00
- Non-Network	$150.00

Class IV Deductible

This deductible is the amount of covered Class IV expenses that must be paid by a Member each calendar year before the Plan begins to pay benefits for that Member's Class IV covered services.

Individual Calendar Year Class IV Deductible	
- Network	None
- Non-network	None

Dental Plan Maximum

This is the maximum amount, per Member, that the Plan will pay each calendar year for covered services in the following Classes combined:

- Network and Non-network Class I.
- Network and Non-network Class II.
- Network and Non-network Class III.

When both Network and Non-network expenses in a Class or Classes apply to the Dental Plan Maximum, then expenses for network services will apply to the non-network maximum and expenses for non-network services will apply to the network maximum.

The Dental Plan Maximum does not apply to Class IV network and non-network covered services.

Individual Calendar Year Dental Plan Maximum	
- Network	$2,000.00
- Non-network	$2,000.00

Class IV Maximum

PPO DENTAL BENEFITS SCHEDULE - Continued

This is the maximum amount that the Plan will pay for each Member's Class IV covered services.

Expenses for Class IV network services will apply to the Class IV non-network maximum. Expenses for Class IV non-network services will apply to the Class IV network maximum.

Individual Lifetime Class IV Maximum	
- Network	$1,000.00
- Non-network	$1,000.00

Coinsurance

A coinsurance is a percentage of the Maximum Reimbursable Charge for covered dental expenses that a Member is required to pay under the Plan. The Plan's coinsurance percentage is shown here. The "What's Covered? (Covered Expenses)" section provides information about the services in each class.

	NETWORK	NON-NETWORK
Emergency Care	80%	80%
Class I - Preventive and Diagnostic	100%	100%
Class II - Basic Restorative, Periodontics, Endodontics, and Oral Surgery	80%	80%
Class III - Major Restorative, Dentures and Bridgework and Prosthodontic Maintenance	50%	50%
Class IV - Orthodontics	50%	50%

ELIGIBILITY

■ Eligible Employees

For the purpose of dental benefits, an eligible Employee is a person who is in the Service of the Employer and is a resident of the United States.

Service

"Service" means work with the Employer on an active, full-time and full pay basis for at least 20.0 hours per week.

■ Eligible Dependents

If you and your spouse are eligible to be covered as Employees: A person who is eligible as an Employee will not be considered as an eligible Dependent. An eligible Dependent child may be considered as a Dependent of only one Employee.

If you are eligible to be covered as an Employee and as a Dependent child of another Employee: A person who is eligible as an Employee will not be considered as an eligible Dependent.

It is your responsibility to notify the Employer when a covered Dependent is no longer eligible for coverage.

Your Dependents must live in the United States to be eligible for coverage.

Eligible Dependents are:

- your legal spouse.
- a child under age 26.

Child

"Child" means:

- your natural child.
- your stepchild.
- your adopted child. This includes a child placed with you for adoption.

  "Placed for adoption" means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child's placement is considered terminated upon the termination of such legal obligation.
- a child who is recognized under a medical child support order as having a right to enrollment under the Plan.
- a foster child.

Handicapped/Disabled Child

The age limit does not apply to a child who becomes disabled, or became disabled, before reaching the age limit and who: cannot hold a self-supporting job due to a permanent physical handicap or intellectual disability; and depends on you for financial support.

"Physical handicap/intellectual disability" means permanent physical or mental impairment that is a result of either a congenital or acquired illness or injury leading to the individual being incapable of independent living.

"Permanent physical or mental impairment" means:

- a physiological condition, skeletal or motor deficit; or
- intellectual disabilities or organic brain syndrome.

A non-permanent total disability where medical improvement is possible is not considered to be a "handicap" for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

At reasonable intervals, but not more often than annually, the Plan may require a Doctor's certificate as proof of the child's disability.

ELIGIBILITY - Continued

Medical Child Support Order

A medical child support order is a *qualified* medical child support order (QMCSO) or a *qualified* national medical support notice issued by a state court or administrative agency that requires the Plan to cover a child of an Employee, if the Employee is eligible for benefits under the Plan.

When the Employer receives a medical support order, the Employer will determine whether the order is "qualified".

If the order is determined to be qualified, and if you are eligible to receive benefits under this Plan, then your Dependent child will be covered, subject to any applicable contribution requirements. Your Employer will provide your Dependent child with necessary information which includes, but is not limited to, a description of coverages and ID cards, if any. Upon request, your Employer will provide at no charge, a description of procedures governing medical child support orders.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee or Dependent in ELIGIBILITY will determine who is eligible for coverage under the Plan.

Coverage will begin on the first day of the month coinciding with or next following the date you satisfy any eligibility waiting periods required by the Employer.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent if you are covered and if you apply for coverage within 31 days after acquiring the new Dependent.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth; and
- For any other adoptive child, from the date of placement.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage. Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

Coverage for late applicants:

- Class I and Class II services are covered as described in the SCHEDULE.
- All other classes of service are covered at 50% of the amounts described in the SCHEDULE.
- After a Member has been continuously covered under the Plan for 12 months, this limit no longer applies.

Your eligible Dependent is not a late applicant if you did not apply to cover the Dependent within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that Dependent. If you apply within 31 days of the date the court order is issued, coverage will start on the court ordered date.

■ Will My Coverage Change?

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class the first day of the month coinciding with or next following the date the Member's class status changes.

All claims will be based on the benefits in effect on the date the claim was incurred.

■ When Will My Coverage End?

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The last day of the calendar month in which your Service ends.
- The date you are no longer eligible for reasons other than end of your Service.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends.
- The date you cease to be eligible for Dependent coverage.
- The date your Dependent ceases to be an eligible Dependent.

- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

Extension of Dental Benefits

An expense incurred in connection with a covered dental service that is completed after a Member's coverage ends, will be considered incurred while coverage is in effect if:

- For fixed bridgework and full or partial dentures - The first impressions are taken and/or abutment teeth fully prepared while the Member is covered, and the device installed or delivered to the Member within 3 calendar months after coverage ends.
- For a crown, inlay or onlay - The tooth is prepared while the Member is covered and the crown, inlay or onlay is installed within 3 calendar months after coverage ends.
- For root canal therapy - The pulp chamber of the tooth is opened while the Member is covered and the treatment is completed within 3 calendar months after coverage ends.

There is no extension for any other dental service.

Continuation of Coverage under Federal Laws and Regulations

If coverage would otherwise terminate under this Plan, you and your Dependents may be eligible to continue coverage under certain federal laws and regulations. See USERRA RIGHTS AND RESPONSIBILITIES, CONTINUATION OF COVERAGE - FMLA and CONTINUATION OF COVERAGE - COBRA.

■ Can Coverage Be Reinstated?

If your coverage ended because of termination of your Service, you may be eligible for reinstatement of coverage if you return to Service within 3 months after the date your coverage ended.

On the date you return to Service, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

See USERRA RIGHTS AND RESPONSIBILITIES for information about reinstatement of coverage upon return from leave for military service.

PPO DENTAL BENEFITS

■ How Does the Dental Plan Work?

For the names of network providers, contact Member Services at the phone number or website shown on the Member ID card. You are responsible for confirming that a provider is a network provider.

Alternate Benefit

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

If the Member requests or accepts a more costly covered service, the Member is responsible for expenses that exceed the amount covered for the least costly service.

A "Predetermination of Benefits" is recommended before treatment begins.

Predetermination of Benefits

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

Review of proposed treatment is advised whenever extensive dental work is recommended when estimated charges exceed $200.00.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials, as requested in the review process. If there is a change in the treatment plan, a revised plan should be submitted.

Covered dental expenses will be determined upon review of the proposed treatment plan. If there is no Predetermination of Benefits, covered dental expenses will be determined when a claim is received.

Predetermination of Benefits is not a guarantee of a set Plan payment. Plan payment is based on the services actually provided, and on the coverage in force at the time services are completed.

Additional Programs

The Plan may offer, or arrange for various entities to offer, programs, discounts, benefits, or other consideration for the purpose of promoting general health and well being. For more information, contact Member Services at the phone number or website address shown on the Member ID card.

If you are covered under the Dental 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. For more information, refer to your enrollment materials, or contact Member Services at the phone number or website address shown on the Member ID card.

■ What's Covered? (Covered Expenses)

The DENTAL BENEFITS SCHEDULE shows Plan coinsurance percentages, any deductibles and any maximums.

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

A covered dental expense means that portion of a Dentist's charge that is payable for a dental service delivered to a covered Member. To be eligible for coverage as a covered expense:

- the service must be ordered or prescribed by a Dentist for a covered Member; and
- the service must be essential for the Necessary care of teeth; and
- the service must be within the scope of coverage limitations; and

PPO DENTAL BENEFITS - Continued

- for Class I, II and III, the service is started and completed while coverage is in effect, except for services described in the "Extension of Benefits" provision; and
- any applicable deductible has been met; and
- any applicable maximum has not been exceeded; and
- the charge does not exceed the amount allowed under the Alternative Benefit provision.

All providers, including any facilities, must be licensed in accordance with the laws of the appropriate legally authorized agency, and acting within the scope of such license.

Maximum Reimbursable Charge

Network providers - The Plan payment for a covered dental service is the Contracted Fee agreed upon with the provider, multiplied by the applicable Class coinsurance percentage shown in the SCHEDULE.

The Member is responsible for any applicable deductibles and Member coinsurance amounts. The provider may not bill the Member for any amount over the Contracted Fee.

"Contracted Fee" refers to the total compensation level that a provider has agreed to accept as payment for a covered dental service.

Non-network providers - The Plan payment for a covered dental service is the Maximum Reimbursable Charge for that service, multiplied by the applicable Class coinsurance percentage shown in the SCHEDULE. The Maximum Reimbursable Charge is determined based on the lesser of:

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

The percentile used to determine the Maximum Reimbursable Charge is the 80th percentile.

The Member is responsible for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to any applicable deductibles and Member coinsurance amounts.

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

CLASS I - Preventive and Diagnostic

The following are Class I covered expenses:

- Clinical oral examinations - Only 2 per calendar year.
- Prophylaxis (cleaning), including periodontal maintenance procedures following active therapy - Only 2 per calendar year.
- Routine x-rays (bitewing) - Only 2 sets per calendar year.
- Non-routine x-rays - Complete series or Panoramic (Panorex) - Only 1, including panoramic film, per consecutive 3 calendar year period.
- Topical application of fluoride, excluding prophylaxis, for a Member under age 19 - Only 1 per calendar year.
- Topical application of sealant, per tooth, on a posterior tooth, for a Member under age 14 - Only 1 application per tooth per 3 calendar years.
- Space maintainers, fixed unilateral - Limited to non-orthodontic treatment.

PPO DENTAL BENEFITS - Continued

CLASS II - Basic Restorative, Periodontics, Endodontics, and Oral Surgery

The following are Class II covered expenses:

- Emergency Care (palliative treatment) of dental pain, minor procedures, when no other definitive dental services are performed. Any x-ray taken in connection with such treatment is a separate dental service.
- Routine extractions.
- Surgical removal of an erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or a section of tooth:
  - Removal of impacted tooth, soft tissue.
  - Removal of impacted tooth, partial bony.
  - Removal of impacted tooth, completely bony.
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed, but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia - Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures that are covered under this Plan.
- I.V. sedation - Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures that are covered under this Plan.
- Osseous surgery - Flap entry and closure is part of the allowance for osseous surgery, and is not a separate dental service.
- Periodontal scaling and root planing - Entire mouth.
- Root canal therapy - Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and is not a separate dental service.
- Amalgam filling.
- Composite/Resin filling.

CLASS III - Major Restorative, Dentures and Bridgework and Prosthodontic Maintenance

The following are Class III covered expenses:

- Adjustments - complete denture - Any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Recement bridge.
- Crowns:
  - Porcelain fused to high noble metal.
  - Full cast, high noble metal.
  - Three-fourths cast, metallic.

  Crown restorations are eligible covered expenses only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
- Removable appliances:
  - Complete (full) dentures, upper or lower.
  - Partial dentures.
  - Lower, cast metal base with resin saddles, including any conventional clasps, rests and teeth.
  - Upper, cast metal base with resin saddles, including any conventional clasps, rests and teeth.
- Fixed appliances:
  - Bridge pontics - Cast high noble metal.
  - Bridge pontics - Porcelain fused to high noble metal.
  - Bridge pontics - Resin with high noble metal.

PPO DENTAL BENEFITS - Continued

- Retainer crowns - Resin with high noble metal.
- Retainer crowns - Porcelain fused to high noble metal.
- Retainer crowns - Full cast high noble metal.

- Prosthesis over implant - A prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.
- Stainless steel crowns, resin crowns for a member under age 16 - Covered only when the tooth cannot be restored by filling, and then only 1 time per consecutive 36-month period.

Class IV - Orthodontics

Each month of active treatment is a separate dental service.

Covered Expenses include:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan, and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or removable appliances - Only one appliance for tooth guidance or to control harmful habits.
- Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the Dentist, up to 4 times per calendar year.

The total amount payable for all covered expenses incurred for orthodontics during a Member's lifetime will not be more than the Orthodontic Maximum shown in the SCHEDULE.

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

Orthodontics - Replacement Provision

Coverage will be provided if orthodontic treatment was started while the Member was covered for orthodontic benefits under a prior (replaced) plan and:

- Orthodontic treatment is continued under this Plan; and
- The Member submits proof that this Plan's Maximum Benefit was not equaled or exceeded by the benefits paid or payable under the prior plan.

For the purpose of this provision, the Maximum Benefit will be calculated determining:

- The lesser of this Plan's Maximum Benefit and the maximum benefit of the prior plan; and
- Subtracting the benefit paid or payable by the prior plan from the amount in the bullet above. The remainder of the benefit is payable under this Plan.

In no event will the Member receive more in orthodontic benefits that the amount the Member would have received had the prior plan remained in effect.

BENEFIT LIMITATIONS

General Limitations and Exclusions

No amount will be payable for:

- charges which would not have been made if the Member did not have coverage.
- charges which the Member is not obligated to pay, or for which the Member is not billed or for which the Member would not have been billed except that they were covered under the Plan. For example, if Cigna determines that a provider is waiving or has waived, discounted, reduced, or forgiven any portion of its charges and/or any portion of deductible, copay, coinsurance amount(s) you are required to pay for a Covered Expense without Cigna's express consent, then Cigna in its role as benefits administrator shall have the sole discretion to: (i) deny the payment of benefits in connection with the Covered Expense; or (ii) reduce the benefits in proportion to the amount of the deductible, copay or coinsurance amount(s) waived, discounted, forgiven or reduced; regardless of whether the provider represents that you remain responsible for any amounts that the Plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost-sharing payment(s) prior to the payment of any benefits under the Plan. This exclusion includes, but is not limited to, charges of a provider who is not a network provider who has agreed to charge you, or has charged you, based upon what you would be required to pay out-of-pocket for treatment provided by a network that provider or some other benefit level not otherwise applicable to the treatment received.
- charges arising out of, or relating to, any violation of a healthcare-related state or federal law, or which themselves are a violation of a healthcare-related state or federal law.
- treatment of a dental disease, defect or Injury which is due to war, declared or undeclared, riot or insurrection.
- charges for unnecessary care, treatment or surgery.
- charges for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- care for health conditions required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition.
- expenses for care provided through or by a public program, to the extent that a Member is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- expenses incurred outside the United States other than expenses for emergency care (any benefits for emergency care performed outside the United States will be limited to a maximum of $100-$200 per 12 consecutive month period).
- charges made by any covered provider who is a member of your family or your Dependent's family.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges made by a provider for broken appointments, phone calls, email or internet evaluations unless otherwise specified as covered under the Plan.
- unless otherwise covered in this Plan, for reports, evaluations, physical examinations not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment, unless such treatment is prescribed and listed as covered in this Plan.
- dental care expenses for the infant child of a Dependent, unless the infant child is otherwise eligible under this Plan.

Missing Teeth Limitation

During the Member's first 12 Months of continuous coverage, the amount payable for replacement of teeth that are missing when a Member first becomes covered under this Plan is limited to 50% of the amount payable for replacement of teeth after the Member becomes covered under this Plan.

BENEFIT LIMITATIONS - Continued

Dental Benefit Limitations and Exclusions

No amount will be payable for:

- any amount that is more than the Maximum Reimbursable Charge.
- services performed solely for cosmetic reasons.
- dental services that do not meet common dental standards.
- services that are deemed to be medical services.
- any charges, including ancillary charges, made by a Hospital, ambulatory surgical center or similar facility.
- procedures, appliances or restorations (except full dentures) whose main purpose is to change vertical dimension; stabilize periodontally involved teeth or restore occlusion.
- bite registration.
- splinting.
- porcelain or acrylic veneers of crowns or pontics on, or replacing, the upper and lower first, second and third molars.
- replacement of a lost or stolen appliance.
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless:
  - replacement is made necessary by the placement of an original opposing full denture or the Necessary extraction of natural teeth; or
  - the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an Injury received while the Member is covered under the Plan.
- replacement of a bridge, crown or denture that is or can be made usable accordingly to common dental standards.
- surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- instruction for plaque control, oral hygiene and diet.

CLAIMS & LEGAL ACTION

■ How To File Claims

As used in this provision, any reference to "you" or "your" refers to the covered Member, and also refers to a representative or provider designated by you to act on your behalf.

A claim form can be requested from the Plan Administrator, through the website address or by calling Member Services at the phone number shown on your ID card. Complete and accurate claim information is necessary to avoid claim processing delays.

Timely Filing of Claims

Cigna will consider claims for coverage, other than Network coverage, under the Plan when proof of loss (a claim) is submitted within one year (365 days) after expenses are incurred. If expenses are incurred on consecutive days, the limit will be counted from the last date expenses are incurred. If the claim is not submitted within the specified time period, it will not be considered valid and will be denied.

Dental Benefits

When using a network provider, you do not need to file a claim if you present your ID card. The network provider will file the claim. When using non-network providers, claims can be submitted by the provider if the provider is willing and able to file on your behalf. If the provider is not submitting on your behalf, you must send the completed claim form and itemized bills to the address shown on the claim form.

■ Claim Determinations and Appeal Procedures

As used in this provision: (a) any reference to "you" or "your" refers to the covered Member, and also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted; and (b) "Physician/Doctor Reviewers" are licensed Physicians/Doctors depending on the care, service or treatment under review.

Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested and the type of health plan. Medical Necessity determinations are made on a postservice basis.

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

Post-Service Determinations

When you or your representative requests a coverage determination or claim payment determination after care has been provided, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that apply to the determination:

- information sufficient to identify the claim.
- the specific reason or reasons for the adverse determination.
- reference to the specific Plan provisions on which the determination is based.

- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
- a description of the Plan's review procedures and the applicable time limits, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, if applicable.
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment or other similar exclusion or limit.
- information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeals process.
- in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COMPLAINTS and APPEALS - Cigna has a process for addressing your concerns.

Start with Customer Service

If you have a concern regarding a person, a service, the quality of care, contractual benefits you may call Customer Service at the phone number shown on your ID card, explanation of benefits or claim form and explain your concern to a Customer Service representative. You may also express that concern in writing.

Customer Service will make every effort to resolve the matter on your initial contact. If more time is needed to review or investigate your concern, a response will be provided 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 may start the appeals procedure.

Internal Appeals Procedure

To initiate an appeal you must submit a request for an appeal in writing to Cigna within 180 days of the date the notice of denial is received. 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 Cigna to register your appeal by telephone. Call Customer Service at the phone number shown on your ID card, explanation of benefits or claim form.

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.

Cigna will respond in writing with a decision within 30 calendar days after receipt of an appeal for a postservice Medical Necessity determination. Cigna will respond within 60 calendar days after receipt of an appeal for any other postservice coverage determination. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if the timeframes under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Dentist would cause you severe pain which cannot be managed without the requested care.

When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

If you are dissatisfied with the internal appeal, you may request that your appeal be referred to an independent review organization, as described in the External Review Procedure provision.

CLAIMS & LEGAL ACTION - Continued

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the Plan. There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify Cigna's Appeals Coordinator within 4 months of receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render a decision within 45 days.

When requested, and if a delay would be detrimental to your condition, as determined by Cigna's Physician reviewer, or if your appeal concerns availability of care, the external review will be completed within 72 hours.

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:

- information sufficient to identify the claim.
- the specific reason or reasons for the adverse determination.
- reference to the specific Plan provisions on which the determination is based.
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below.
- a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to bring a civil action under ERISA Section 502(a), if applicable.
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that was based on Medical Necessity, experimental treatment or other similar exclusion or limit.
- information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeals process. A final notice of an adverse determination will include a discussion of the decision.

"Relevant Information" means any document, record or other information that:

- was relied upon in making the benefit determination.
- was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination.
- demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination.
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for 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 ERISA Section 502(a) 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 appeal processes, as applicable. Legal action must be taken for network expenses within 3 years after a claim is submitted, and for expenses other than network expenses within 3 years after proof of claim is required under the Plan.

What If a Member Has Other Coverage? (Coordination of Benefits)

This Coordination of Benefits provision applies if you or any one of your Dependents is covered under more than one Plan, and determines how benefits payable from all Plans will be coordinated. Claims should be filed with each Plan.

As used in this provision, references to "you" or "your" refers to each covered Member.

Under this provision, total payments from the Primary and Secondary Plans will never be more than the expenses actually incurred.

Definitions

For the purpose of this provision, the following terms have the meanings described here:

- "Plan" means any of the following that provides health care benefits, services or treatment:
  - this Plan.
  - group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including Closed Panel coverage.
  - governmental benefits as permitted by law, except Medicaid, Medicare and Medicare supplement policies.
  - health care 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" means a Plan that provides health care benefits primarily in the form of services or supplies through a panel of employed or contracted providers, and that limits or excludes benefits provided outside of the panel, except in the case of emergency or if referred by a provider within the panel.
- "Primary Plan" means the Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.
- "Secondary Plan" means 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" means a necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

  Examples of expenses or services that are not Allowable Expenses include, but are not limited to, the following:
  - An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
  - If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
  - If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement is the Allowable Expense.
  - If your benefits are reduced under the Primary Plan (through 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" means a calendar year, but does not include any part of a year during which you are not covered under this Plan or any date before this provision or any similar provision takes effect.
- "Reasonable Cash Value" means an amount which a duly licensed provider of health care services or supplies usually charges patients and which is within the range of fees usually charged for the same service or supply by other health care providers located within the immediate geographic area where the health care service or supply is rendered under similar or comparable circumstances.

CLAIMS & LEGAL ACTION - Continued

Order of Benefit Determination Rules

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

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

- The Plan that covers you as an enrollee or an employee is the Primary Plan and the Plan that covers you as a dependent is the Secondary Plan.
- If you are a dependent child whose parents are not divorced or legally separated, the Primary Plan is the Plan that covers the parent whose birthday falls first in the calendar year as an enrollee or employee.
- If you are the dependent of divorced or separated parents, benefits for the Dependent are determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's dependent) is the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee's dependent) is 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 does not apply.
- The Plan that covers you under a right of continuation provided by federal or state law is the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's dependent) is 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 does not apply.
- If one of the Plans determines the order of benefits based on 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 rule determines the order of benefits.

If none of the above rules determine the order of benefits, the Plan that has covered you for a longer period of time is the Primary Plan.

Effect on the Benefits of This Plan

The Coordination of Benefits provision is applied throughout each Claim Determination Period.

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.

If this Plan is the Secondary Plan, it pays the lesser of:

- the Allowable Expenses that were not reimbursed under the other Plan; or
- the amount this Plan would have paid if there were no other coverage.

When the benefits of a government Plan are taken into consideration, the Allowable Expense is limited to the benefits provided by that Plan.

When the Coordination of Benefits provision reduces the benefits payable under this Plan, each benefit will be reduced proportionately and only the reduced amount will be charged against any benefit limits under this Plan.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan and the benefit payments this Plan actually paid as the Secondary Plan, will be recorded as a benefit reserve for you.

As each claim is submitted, the following will be determined: this Plan's obligation to cover services and supplies under this Plan; whether a benefit reserve has been recorded for you; and whether there are any unpaid eligible Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, the benefit reserve recorded for you will be used to pay up to 100% of the total of all eligible 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 this Plan pays charges for benefits that should have been paid by the Primary Plan, or if this Plan pays charges in excess of those for which this Plan is obligated to pay, this Plan has the right to recover the actual payment made or the Reasonable Cash Value of any services.

This Plan may seek recovery from any person to, or for whom, or with respect to whom, such services or supplies were provided or such payments made by any insurance company, health care plan or other organization. If requested, you must execute and deliver to this Plan any such instruments and documents as determined necessary to secure the right of recovery.

Right to Receive and Release Information

Without consent or notice to you, information may be obtained from you, and information may be released to any other Plan with respect to you, in order to coordinate your benefits pursuant to this provision. You must provide any information requested in order to coordinate your benefits pursuant to this provision. 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 another Plan, is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim may be denied. If the requested information is subsequently received, the claim will be processed.

■ Expenses For Which A Third Party May Be Responsible

This Plan does not cover:

- expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgement 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 dental 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-dental expense damages.

No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine" or "Attorney's Fund Doctrine".

The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

The Plan hereby disavows all equitable defenses in the pursuit of its right of recovery. The Plan's recovery rights are neither affected nor diminished by equitable defenses.

In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future dental benefits hereunder until the Participant has fully complied with his/her reimbursement obligations hereunder, regardless of how those future dental benefits are incurred.

Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Participants must assist the Plan in pursing any recovery rights by providing requested information.

Payment of Benefits

As used in this provision, any reference to "you" or "your" refers to the covered Member, and also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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.

Plan payment may be made to you for the cost of any covered expenses received from a provider who is not a network provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

CLAIMS & LEGAL ACTION - Continued

If any person to whom benefits are payable is a minor or is not able to give a valid receipt for any payment due, such payment may be made to the person's legal guardian. If no request for payment has been made by the person's legal guardian, Plan payment may be made to the person or institution appearing to have assumed custody and support of the person.

When a Plan participant passes away, and notice is received that an executor of the estate has been established, benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

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

■ Other Information a Member Needs to Know

Legal Actions

A Member may bring a legal action to recover under the Plan. For legal actions not related to the Plan's Appeals Procedure, such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Relationship Between Cigna and Network Providers

Providers under contract with Cigna are independent contractors. Network providers are neither agents nor employees of Cigna, nor is Cigna, or any employee of Cigna, an agent or employee of Network providers. Cigna will not be responsible for any claim or demand on account of damages arising out of, or in any way connected with, any injuries suffered by the Member while receiving care from any Network provider or in any Network provider's facilities.

GLOSSARY

Dentist

A person practicing dentistry or oral surgery within the scope of his or her license. It also includes a provider operating within the scope of his or her license, when the provider performs a covered dental service.

Dependent

See ELIGIBILITY.

Doctor/Physician

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts if the practitioner performs a service within the scope of his or her license and for which this Plan provides coverage.

Emergency Care/Services

Required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition; usually minor procedures performed in response to serious symptoms, which temporarily relive significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

Employee

See ELIGIBILITY.

Employer

- Community Action Team, Inc.; and
- Any affiliated companies listed in the application of the Employer. The Employer may add an affiliated company after the effective date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

Hospital

An institution:

- licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Doctors; and provides 24-hour service by registered graduate nurses; or
- which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Injury

An accidental bodily injury.

Maximum Reimbursable Charge

See WHAT'S COVERED? (Covered Expenses).

Medicare

Title 18 of the United States Social Security Act of 1965 as amended from time to time and the coverage provided under it. This includes coverage provided under Medicare Advantage plans.

Member

An Employee and any covered Dependent.

GLOSSARY - Continued

Necessary

A procedure, service or supply that is required by, and appropriate for, treatment of a dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with a dental consultant.

Plan

The dental benefits described in this booklet.

Service

See ELIGIBILITY.

Sickness

A physical illness.

You and Your

An Employee.

USERRA RIGHTS AND RESPONSIBILITIES

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service. This includes the right to continue the dental coverage that you (the Employee) had in effect for yourself and your Dependents.

"Uniformed Service" means the performance of active duty in the Uniformed Services under competent authority which includes training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of the assigned duties.

You must notify your Employer verbally or in writing of your intent to leave employment and terminate your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

Continued Dental Coverage

Under USERRA, you are eligible to elect continued dental coverage for yourself and your Dependents when you terminate Service with the Employer for the purpose of Uniformed Service.

The Employer should establish reasonable procedures for electing continued dental coverage and for payment of contributions. See the Plan Administrator for details.

If you do not provide advance notice of your leave and you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service.

However, if you are excused from giving advance notice because it was unreasonable or impossible for you to provide advance notice due to reasons such as military necessity, then coverage will be retroactively reinstated if you elect coverage for yourself and your Dependents and pay all unpaid contributions within the period specified in the Employer's reasonable procedures.

If you provide advance notice of your leave but you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service, when the duration of Uniformed Service is at least 30 days.

However, coverage will be retroactively reinstated if the Employer has established reasonable procedures for election of continued coverage after the period of Uniformed Service begins, and you elect coverage for yourself and your Dependents and pay all unpaid contributions within the time period specified in the procedures.

If the Employer has not established reasonable procedures, then the Employer must permit you to elect continued coverage for yourself and your Dependents and pay all required contributions at any time during the period of continued coverage, and the Employer must retroactively reinstate coverage.

If you elect continued coverage but do not make timely payments for the cost of coverage

If the Employer has established reasonable payment procedures and you do not make payments according to the procedures, then coverage for you and your covered Dependents will terminate as described in the procedures.

Period of Continued Coverage

During a leave for Uniformed Service, the period of continued coverage begins immediately following the date you and your covered Dependents lose coverage under the Plan, and it continues for a maximum period of up to 24 months.

Cost of Continued Coverage

If the period of Uniformed Service is less than 31 days, you are not required to pay more than the amount that you paid as an active Employee for that coverage for continued coverage.

USERRA RIGHTS AND RESPONSIBILITIES - Continued

If the period of Uniformed Service is 31 days or longer, then you will be required to pay up to 102% of the applicable group rate for continued coverage.

COBRA Coverage

If you are entitled to COBRA continuation coverage, then the COBRA coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than USERRA coverage.

Reinstatement of Coverage

Coverage for an Employee who returns to Service with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

CONTINUATION OF COVERAGE - FMLA

This provision applies if the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), as amended. If you are eligible for FMLA leave and if the Employer approves your FMLA leave, coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If your coverage ends during FMLA leave, a COBRA qualifying event occurs if you do not return to work on the date you are scheduled to return from your FMLA leave. See the Plan Administrator with questions about FMLA leave.

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA

COBRA continuation coverage is a temporary extension of coverage under the Plan, and was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Under this federal law, you and/or your covered Dependents (a covered Member) if a COBRA qualified beneficiary, must be given the opportunity to continue Plan coverage when there is a "qualifying event" that would result in loss of coverage under the Plan. The law permits continuation of the same Plan coverage under which the qualified beneficiary was covered on the day before the qualifying event, unless the qualified beneficiary moves out of the Plan's coverage area or the Plan is no longer available. If coverage options are available, a qualified beneficiary has the same options to change coverage as others who are covered under the Plan.

COBRA continuation coverage is available for you and your covered Dependents for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct.
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in loss of coverage under the Plan:

- your death.
- your divorce or legal separation.
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Only a qualified beneficiary, as defined by federal law, may elect COBRA continuation coverage. A qualified beneficiary may include the following individuals who were covered under the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has an independent right to elect or decline COBRA continuation coverage, even if you decline or are not eligible for COBRA continuation coverage.

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

The following individuals are not qualified beneficiaries for the purposes of COBRA continuation coverage: domestic partners, spouses who do not meet the definition of spouse under federal law, and children (such as stepchildren, grandchildren) who have not been legally adopted by you. Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The provisions "Secondary Qualifying Events" and "Medicare Extension for Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage, or within the disability extension period. Under no circumstances with COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, both of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- a copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate, for all individuals covered under the extension, on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation Coverage" will also apply to the disability extension period.

Medicare Extension

When the qualifying event is your termination of employment or reduction in work hours, and you became covered under Medicare (Part A, Part B or both) within the 18 months before the qualifying event, the maximum COBRA continuation period for you is 18 months from the date of your termination of employment or reduction in work hours, and for your Dependents the maximum continuation period is 36 months from the date you became covered under Medicare.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate when any of the following occurs:

- the end of the COBRA continuation period of 18, 29 or 36 months; as applicable.
- failure to pay the required cost of coverage as described in "COBRA Premiums".
- cancellation of the Employer's Plan.
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under Medicare (Part A, Part B or both).

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage. In such a situation, COBRA continuation coverage will continue until the earlier of: the date the condition becomes covered under the other plan or the occurrence of any of the events listed above.
- after the date the qualified beneficiary qualifies as described in "Disability Extension", the beneficiary is no longer disabled.
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving COBRA continuation (e.g., fraud).

Employer Notice Requirements

The Employer is required to provide the following notices:

- *Initial Notice* - An initial notice of COBRA continuation rights must be provided within 90 days after Plan coverage begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA election notice.
- *Election Notice* - COBRA continuation coverage will be offered to qualified beneficiaries only after the Employer's representative or Plan Administrator has been timely notified that a qualifying event has occurred, and must be provided to you and/or your Dependents within the timeframe required by COBRA.

  When the qualifying event is termination of employment, reduction of employment hours or the Employee's death, a COBRA continuation election notice must be provided to you and/or your Dependents:
  - if the Plan provides that the COBRA continuation coverage period starts upon the loss of coverage, within 44 days after loss of coverage under the Plan.
  - if the Plan provides that the COBRA continuation coverage period starts upon the occurrence of a qualifying event, within 44 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

The COBRA continuation election notice will list the individuals who are eligible for COBRA continuation coverage, and provide information about the applicable cost of coverage. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election in writing no later than the due date stated in the election notice. If written notice is mailed, it must be post-marked no later than the due date stated in the election notice. If you do not make proper notification by the due date stated in the election notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. COBRA continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect COBRA continuation on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation coverage.

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

Cost of COBRA Continuation Coverage

Each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The cost during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation, the Employee or family member will be charged 102% (or 150%, if applicable) of the active Employee cost of coverage. If the spouse or one Dependent child alone elects COBRA continuation coverage, the individual will be charged 102% (or 150%, if applicable) of the active Employee cost of coverage. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%, if applicable) of the applicable family cost of coverage.

The first COBRA continuation coverage payment must be made no later than 45 calendar days after the date of your election (if mailed, this is the date the election notice is postmarked). The qualified beneficiary is responsible for making sure that the amount of the first payment is enough to cover the entire initial period from the date coverage would have otherwise terminated, up to the date the qualified beneficiary makes the first payment. If the first payment is not made within the 45-day period, all COBRA continuation rights under the Plan will be lost. Claims incurred during the period covered by the initial payment period will not be processed until the payment is made.

After the first payment is made, the qualified beneficiary is required to pay for each subsequent period of coverage. If payment is made on or before its due date, coverage under the Plan will continue for that coverage period without any break.

A grace period of 30 days after the first day of the coverage period will be given to make each periodic payment. Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if payment is received after the due date, coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If required payment is received before the end of the grace period, coverage will be reinstated back to the beginning of the coverage period. This means that any claim(s) submitted while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated. If payment is not made before the end of the grace period for that coverage period, all rights to COBRA continuation under the Plan will be lost.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience any of the following qualifying events, you or your Dependent(s) must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would end as a result of the qualifying event:

- your divorce or legal separation.
- your child no longer qualifies as a Dependent under the Plan.
- the occurrence of a secondary qualifying event as described in “Secondary Qualifying Events” (this notice must be received prior to the end of the initial 18-month or 29-month COBRA period). See “Disability Extension” for additional notice requirements.

Notice must be made in writing and must include: the name of the Plan; name and address of the Employee covered under the Plan; name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g. divorce decree, birth certificate, disability determination, etc.).

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. Coverage is subject to the Plan's notice and/or application process for active Employees adding a new Dependent. Only your newborn or adopted Dependent child is a qualified beneficiary for the purpose of continuing COBRA coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. Any other Dependent added while your coverage is being continued is not a qualified beneficiary for the purpose of continuing COBRA coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

Health FSA

The maximum COBRA coverage period for a health flexible spending arrangement (Health FSA), if maintained by your Employer, ends on the last day of the Flexible Benefits Plan Year in which the qualifying event occurred.

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 31 days of the date you meet criteria described in the following provisions.

Change of Status

A change in status is defined as:

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

Court Order

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

Medicare or Medicaid Eligibility/Entitlement

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

Change in Cost of Coverage

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

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

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN - Continued

Changes in Coverage of a Spouse or Dependent Child Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent child:

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

ERISA GENERAL INFORMATION

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

The name of the Plan is: Community Action Team, Inc.

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

Community Action Team, Inc.

124 N. 18th St.

St. Helens, OR 97051

503-397-3511

The Employer Identification Number (EIN) is: 93-0554156

The Plan Number assigned by the Employer is: 501

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

The name, address and ZIP code of the designated agent for service of legal process is: Employer named above

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

Contributions are determined by the Employer. Employee contributions, if any, for a time period for which the Employee is not covered under the Plan may be refunded by the Employer. Please see your Plan Administrator for details.

The health benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Cigna provides contract administration by processing claims and provides other services to the Employer related to the self-funded benefits. Cigna does not insure nor guarantee the self-funded benefits.

The fiscal records of the Plan are maintained on the basis of Plan years ending June 30.

The preceding pages set forth the Plan's eligibility requirements, termination provisions and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of benefits.

Procedures to be followed in presenting claims for benefits and what to do when claims are denied in whole or in part are described in CLAIMS & LEGAL ACTION.

Plan Type

The Plan is a health care benefit plan.

Plan Trustee(s)

A list of the Trustee(s) of the Plan, if any, including name, title and address, is available upon request to the Plan Administrator.

ERISA GENERAL INFORMATION - Continued

Collective Bargaining Agreement(s)

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and whether a particular employer or employee organization is a sponsor. A copy of the agreement, if any, is available for examination upon written request to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- You may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

  However, employers with fewer than 100 plan participants at the beginning of the plan year are not required to: furnish statements of the plan's assets and liabilities and receipts and disbursements or allow examination of the Annual Report, or furnish copies of the Annual Report or any Terminal Report.

Continue Group Health Plan Coverage

If a group health plan is subject to COBRA, you may be eligible to continue health care coverage for yourself or your Dependents if there is a loss of coverage under the plan as a result of a COBRA qualifying event. You or your Dependents may have to pay for such coverage. You may review the documents governing the plan or the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

STATEMENT OF ERISA RIGHTS - Continued

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain without charge copies of documents relating to the decision and to appeal any denial, all within certain time schedules.

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

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

Assistance With Your Questions

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