

*Home Office: Bloomfield, Connecticut*

*Mailing Address: Hartford, Connecticut 06152*

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

**CERTIFICATE RIDER**

No. CR7BI026-1

Policyholder: American Foreign Service Protective Association (AFSPA)

Rider Eligibility: Each Member as reported to the insurance company by your Fund.

Policy No. or Nos. 3217088-DPPO2

EFFECTIVE DATE: January 1, 2019

If this rider ever becomes contrary to any District of Columbia laws, statutes, regulations, notices or bulletins, this rider becomes null and void.

You will become insured on the date you become eligible if you are in Active Service on that date or if you are not in Active Service on that date due to your health status. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

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

  
*Anna Krishtul, Corporate Secretary*

HC-RDR1

04-10  
V3



The pages in your certificate coded **HC-LEL1 V3** , **HC-DBW1 V4 M** , **HC-DEX1 V1** and **HC-TRM3 V1** are replaced by the pages coded **HC-LEL1 V3 M** , **HC-DBW1 V4 M** , **HC-DEX1 V1** and **HC-TRM3 V1** attached to this certificate rider.

The page coded **HC-DEN8 V1** attached to this certificate rider is added to your certificate.

The following are being added to THE SCHEDULE — **Cigna Dental Preferred Provider Insurance**— in your certificate entitled **Class IX Lifetime Maximum** and **Class IX**.

**Late Entrant Limit**

Your Fund will not allow you to enroll for dental insurance until the next open enrollment period.

No coverage except for Class I services for 12 months.

This provision does not apply to new hires.

HC-LEL1

04-10

V3 M

**Cigna Dental Preferred Provider Insurance**

**The Schedule**

BENEFIT HIGHLIGHTS	CIGNA DPPO ADVANTAGE PARTICIPATING PROVIDER	CIGNA DPPO PARTICIPATING PROVIDER AND NON-PARTICIPATING PROVIDER
<b>Class IX Lifetime Maximum</b>	\$2,500	\$2,500
<b>Class IX</b> Implants	50%	50%

## Waiting Periods for Major Treatment Initial Member Group and New Member Group

You may access your Member dental benefit insurance once you have satisfied the waiting periods.

- there is no waiting period for Class I services;
- there is no waiting period for Class II services;
- there is no waiting period for Class III services;

If the plan contains Orthodontic benefits then:

- after 12 consecutive months of coverage Member dental benefits will increase to include Class IV procedures.

If the plan contains Dental Surgical Implant benefits then:

- after 12 consecutive months of coverage Member dental benefits will increase to include Class IX procedures.

You may be asked to provide evidence of the prior coverage applied to satisfy applicable waiting periods.

## Waiting Periods for Major Treatment – Dependents

The Dependent waiting period is calculated separately from the Member waiting period. Satisfaction of the Dependent waiting period begins when the eligible Member enrolls for Dependent insurance.

A Dependent may access dental benefit insurance once they have satisfied the following waiting periods.

- there is no waiting period for Class I services;
- there is no waiting period for Class II services;
- there is no waiting period for Class III services;

If the plan contains Orthodontic benefits then:

- after 12 consecutive months of coverage Dependent dental benefits will increase to include Class IV procedures.

If the plan contains Dental Surgical Implant benefits then:

- after 12 consecutive months of coverage Member dental benefits will increase to include Class IX procedures.

Dependents may be asked to provide evidence of the prior coverage applied to satisfy applicable waiting periods.

HC-DBW1

04-10  
V4 M

## Covered Dental Expense

### Class IX Services – Implants

Covered Dental Expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.

Implant coverage may have a separate deductible amount, yearly maximum and/or lifetime maximum as shown in The Schedule.

HC-DENS

04-10  
V1

## Expenses Not Covered

Covered Expenses do not include expenses incurred for:

- procedures which are not included in the list of Covered Dental Expenses.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- the alteration or restoration of occlusion.
- the restoration of teeth which have been damaged by erosion, attrition or abrasion.
- bite registration or bite analysis.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.

- core build-ups.
- replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
  - replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or
  - the partial denture is less than 84 consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
  - replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional Necessary extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
- the removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- the replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (lamine).
- treatment of jaw fractures and orthognathic surgery.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- procedures performed by a Dentist who is a member of the covered person's family (the covered person's family is limited to spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents), except in the case of a dental emergency and no other Dentist is available.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- diagnostic casts, diagnostic models, or study models.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of \$100 - \$200 per consecutive 12-month period).
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party.
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- services for which benefits are not payable according to the "General Limitations" section.

HC-DEX1

04-10  
VI

## Termination of Insurance

### Members

Your insurance will cease on the earliest date below:

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

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

### Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Fund: stops paying premium for you; or otherwise

cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

### **Injury or Sickness**

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

### **Dependents**

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

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

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