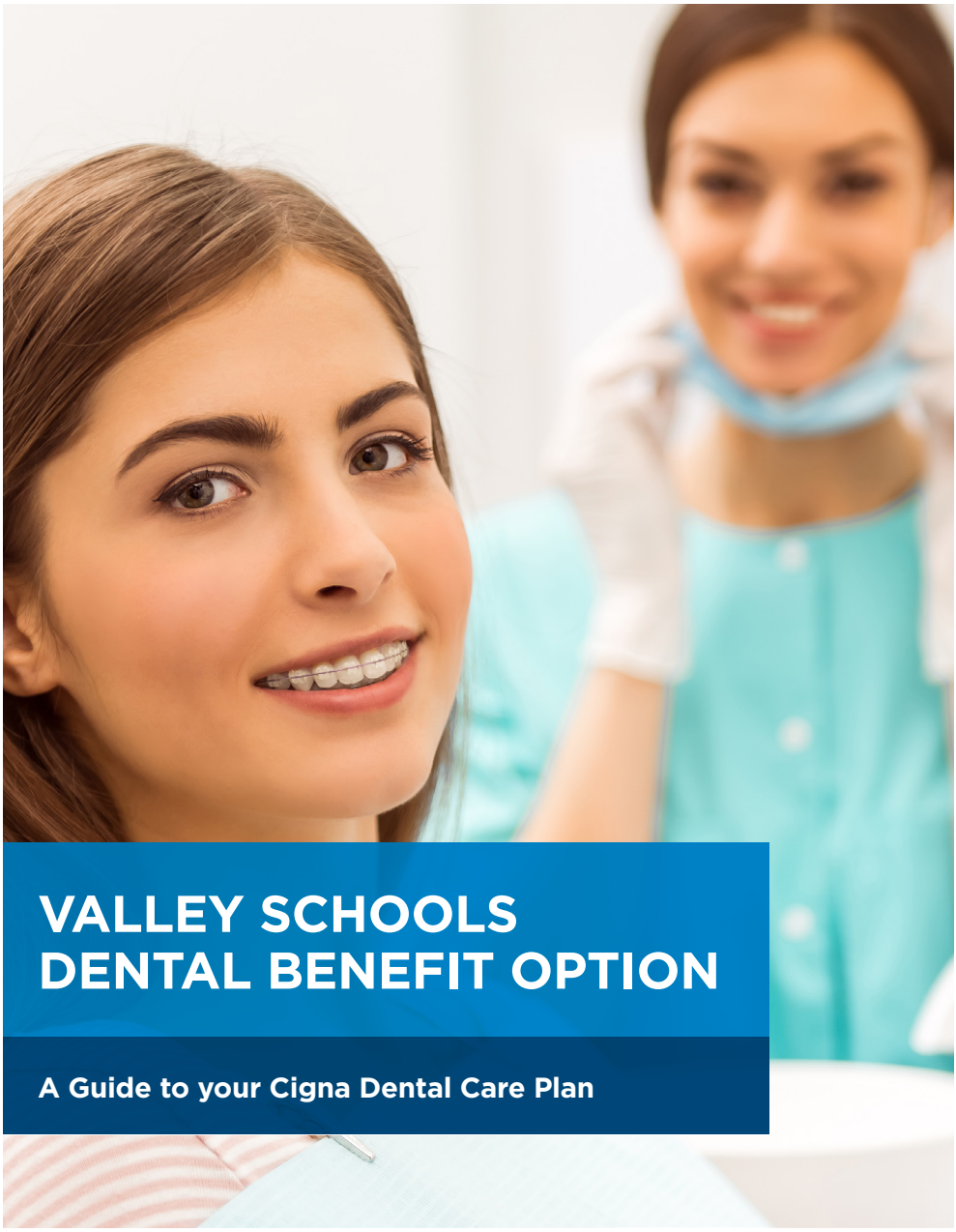

VALLEY SCHOOLS DENTAL BENEFIT OPTION

A Guide to your Cigna Dental Care Plan

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IMPORTANT PLAN INFORMATION

We are pleased to provide information about the Cigna Dental Care® (DHMO[1]) plan. This plan offers a full range of benefits through a network of plan dentists.

Important details

During open enrollment, you will be able to select a network general dentist. If you do not select one, a network general dentist will be auto-assigned to you to manage your overall dental care. If you or covered family members would like to change your general dentist, you can do so following the instructions in this brochure. Children under the age of 7 may choose a network pediatric dentist. If you need assistance in changing your dentist, contact Cigna at **800.Cigna24**.

- You will pay the copay amount listed on your Patient Charge Schedule (PCS) for covered dental services performed by your network dentist.
- If your network general dentist does not perform the specialty care procedure you need, he/she can direct you to a participating network specialist.
- Procedures not listed on your Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.
- Preauthorization of payment is not required for specialty referrals for pediatric and orthodontic services.
- Remember: If you seek covered services from a dentist who does not participate in the Cigna Dental Care network, your plan will not pay except in the case of an emergency, or as required by law.

What's covered

You can save money on a wide range of services, including:

- **Preventive care** – cleanings, fluoride, sealants, bitewing x-rays, full-mouth x-rays and more.
- **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam).
- **Major services** – crowns, bridges, dentures, root canals, oral surgery, extractions, treatment for periodontal (gum) disease and more.
- **Specialty care** – prior authorization may be required for specialty care.
- **Orthodontic care** – coverage for braces for children and adults.
- **General anesthesia** – when medically necessary.
- **Temporomandibular joint (TMJ)** – diagnosis and treatment procedures, including cone beam x-ray and appliance.

Alternate coverage provisions may apply for covered services if noted on your Patient Charge Schedule.

Plan features:

- **No deductibles** – you don't have to reach a certain level of out-of-pocket expenses before your coverage kicks in.
- **No calendar year maximums** – your coverage isn't limited by a calendar year maximum.
- There are **no claim forms** to file when using network dentists and **no waiting periods** for coverage.
- Coverage for dental conditions that exist at the time you enroll in the plan are not excluded if they are otherwise covered under your Patient Charge Schedule. Treatment started before your coverage begins will generally not be covered.[2] If you or a family member started orthodontic treatment before you joined the Cigna Dental Care plan, your plan may help pay for covered costs. See page 6 for more information.

YOUR QUESTIONS ANSWERED

Q: How does the Cigna Dental Care® (DHMO) Plan work?

A: When you sign up in the Cigna Dental Care Plan, you will be able to select a network general dentist during open enrollment. If you do not select one, a network general dentist will be auto-assigned to you to manage your overall dental care. You then receive a Patient Charge Schedule, or PCS, that lists the specific dental procedures covered by the plan and the amount you will pay the dentist (your copays). These copays apply only when you receive treatment from the dentists or dental specialists in our Cigna Dental Care DHMO Network.

If a dental procedure is not listed on your PCS, it is not covered and you will have to pay according to the dentist's regular fees. If you receive a covered service from a dentist who does not participate in the Cigna Dental Care DHMO network, your dental benefits may not be covered at all. You can take your PCS to dental appointments to discuss treatment options and costs with your dentist (but it is not required).

Q: How do I change the dentist auto-assigned to me when I sign up for the plan?

A: You can find a network dentist by visiting **Cigna.com** or go to your personalized website at **myCigna.com** after you sign up. If you need help finding a dentist, you can call the customer service number below and request to have a list of providers mailed, emailed or faxed to you. You can change your network dentist at any time; changes made by the 15th of the month will go into effect the first of the following month. Remember, if you visit a non-network dentist, your treatment may not be covered at all.

If you'd like to speak with someone, call customer service at **800.Cigna24**. You can also follow the phone prompts to use our automated Dental Office Locator. The automated system will speak the names of the dentists in your area, mail, email or fax a list of dentists to you.

Q: If I'm new to the Cigna Dental Care Plan, can I keep my current dentist?

A: That depends. If your current dentist participates in the Cigna Dental Care DHMO Network, you can choose him/her as your network general dentist. You can look online at **Cigna.com** to find out, or ask your dental office directly. Sometimes, Cigna's online Dental Office Directory may show that your dental office is not accepting new patients. If this happens, please contact customer service at **800.Cigna24** for assistance.

Q: Do I need a referral to visit a dental specialist?

A: Yes. If you require specialty care, your network general dentist will refer you to a network dental specialist – and handle any paperwork. Referrals are required for all network specialists, except orthodontists and pediatric dentists. Prior authorization may be required for certain types of specialty care and there may be a different copay.

Q: Do I need to show my ID card when I arrive at the dentist's office?

A: No. ID cards are not required to use the plan. When you call to schedule your appointment, just let your selected network dental office know that you are covered under the Cigna Dental Care DHMO Plan. If for some reason the dental office does not see your name on its list of Cigna DHMO customers, they can call us to verify. You can also call customer service at **800.Cigna24** if you need more help.

Q: When do I have to pay the dentist?

A: That depends on the financial arrangement between you and your network dentist. We encourage you to discuss costs and payment arrangements for dental treatment with your dentist before you receive care. Most dentists will work with their patients to arrange payment plans for more costly treatments.

Q: Will my network dentist submit a claim to Cigna after I receive treatment?

A: No. There are no claim forms required when receiving care from a network dentist.

Q: Are braces covered?

A: Yes. A maximum benefit of 24 months of interceptive and/or comprehensive orthodontic treatment is covered as shown in the Patient Charge Schedule. Cases beyond 24 months may require additional payments by the patient, which are based on the dentist's contracted fee and may be different from the copay listed in the Patient Charge Schedule. If you or your family member started treatment before you joined the Cigna Dental Care Plan (called "orthodontics in progress"), your new coverage may help pay some of your orthodontic costs. After you enroll, your orthodontist can complete a standard Orthodontics in Progress form or you can get one by calling Cigna customer service at **800.Cigna24**. To complete the form, you must know: the phase of treatment and the number of months of treatment you have left when your new Cigna plan starts.

Q: What if I have a dental emergency and can't get treatment from my DHMO network dentist?

A: **Emergency services:** If you are out of your service area or unable to contact your network general dentist, you may receive emergency services by any licensed dentist for unexpected but necessary services. Emergency services are limited to relieving severe pain, controlling excessive bleeding and eliminating serious and sudden ("acute") infection. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care and you should return to your network general dentist for these procedures.

Emergency care out of your service area: For emergency covered services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency covered services and your Patient Charge, up to a total of $50 per incident (this amount may vary by state). To request reimbursement, send the dentist's itemized statement to Cigna Dental at the address listed for your state on your plan materials.

Emergency care after hours: There is a copay listed on your PCS for emergency care received after regularly scheduled office hours. This copay will be in addition to other copays that may apply.

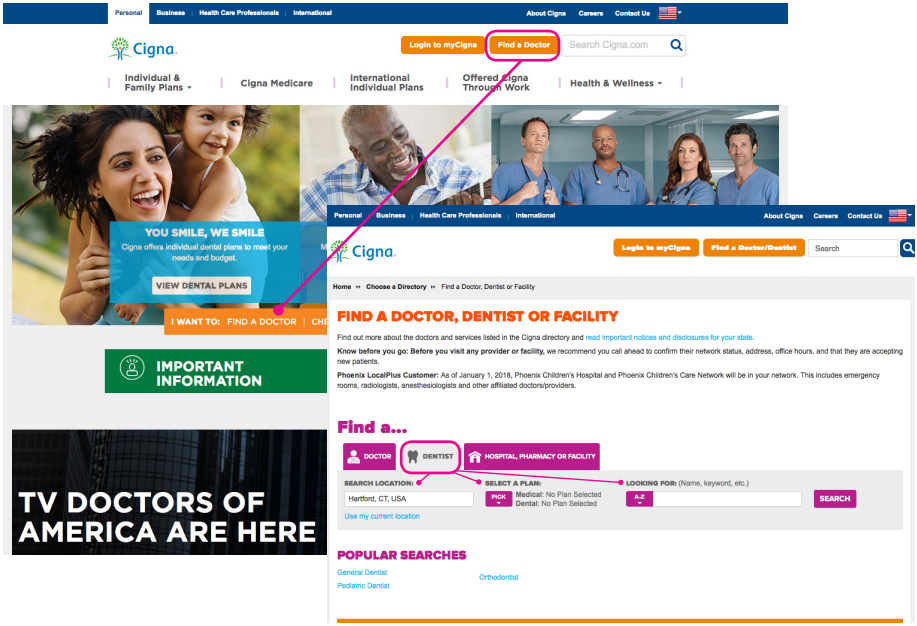
HOW TO FIND A DENTIST

It's easy to find a Cigna network dentist or specialist.

Before you enroll, you can check to see if your dentist is in the Cigna Dental Care DHMO network. Here's how.

Visit Cigna.com

- Click on **"Find a Doctor"** at the top of the screen.
- Click on **"Plans through your employer or school."**
- Choose the **"Dentist"** tab.
- Enter search location – city, state or zip code.
- Click on the **"Pick"** button. Then select **"Cigna Dental Care HMO"** and press **"Choose."**
- Review the lists given by specialty. Or narrow your search by typing in provider name, specialty or office name.
- Click on a dentist's name for more details, such as office hours and location listings with map view.



Once you're enrolled, register for myCigna.com to find a network dentist, compare the cost of procedures and so much more.

It's easy to set up.

Visit **myCigna.com** or the myCigna® App today:

- **Select** "Register"
- **Enter** your name, address and date of birth
- **Confirm** your identity with your Cigna ID number, Social Security number, or with the myCigna security questionnaire
- **Create** a user ID and password
- **Review** then select "Submit"

Already have an ID but haven't visited in a while? That's ok! If you don't remember your ID or password, just click "forgot user ID" or "forgot password" on the registration page and we'll help you out.

You can also find a network dentist 24/7/365 by calling the number on your ID card, or 800.Cigna24.

- Use the Dental Office Locator via Speech Recognition.
- Speak with a customer service representative, who can send you a customized network directory listing via email.
- Ask coworkers. Then tell us which office you choose. Each covered family member can select his/her own network general dentist.

Under your plan, you have coverage for **hundreds** of dental procedures. This overview shows you a small sampling of covered services and what you will pay compared to your estimated **cost without coverage**. See savings below. You can find a full list of dental procedures on the Patient Charge Schedule available from your employer.

SAMPLING OF COVERED PROCEDURES	WHAT YOU'LL PAY[2]	
	COST WITH CIGNA DENTAL CARE GENERAL DENTIST	ESTIMATED COST WITHOUT DENTAL COVERAGE
Adult cleaning (two per calendar year, additional cleaning $45)	$0	$70–$136 each
Child cleaning (two per calendar year, additional cleaning $30)	$0	$53–$102 each
Periodic oral evaluation	$0	$40–$76
Comprehensive oral evaluation	$0	$62–$118
Topical fluoride (two per calendar year)	$0	$28–$53
X–rays – (bitewings) 2 films	$0	$33–$63
X–rays – panoramic film	$0	$84–$161
Sealant – per tooth	$17	$42–$80
Amalgam filling (silver colored) – 2 surfaces	$22	$118–$226
Composite filling (tooth–colored) – 1 surface, Anterior	$22	$120–$231
Molar root canal (excluding final restoration)	$530	$852–$1,640
Periodontal (gum) scaling and root planing – 1–3 teeth per quadrant	$64	$179–$344
Periodontal (gum) maintenance	$78	$109–$209
Removal/extraction of erupted tooth	$53	$120–$231
Removal/extraction of impacted tooth – soft tissue	$125	$370–$712
Crown – porcelain fused to high noble metal	$470	$849–$1,634
External bleaching for home application, per arch; includes materials and fabrication of custom trays	$165	$400
Occlusal orthotic device, by report (for treatment of TMJ)	$455	$640–$1,233

Chart is for illustrative purposes only.

SUMMARY OF LIMITATIONS

PROCEDURE	LIMIT
Oral evaluations	Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145)
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Periodontal root planing and scaling	Limit 4 quadrants per consecutive 12 months
Periodontal maintenance	Limited to 4 per year and (only covered after active periodontal therapy)
Crowns and inlays	Replacement 1 every 5 years
Bridges	Replacement 1 every 5 years
Dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient
Relines, rebases	One every 36 months
Denture adjustments	Four within the first 6 months. Denture adjustments after installation
Prosthesis over implant	Replacement 1 every 5 years if unserviceable and prosthesis over implant cannot be repaired
Temporomandibular joint (TMJ) treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months
General anesthesia/IV sedation	General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the PCS. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the PCS. Plan limitation for this benefit is 1 hour per appointment.

Your network general dentist will help facilitate referral(s) you may need for care with a network specialty dentist. Referrals are not required for care with network pediatric dentists for children (under the age of 7) and for care with a network orthodontist. You should verify with your Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna before treatment begins. The copays on your PCS also apply to covered network specialist care.

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

- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States government or by a state or municipal government if the person had no insurance
- Services received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- Services for the charges which the person is not legally required to pay
- Charges which would not have been made if the person had no insurance
- Services received due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of wars
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- General anesthesia or IV sedation when used for the purpose of anxiety control or patient management
- Prescription medications
- Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction

- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen or damaged due to patient abuse, misuse or neglect
- Any services related to surgical implants, including placement, repair, maintenance, removal, and implant abutment(s) unless specifically listed on your PCS
- Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- The completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage unless specifically listed on your PCS
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental Coverage, unless specifically listed on your PCS
- Consultations and/or evaluations associated with services that are not covered
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement

- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics
- As to orthodontic treatment: incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment

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

This document outlines the highlights of your plan. For a complete list of both covered and non-covered services, including benefits required by your state, see your insurance certificate or plan description. If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.

HOW TO ENROLL AND HOW TO CHANGE YOUR GENERAL DENTIST

Enroll today

Make sure that you don't miss your opportunity to enroll for this important benefit. All you need to do is:

1. Review your plan materials and consider your family's needs.
2. Contact your Human Resources benefits coordinator for enrollment instructions.
3. Review your auto-assigned general dentist. If you wish to change your dentist, you can do so by following the instructions below.

Change your auto-assigned general dentist

1. The list of DHMO network dentists is available at **Cigna.com**, via our mobile app, or by calling customer service at **800.Cigna24**. To receive the most benefits from the Cigna Dental Care Plan you must select and use a network general dentist.
2. Contact your Human Resources Benefits department.

NEED MORE? GET MORE?

Cigna Dental Oral Health Integration Program®

What is the Cigna Dental Oral Health Integration Program?

It's a program that reimburses out-of-pocket costs for specific dental services used to treat or help prevent gum disease and tooth decay. The program is for people with certain medical conditions that may be impacted by dental care. There's no additional cost for the program – if you qualify, you get reimbursed!

Do I qualify?

If you have a Cigna dental plan, you're eligible for the program. You must currently be under treatment by a doctor for any of the following conditions:

- Heart disease
- Stroke
- Diabetes
- Head and neck cancer radiation
- Maternity
- Chronic kidney disease
- Organ transplants

How does it work?

When you visit your dentist, you will pay your usual copay. As a reminder, your copay is the fixed amount you pay for covered services. Next, your dentist will send Cigna your information and we will review the claim and refund your copay for eligible services. Once we receive your claim, you can expect to be reimbursed in about 30 days for eligible services.

Using the program is as easy as 1, 2, 3!

Together, we can make sure proper dental care is given to those who need it most.

1. Participants fill out the Registration Form. This is required only one time per qualifying medical condition. The Registration Form is available on **myCigna.com**, **Cigna.com** or by calling the number on the ID card or policy.
2. Participants mail in the completed form to Cigna at the address listed on the Registration Form.
3. Program participants visit their dentist for the covered service and pay the dentist their usual copay amount for that procedure. We'll send reimbursement in about 30 days for eligible services.

1. Cigna Dental Care is a brand name used to refer to product designs that may vary by state. In Arizona, this plan is considered a prepaid dental plan. Cigna Dental Care plans are insured by Cigna Dental Health Plan of Arizona, Inc. Plans may not be available in all areas.
2. NetMinder. DHMO data as of March 2016 and is subject to change. The Ignition Group makes no warranty regarding the performance of the data and the results that will be obtained by using. These are examples used for illustrative purposes only. Your actual costs and plan coverage will vary. Plan limitations and exclusions may apply. See your plan materials for details.

The information provided in this brochure outlines only the highlights of these plans. Review the enclosed plan summary for more information about covered and non-covered services. All group dental plans and insurance policies have exclusions and limitations. For costs and complete details of coverage, see your plan documents. The dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided to their patient. They are not agents of Cigna.

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