

**Summary Plan
Description
for
Employees of URS
Federal Services**

Effective January 1, 2014

Dental Section

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The information in this SPD applies to the following eligible employees of URS Federal Services, including employees formerly known as Federal Technical Services and Federal Support Services:

- Non-represented employees
- Represented employees who are eligible for the URS Federal Services non-represented employee benefit programs

Separate SPDs apply to URS Corporate employees and to employees of URS Infrastructure & Environment, Energy & Construction and Oil & Gas.

Please note that eligibility for and enrollment in the benefits described in this SPD section may differ by contract, collective bargaining agreement or based on your employee class. Additionally, the benefits for which you are eligible, including the cost of the benefits, the amount of coverage and the terms of the coverage may differ by contract or collective bargaining agreement or based on your employee class. Separate booklets may be available in such situations.

Plan Highlights

Your Dental Plan Coverage Choices

URS Federal Services offers the following dental plans for which you may be eligible:

- **The Cigna Preferred Provider Organization (PPO) High and Low Option Plans.**
- **GeoBlue Dental Plan** (for international employees)
International employees may also elect the Cigna PPO High or Low Option Plan. In order to elect the GeoBlue dental plan, you must enroll in the GeoBlue medical plan.
- **Blue Cross Blue Shield of Alabama (employees working on the Ft. Rucker contract)**
- **Blue Cross Blue Shield of Alabama (employees working on the COSS contract)**

The following sections contain information about eligibility, enrollment and costs, how the plans work and which dental expenses are covered and are not covered specific to the Cigna PPO High and Low option plans. For detailed coverage information on the GeoBlue Dental Plan or Blue Cross Blue Shield of Alabama plan, refer to you plan booklet.

Eligibility and Enrollment

Eligibility

See *Who Is Eligible for URS Federal Services Employee Benefits* in the **Introduction** section.

Depending on international assignment, expatriate and third country national employees are eligible for the GeoBlue dental plan. “Expatriate” means an employee who is working outside his or her country of citizenship. “Third country national” means an employee who is not a U.S. citizen, works outside of his or her country of citizenship and works outside of his or her country of domicile. For detailed coverage

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information on the GeoBlue Dental Plan, refer to your plan booklets, available from the health plan or by contacting your Human Resources representative.

The plan booklets – together with the material contained in the URS Federal Services SPD – constitute your Summary Plan Description (SPD).

Please note: if you enroll an ineligible dependent - or any other person - as a result of fraud or intentional misrepresentation of fact, you will be subject to URS' disciplinary action(s), which may include the retroactive termination of your and/or your dependent's coverage. For example, if you intentionally misrepresent that your dependent meets the definition of dependent in order to obtain coverage, your and your dependent's benefits may be terminated and/or you may be required to reimburse the benefit plan for all expenses paid while your dependent was ineligible for coverage. Expenses may include but are not limited to premiums, claims and administrative fees. Intentional misrepresentation of eligibility may result in disciplinary action, civil action to recover losses and termination of your employment. Ineligible dependents may include ex-spouses, former domestic partners, or children who are over the plan's age limit. You may be asked for documentation of your dependent's eligibility for benefits, including but not limited to proof of marriage, dissolution of marriage, termination of domestic partnership, birth, adoption, disability. Failure to produce documentation may result in you or your covered dependent being disenrolled from the plan.

Enrolling in the Dental Plan

To enroll in a dental plan, visit the Employee Self Service website at <https://portal.adp.com>, or call the Benefit Service Center at (800) 550-0726. You need to enroll within 31 days of your first day of work or eligibility, or within 31 days of a Qualifying Status Change. For more information see *Qualified Status Changes* in the **Introduction** section.

ID Cards: Cigna mails ID cards to members' home address upon enrollment. You can also print an ID card from the Cigna website, <http://cigna.com>.

Enrollment Periods

If you do not enroll within the 31-day period that begins on your first day of work or eligibility, you must wait until the next open enrollment period to enroll for coverage, unless you have a Qualified Status Change that would allow you to enroll mid-year. See *When Changes in Your Life Affect Your Benefits* in the **Introduction** section for details.

When Coverage Begins and Ends

Coverage elected within 31 days will be effective on your first day of active employment, which is your first day at work. See *When Your Coverage is Effective* in the **Introduction** section for more information about when your coverage begins.

For information about when your coverage ends, see *When Coverage Ends* in the **Introduction** section.

Cost of Coverage

You pay a portion of the cost for your dental coverage. Your cost depends on the dental plan you select and the level of coverage you choose (for yourself or for you and your eligible dependents). Under most circumstances, your share of the premium for dental coverage is deducted from your pay on a pre-tax basis.

In addition to the premiums you pay for coverage, there are other costs associated with the dental plans. For instance, under the Cigna PPO High or Low Option Dental Plan, you may pay a deductible or, once the deductible is reached, a portion of the cost for covered services, known as co-insurance.

Coverage Levels

Under each dental plan, you can select different levels of coverage. You can choose to cover:

- yourself only;
- yourself plus your spouse or domestic partner;
- yourself plus your child (or children); or
- yourself plus your spouse or domestic partner and your child (or children).

With the exception of the GeoBlue plans, you can select a different level of coverage for the medical plan than you do for dental coverage. For example, if you have a very young child, you may choose to cover your child under the medical plan, but not the dental plan. It is generally recommended that children have their first dental exam at age three, unless they are experiencing dental problems. However, you may choose to enroll your child in dental coverage at birth or at any open enrollment. International employees enrolled in the GeoBlue medical and dental plans must select the same level of coverage for both plans.

Declining Coverage

You can decline dental plan coverage when you first become eligible or during any open enrollment period. If you decline coverage, you must wait until the next open enrollment period to enroll for coverage, unless you have *Qualified Status Change* as described in the ***Introduction Section*** that would allow you to enroll mid-year.

How the Cigna PPO High and Low Option Dental Plans Work

In most locations, URS Federal Services offers two dental plans – Cigna PPO High Option and Cigna PPO Low Option. Both of the dental plans help you and your family maintain good dental health by promoting preventive care and providing a broad range of dental services when treatment is needed.

Your Dental Benefits At A Glance, beginning on page 6, provides a summary of your dental benefits.

Choosing a Dental Provider

The Cigna PPO Plans allow you to receive care from a network of dental providers, known as a Preferred Provider Organization, at a relatively low cost to you. These network providers are contracted with Cigna. You can also receive care from non-Cigna providers outside the dental PPO network. All covered services received out of network are subject to Usual, Customary and Reasonable (UCR) limits and you are responsible for any charges in excess of UCR limits.

Network Care

When you go to network providers, your cost for care is based on lower, negotiated rates with these providers. Most employees will have reasonable access to general dentists within the network. Regardless of the type of service you need (including orthodontia or other specialty services), you are considered to live in a network area if you have access to two network general dentists within 25 miles of your home zip code. Cigna only contracts with general dentists in some areas. If you live in one of these areas, you will incur non-network charges regardless of what orthodontist, or other specialty service provider you choose. A directory of network providers is available on Cigna's website at <http://cigna.com>, or you can call Cigna Healthcare for assistance at (800) 244-6224.

Non-Network Care

You may also choose to receive care from providers outside of the network, but your share of the costs for non-network care will be higher. This is because network providers have agreed to accept payments based on negotiated rates, which are often lower than those charged by non-network providers. The costs associated with services and supplies rendered will be subject to usual customary and reasonable (UCR) fees. For any amount over the UCR you will be required to pay.

Out-of-Area Care

Depending on where you live, you may be unable to access network providers. If that is the case, you will be covered at network benefit levels, subject to usual, customary and reasonable (UCR) fees. However, if you live in a network service area and use non-network providers, your expenses are covered at non-network levels. In general, you are considered to be in a network service area if you have access to two general dental providers within 25 miles of your home zip code. Therefore, if you have access to two general dentists within 25 miles of your home zip code, services received from any non-network provider will be processed at the out of network benefit level.

A directory of network providers is available on Cigna's website at <http://cigna.com>, which has the most up-to-date list of network providers. You can also reach Cigna Healthcare by phone at (800) 244-6224. Be sure to check if the dentist you prefer is accepting new patients.

What You Pay

With the Cigna PPO High or Low Options, the plan pays 100% for preventive services with no deductible. For other covered services, you pay an annual deductible then the plan covers

a certain percentage of your remaining eligible dental expenses. The deductibles are different under the High or Low Options and for network versus non-network providers.

Carry-over Feature

Any amount you pay toward your deductible in the last three months of a calendar year applies to the following year's deductible.

Usual, Customary, and Reasonable (UCR) Charges

A charge is considered Usual, Customary, and Reasonable (UCR) if it is the usual charge made by the provider for a similar service or supply and does not exceed the customary charge made by most providers of that service or supply in the geographic area where the service is received. UCR charges are determined by Cigna. Benefits payable for non-network and out-of-area charges are based on UCR charges for the geographic location in which services are provided.

Keep in mind that you are responsible for paying any amounts over the UCR charges for the services or supplies you receive. These amounts do not count toward your deductible.

Alternate Benefit Provision

When more than one dental service could provide suitable treatment based on accepted dental standards, Cigna will determine the service, on which payment will be based, and the expenses that will be included as covered expenses. Cigna will provide benefits for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your dentist may apply this benefit payment to the treatment of your choice; however, keep in mind that you are responsible for any expenses incurred which exceed the covered expenses. For this reason, Cigna strongly recommends using pre-determination of benefits when major dental services are needed, so that you and your dentist know in advance what the plan will cover before any treatment begins.

Pre-Determination of Benefits

If you need dental treatment other than extractions, fillings or routine preventive care, or if your treatment is likely to cost more than \$200, ask your dentist to submit a written treatment plan to Cigna – before scheduling treatment.

Please note: Predetermination of benefits does not guarantee payment. The estimate of payable benefits may change based on the benefits, if any, that are covered by the plan at the time services are completed.

Enhanced Preventive Care

If you are enrolled in the Cigna High or Low Option PPO plans and have been diagnosed with any of the following conditions and/or are undergoing certain treatments for any of the conditions listed below, you may be eligible for additional benefits. See plan for details, enhanced benefits vary by condition.

- Diabetes

- Heart Disease
- Stroke
- Pregnancy
- Chronic Kidney Disease
- Organ Transplant
- Head and Neck Cancer radiation

You must pay for the periodontal services in advance and then file a claim for reimbursement.

Your Dental Benefits At A Glance

Your Dental Benefits				
<i>Note: Out-of-area and non-network providers are subject to UCR.*</i>	Cigna PPO High Option		Cigna PPO Low Option	
	Network***	Non-Network	Network	Non-Network
Deductibles				
Provider	Choose a dentist in Cigna's PPO Core network	Choose any dentist	Choose a dentist in Cigna's PPO Core network	Choose any dentist
Individual deductible	\$50	\$100	\$75	\$150
Family deductible	\$100	\$200	\$150	\$300
Preventive Services				
<i>Note: The deductible does not apply to these services. Out-of-area and non-network providers are subject to UCR.*</i>	Network*** Plan pays:		Non-Network Plan pays:	
Routine cleanings	100% (twice each calendar year)			
Oral exams	100% (twice each calendar year)			
Bitewing X-rays	100% (twice each calendar year)			
Full mouth X-rays	100% (one complete set every three years)			
Panoramic X-rays	100% (once every three years)			
Fluoride treatments	100% (once each calendar year; children under age 19)			
Sealants	100% (children under age 14; one treatment per posterior tooth every three years)			
Space maintainers	100%			

Your Dental Benefits At A Glance (Continued)

Your Dental Benefits				
<i>Note: Out-of-area and non-network providers are subject to UCR.*</i>	Cigna PPO High Option		Cigna PPO Low Option	
	Network***	Non-Network	Network	Non-Network
Basic Services				
Extractions, Fillings, Oral surgery**, Anesthesia, Periodontal treatments, Endodontics, Root canal therapy, Denture adjustment and repairs.	80% after deductible	60% after deductible; subject to UCR*	70% after deductible	50% after deductible; subject to UCR*
Major Services				
Bridges, Crowns, Gold Fillings, Dentures and Implants	70% after deductible	50% after deductible; subject to UCR*	60% after deductible	40% after deductible; subject to UCR*
Orthodontic Treatment	50% of the cost to a maximum \$1,500 lifetime benefit	50% of UCR* to a maximum \$1,000 lifetime benefit	50% of the cost to a maximum \$1,250 lifetime benefit	50% of UCR* to a maximum \$750 lifetime benefit
TMJ Treatment	80% of the cost to a maximum \$1,000 lifetime benefit	80% of UCR* to a maximum \$1,000 lifetime benefit	80% of the cost to a maximum \$1,000 lifetime benefit	80% of UCR* to a maximum \$1,000 lifetime benefit
Maximum Benefits				
Calendar year maximum	\$1,500	\$1,000	\$1,250	\$750
Orthodontia lifetime maximum	\$1,500	\$1,000	\$1,250	\$750
TMJ lifetime maximum	\$1,000	\$1,000	\$1,000	\$1,000
<i>PPO network and non-network maximums are not combined. Any charges you incur, whether network or non-network, will apply to both calendar year maximums. For example, if you incur \$800 of non-network eligible expenses in a calendar year under the High Option, a maximum of \$200 in non-network benefits or \$700 in network benefits will be paid for the balance of the year.</i>				

* UCR stands for "Usual, Customary and Reasonable," which are the normal charges to provide a particular dental service in your geographic area.

** Oral surgery includes pulling teeth and cutting procedures in the mouth. Some procedures may also be covered by your medical plan.

*** Out-of-area providers covered at network benefit level

Please note: Calendar year and lifetime maximums apply to each person covered under the dental plan and there are separate benefit maximums for calendar year, orthodontia, and Temporomandibular Joint Syndrome (TMJ). Network and non-network benefit maximums cross-accumulate.

What the Cigna PPO High and Low Option Dental Plans Cover

Emergency Benefits

Emergency care is covered at 100% with no deductibles or copayments. Non-network and out-of-area services are subject to UCR limits. In a medical emergency, your medical plan may cover dental charges related to an injury. Check with your medical plan for more information on what dental services may be covered.

Oral Surgery

After the deductible, oral surgery is covered at 80% in network and 60% of UCR for non-network services under the High Option Plan and at 70% in network and 50% of UCR for non-network services under the Low Option Plan. Some procedures may be covered by your medical plan. Check with your medical plan for more information on what dental services may be covered.

Covered Expenses

Preventive, basic, and major procedures are covered. All non-network and out-of-area services are subject to UCR limits. Preventive services are covered at 100% with no deductible. Basic and major services are covered at different levels after you meet your deductible. See

Your Dental Benefits At A Glance, beginning on page 7, for a listing of covered services and what percentage of the cost you pay for services.

Orthodontia

Covered services include diagnostic procedures and appliances to realign teeth. Necessary space maintainers and extractions are covered under preventive and basic services. The lifetime maximum orthodontia benefits are different under the High or Low Option and for network versus non-network providers.

Benefits for orthodontia will be paid in equal installments on a quarterly basis, based on treatment length.

Temporomandibular Joint Syndrome (TMJ)

Treatment includes: office visits (limited to six per six-month period); transcutaneous electro-neural stimulation (limited to four per six-month period); trigger point injection of local anesthetic into muscle fascia (limited to four per six-month period); and mandibular orthopedic repositioning appliance (limited to one per five-year period).

What the Cigna PPO High and Low Option Dental Plans Don't Cover

Cigna PPO Exclusions and Limitations

The following services are not covered under the Cigna PPO High or Low Option plans:

- services performed only for cosmetic reasons
- replacement of a lost or stolen appliance
- replacement of a bridge, crown, or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of any injury received while a person is insured for these benefits
- any replacement of a bridge, crown, denture, or mandibular orthopedic repositioning appliance that is still useable according to common dental standards
- porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second, or third molars
- bite registrations, precision or semi-precision attachments, or splinting
- instruction for plaque control, oral hygiene, and diet
- dental services that do not meet common dental standards
- services Cigna deems to be medical services
- services and supplies received from a hospital
- charges the person is not legally required to pay
- charges in connection with an injury arising out of any employment for wage or profit
- charges in connection with a sickness that is covered under workers' compensation or similar law
- charges made by a hospital owned or operated by, or that provides services for, the U.S. Government, if charges are directly related to a condition associated with military service
- payments that are unlawful where you live when the expenses are incurred
- charges that are more than the contracted fee or applicable Usual, Customary and Reasonable charges
- charges for unnecessary care, treatment, or surgery
- if you are entitled to payment for dental expenses through a public assistance program, other than Medicaid or Medi-Cal
- charges in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society
- expenses payable under the mandatory part of any auto insurance policy written to comply with: 1) a "no-fault" insurance law; or 2) an uninsured motorist insurance law

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Coordination of Benefits with Other Plans

You and your family may have dental coverage under both a URS Federal Services plan and another plan, such as your spouse's/domestic partner's employer's plan. In that case, the benefits from the URS Federal Services plan may be reduced or offset by other benefits to which you may be entitled. This is called "Coordination of Benefits" (COB).

If you or any of your dependents are covered under more than one dental plan, non-duplication of benefits will apply. This means that the URS Federal Services plan will not pay more than it would have paid as the primary plan.

If the URS Federal Services plan is primary, it pays benefits as though no other plan exists. The secondary plan may or may not pay additional benefits, depending on its coordination of benefits provisions.

If the URS Federal Services plan is secondary, it will not pay a benefit if the other plan has paid an amount equal to or greater than the benefit normally payable under the URS Federal Services plan. If the other plan has paid less than the amount normally payable under the URS Federal Services plan, the URS Federal Services plan will pay the difference up to the amount it would have paid if it had been primary.

Example: You have a \$100 covered in-network expense for basic services under the High Option Dental Plan. You have already met the annual deductible. The benefit is payable at 80%:

1. If the URS Federal Services plan is primary, the benefit is \$80.
2. If the URS Federal Services plan is secondary and the primary plan pays \$80 or more, the URS Federal Services plan will pay nothing.
3. If the URS Federal Services plan is secondary and the primary plan pays less than \$80, the URS Federal Services plan will pay the difference. For example, if the other plan pays \$70, the URS Federal Services plan would pay \$10.

Order of Payment

The first of the following conditions that applies in your case determines which plan pays benefits first:

- a plan that does not have COB rules pays before a URS Federal Services plan
- the plan that covers the person other than as a dependent (for example, as an employee) pays first; the plan that covers the person as a dependent pays second
- if the claim is for a dependent child and you are not separated or divorced (whether or not you were ever married), and the child is covered by both parents' plans, the plan of the parent with a birthday earlier in the calendar year generally pays first; if both parents share the same birthday, the plan that has covered a parent longest pays first
- in the case of divorced or separated parents, the sequence used to determine which plan pays first is:

- parent subject to court decree or administrative order to provide health insurance;
 - then, parent with custody;
 - then, spouse/domestic partner of parent with custody;
 - then, parent without custody; or
 - then, spouse/domestic partner of parent without custody.
- if separated, divorced parents or domestic partners whose relationship ended share joint custody, but the court decree does not state that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of payment that applies to dependent children of parents who are not separated or divorced.
 - if the patient is covered as an active employee (or dependent of an active employee) under one plan and as a retired or laid-off employee (or dependent of a retired or laid-off employee) under another plan, the active employee's plan will pay first.
 - the plan that has covered the patient for the longest period of time pays first.
 - if none of the preceding rules determines the primary plan, the plans share the allowable expenses equally.

URS Federal Services has the right to provide or obtain any information needed to determine benefits under the COB provision, as allowed under applicable law. If you receive an overpayment, you or your insurance company may have to repay the excess benefit payment. Also, the URS Federal Services plan may repay another plan that has overpaid, and this payment counts as payment of benefits under the URS Federal Services plan.

Claims Procedures

See the *Claims* section for more information about filing claims.