Oberlin College

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2015

CN015
3197756

This document printed in February, 2015 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Oberlin College

GROUP POLICY(S) — COVERAGE
3197756 - DHMO  CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2015

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Anna Krishtul, Corporate Secretary
Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.
Important Notices

Health Care Services
A denial of claim or a clinical decision regarding health care services will be made by qualified clinical personnel. Notice of denial or determination will include information regarding the basis for denial or determination and any further appeal rights.

Non-English Assistance
For non-English assistance in speaking to Member Services, please use the translation service provided by AT+T. For a translated document, please contact Customer Service at the toll-free telephone number shown on your ID card.

The following applies only to the In-Network plan.

Utilization Review Procedures
After receipt of necessary information, utilization review shall be performed and a determination shall be provided by telephone and in writing to you and your provider; for healthcare services which require preauthorization, in 3 working days; and to the provider for continued or extended treatment prescribed by a provider, in one working day.

A determination will be made for health care services received within 30 days of receipt of necessary information.

If an adverse determination has been rendered in the absence of a discussion with the provider, the provider may request reconsideration of the adverse determination.

Except in the case of a retrospective review, the reconsideration shall occur within 1 working day after receipt of the request and shall be conducted by your provider and clinical peer reviewer making the initial determination, or his designee. If the adverse determination is upheld after reconsideration, the reviewer shall provide notice as stated above. This does not waive your right to an appeal.

Please contact Member Services by calling the toll-free telephone number shown on your ID card.

New York Disclosure and Synopsis Statement
The accident and health insurance evidenced by this certificate provides dental insurance only.

The Patient Charge Schedule highlights the benefits of the plan. The benefits shown may not always be payable because the plan contains certain limitations and exclusions. Dental benefits, for instance, are not payable for such things as work-related injuries or unnecessary care. These limitations and others can be found in their entirety on subsequent pages of the certificate.

Eligibility - Effective Date

Employee Insurance
This plan is offered to you as an Employee.

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least the requirements listed below:
  - you are an administrative assistant who is appointed and scheduled to work at least 18 hours per week for at least nine (9) months per calendar year; or
  - you are a unionized service employee who is appointed and scheduled to work at least 20 hours per week on either a full year or school year basis;
  - you are a unionized security employee who is appointed and scheduled to work at least 20 hours per week on either a full year or school year basis;
  - you are a unionized security employee who is appointed and scheduled to work 20 hours per week;
  - you are a faculty member who is appointed at least 4/9 of a full-time appointment;
  - you are an administrative or professional staff worker who is appointed to work at least half-time for nine (9) months per calendar year;
  - you are an intern in active appointments of half-time or more.

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

Eligibility for Dependent Insurance
You will become eligible for Dependent insurance on the later of:
- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

If both spouses/partners are employed by Oberlin College the following will apply:
- A spouse/partner with no children: Each must enroll for Single coverage, effective July 1, 1996.
- A spouse/partner employed elsewhere and eligible for medical coverage must carry Single coverage with their own employer, effective January 1, 2002.
- A spouse/partner may also be enrolled on the Oberlin College plan as a secondary plan.

All references to spouse shall be deemed to mean your spouse or domestic partner.

Employees with eligible dependents are required to document eligibility. Proof that an individual is a qualified dependent (marriage or birth certificate, guardianship orders, as applicable) is required at the time of initial enrollment and may be required periodically thereafter. Failure to provide proof of dependent eligibility within 30 days of a request for such proof may result in termination of health plan coverage.

- Spouse – Photocopy of marriage certificate, and the top portion of the first page of the employee’s most recent Federal Tax Return that shows the dependent listed as “Spouse”. Note: All financial information and Social Security Numbers may be redacted.
- Same-Sex Domestic Partner – Signed affidavit of domestic partnership and supporting documentation as required by the affidavit.
- Natural or adopted child – Photocopy of birth certificate or legal adoption agreement showing employee as parent.
- Step-child – Photocopy of birth certificate or adoption agreement showing the name of employee’s spouse/domestic partner as parent.
- Foster child – Photocopy of legal agreement/document/guardianship order showing employee’s legal commitment.

Note:
- Ex-spouses will not be eligible, even with a court order.

Same-Sex Domestic partner and their children are eligible for benefits, but the value of benefits provided to these individuals will be added to the employee’s taxable income.

Waiting Period
First day of calendar month following the date that the Employee satisfies the Eligibility Requirement; the Actively at Work Requirements; and the Enrollment Requirements of the Plan.

Classes of Eligible Employees
Faculty who have min. 4/9 appointment, A & PS, and Confidential staff who work min. 20 hrs. or more per wk for min. 9 months; Service employees employed on either a full year/school year basis, and work min. 20 hrs. per week; Security employees employed on either a full year/school year basis and work min. 18 hours per week; AAs who work min. .36FTE in 9 month position or .40FTE in positions designated more than 9 months per fiscal year.

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

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

Late Entrant – Employee
You are a Late Entrant if:
- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

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

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

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

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until Cigna agrees to insure that Dependent. Your Dependents will be insured only if you are insured.

**Late Entrant – Dependent**

You are a Late Entrant for Dependent Insurance if:

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

**Death of Employee While Still Active**

The Spouse or Same-Sex Partner of an active employee will be offered COBRA coverage if the employee dies while actively working. The only exception is as follows and must meet all requirements.

- Employee and spouse or partner were eligible and enrolled in the Oberlin Health Plan;
- Employee had worked for Oberlin College for at least ten (10) years;
- Employee had reached the retirement age of at least 62; and
- Surviving spouse or partner does not have health coverage from their employer

**Choice of Dental Office**

When you elect Employee Insurance, you may select a Dental Office from the list provided by CDH. If your first choice of a Dental Office is not available, you will be notified by CDH of your designated Dental Office, based on your alternate selection. You and each of your insured Dependents may select your own designated Dental Office. No Dental Benefits are covered unless the Dental Service is received from your designated Dental Office, referred by a Network General Dentist at that facility to a specialist approved by CDH, or otherwise authorized by CDH, except for Emergency Dental Treatment. A transfer from one Dental Office to another Dental Office may be requested by you through CDH. Any such transfer will take effect on the first day of the month after it is authorized by CDH. A transfer will not be authorized if you or your Dependent has an outstanding balance at the Dental Office.

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**Dental Benefits – Cigna Dental Care**

**Your Cigna Dental Coverage**

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you.

**Member Services**

If you have any questions or concerns about the Dental Plan, Member Services Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Member Services from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

**Other Charges – Patient Charges**

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

**Choice of Dentist**

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Member Services at 1-800-Cigna24 for a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 7 to a network Pediatric Dentist, the network Pediatric Dentist’s
office will have primary responsibility for your child’s care. Your Network General Dentist will provide care for children 7 years and older. If your child continues to visit the Pediatric Dentist after his/her 7th birthday, you will be fully responsible for the Pediatric Dentist’s Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled “Office Transfers” if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Member Services.

**Your Payment Responsibility (General Care)**

For Covered Services provided by your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-network Dentist. You will pay the non-network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See the Specialty Referrals section regarding payment responsibility for specialty care.

All contracts between Cigna Dental and network Dentists state that you will not be liable to the network Dentist for any sums owed to the network Dentist by Cigna Dental.

**Emergency Dental Care – Reimbursement**

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

- **Emergency Care Away From Home**
  
  If you have an emergency while you are out of your Service Area or unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist’s Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

- **Emergency Care After Hours**
  
  There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

**Limitations on Covered Services**

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

- **Pediatric Dentistry** – Coverage for treatment by a Pediatric Dentist ends on your child’s 7th birthday. Effective on your child’s 7th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.

- **Oral Surgery** – The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.

- **Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** - When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per
year with replacement of a surgical implant frequency limitation of one every 10 years.

- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. 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 5 calendar years old, is not serviceable and cannot be repaired.

**Services Covered Under Your Dental Plan**

Coverage includes, but is not limited to, the following, refer to your Patient Charge Schedule for details of your plans covered services:

- Periodontal (gum tissue and supporting bone) Services – Periodontal regenerative procedures include one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.
- Localized delivery of antimicrobial agents is included for up to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- Clinical Oral Evaluations – Up to a total of 4 evaluations (Periodic oral evaluations, and/or comprehensive oral evaluations, and/or comprehensive periodontal evaluations, and/or oral evaluations for patients under three years of age are covered during a 12 consecutive month period.
- If bleaching (tooth whitening) is listed as a covered service on your Patient Charge Schedule, the method covered is specific to the use of take-home bleaching gel with trays.
- When listed on your Patient Charge Schedule, general anesthesia, IV sedation and nitrous oxide are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. General Anesthesia and IV sedation when used for anxiety control or patient management do not meet the criteria of medical necessity.
- Services that meet commonly accepted dental standards and are listed on your Patient Charge Schedule.
- Consultations and/or evaluations associated with services that are covered endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a good or favorable periodontal prognosis.
- When listed on your Patient Charge Schedule, bone grafting and/or guided tissue regeneration is covered when performed for the treatment of periodontal disease at a tooth site other than the site of an extraction, apicoectomy or periradicular surgery.
- Root canal treatment in the presence of injury to, or disease of, the pulp (nerve tissue) of a tooth.

- Restorative, fixed prosthodontic and removable prosthodontic services when listed on your patient charge schedule and provided by your Network General Dentist.
- Localized delivery of antimicrobial agents when performed in conjunction with traditional periodontal therapy and less than nine (9) of these procedures are performed on the same date of service.
- Infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided.
- Cigna Dental considers the recementation of any inlay, onlay, crown, post and core or fixed bridge, when performed within 180 days of initial placement to be incidental to and part of the charges for the initial restoration.
- When listed on your Patient Charge Schedule, Cigna Dental considers the recementation of any implant supported prosthesis (including crowns, bridges and dentures), when performed within 180 days of initial placement to be incidental to and part of the charges for the initial restoration.
- Services listed on your Patient Charge Schedule when performed for the treatment of pathology or disease not related to congenital conditions.
- When listed on your Patient Charge Schedule the replacement of an occlusal guard (night guard) once, every 24 months.

**Services Not Covered Under Your Dental Plan**

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

- services not listed on the Patient Charge Schedule.
- services provided by a non-network Dentist without Cigna Dental's prior approval (except in emergencies).
- 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 war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless the service is specifically listed on your Patient Charge Schedule.
- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.
• for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated run by the United States Government or by a state or municipal government if the person had no insurance.
• due to injuries which are intentionally self-inflicted.
• prescription medications.
• procedures, appliances or restorations if the main purpose is: change vertical dimension (degree of separation of the jaw when teeth are in contact); or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion.
• 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.
• surgical placement of a dental implant, repair, maintenance or removal of a dental implant, implant abutment(s), or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
• services considered to be unnecessary or experimental in nature.
• procedures or appliances for minor tooth guidance or to control harmful habits.
• hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for network Dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
• the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
• 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 Patient Charge Schedule.
• crowns, bridges and/or implant supported prosthesis used solely for splinting.
• resin bonded retainers and associated pontics.

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

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

**Appointments**
To make an appointment with your network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

**Broken Appointments**
The time your network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent break an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

**Office Transfers**
If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24. Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

**Specialty Care**
Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental network includes the following types of specialty dentists:
• Pediatric Dentists – children's dentistry.
• Endodontists – root canal treatment.
• Periodontists – treatment of gums and bone.
• Oral Surgeons – complex extractions and other surgical procedures.
• Orthodontists – tooth movement.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

**Specialty Referrals**

**In General**
Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatric
Dentistry and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in the Orthodontics section. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental’s authorization. If you are unable to obtain treatment within the 90-day period, please call Member Services to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist’s Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Member Services.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist’s Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist’s Usual Fee.

Orthodontics (This section is only applicable if Orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Member Services at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

Orthodontics In Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Member Services at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an

• Retention (Post Treatment Stabilization) – the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

Patient Charges

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if banding/appliance insertion does not occur within 90 days of such visit; your treatment plan changes; or there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a prorated basis.

Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

• incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
• orthognathic surgery and associated incremental costs;
• appliances to guide minor tooth movement;
• appliances to correct harmful habits; and
• services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

Definitions –

• Orthodontic Treatment Plan and Records – the preparation of orthodontic records and a treatment plan by the Orthodontist.

• Interceptive Orthodontic Treatment – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.

• Comprehensive Orthodontic Treatment – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist’s treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

Coordination of Benefits

This section is intended to establish uniformity in the permissive use of overinsurance provisions and to avoid claim delays and misunderstandings that could otherwise result from the use of inconsistent or incompatible provisions among plans.

A coordination of benefits (COB) provision is one that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this section, it does not have to pay its benefits first.

A plan that does not include such a COB provision may not take the benefits of another plan into account when it determines its benefits. There are two exceptions:

- a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder; and

- any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

Definitions

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

Plan

A plan is a form of coverage written on an expense-incurred basis with which coordination is allowed. The definition of Plan in a contract must state the types of coverage which will be considered in applying the COB provision of that contract.

This section uses the term Plan. However, a contract may, instead, use program or some other term.

Plan shall not include individual or family:

- insurance contracts;
- direct-payment subscriber contracts;
- coverage through health maintenance organizations (HMO’s); or
- coverage under other prepayment, group practice and individual practice Plans.

Plan may include:

- group insurance and group or group remittance subscriber contracts;
- uninsured arrangements of group coverage;
- group coverage through HMO’s and other prepayment, group practice and individual practice Plans; and
- blanket contracts, except as stated in the last paragraph of this section.

Plan may include the medical benefits coverage in group and individual mandatory automobile “no-fault” and traditional mandatory automobile “fault” type contracts.

Plan may include Medicare or other governmental benefits. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program. However, Plan shall not include a State Plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental Plan.

Plan shall not include blanket school accident coverages or such coverages issued to a substantially similar group as defined in section 52.70(d)(6) of the NY Insurance Law, where the policyholder pays the premium.

This Plan

In a COB provision, the term This Plan refers to the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced on account of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan.
A contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

**Primary Plan**

A Primary Plan is one whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either:

- the plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this section; or
- all plans which cover the person use the order of benefit determination rules required by this section and under those rules the Plan determines its benefits first.

There may be more than one Primary Plan (for example, two plans which have no order of benefit determination rules).

**Secondary Plan**

A Secondary Plan is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this section decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this section, has its benefits determined before those of that Secondary Plan.

**Allowable Expense**

Allowable expense is the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the Plans involved, except where a statute requires a different definition. However, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A Plan which provides benefits only for any such items of expense may limit its definition of allowable expenses to like items of expense.

When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service will be considered as both an allowable expense and a benefit paid.

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of Allowable Expense must include the corresponding expenses or services to which COB applies.

**Claim Determination Period**

A Claim Determination Period is the period of time, which must not be less than 12 consecutive months, over which allowable expenses are compared with total benefits payable in the absence of COB, to determine:

- whether overinsurance exists; and
- how much each Plan will pay or provide.

A Claim Determination Period is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the contract. A person may be covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period.

As each claim is submitted, each Plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later allowable expenses are incurred in the same Claim Determination Period.

**Reasonable Cash Value**

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area.

**Order of Benefit Determination Rules**

The Primary Plan must pay or provide its benefits as if the Secondary Plan or Plans did not exist. A Secondary Plan may take the benefits of another Plan into account only when, under these rules, it is secondary to that other Plan.

When there is a basis for a claim under more than one Plan, a Plan with a coordination of benefits provision complying with this section is a Secondary Plan which has its benefits determined after those of the other Plan, unless the other Plan has a COB provision complying with this section in which event the order of benefit determination rules will apply.

The order of benefit payments is determined using the first of the following rules which applies:

- the benefits of a Plan which covers the person as an employee, member (that is, other than as a dependent) are determined before those of a Plan which covers the person as a dependent;
- except as stated in subparagraph (3) of this paragraph, when a Plan and another Plan cover the same child as a dependent of different persons, called parents:
  - the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
  - if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined
before those of the Plan which covered the other parent for a shorter period of time;

- if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits;

- the word birthday refers only to month and day in a calendar year, not the year in which the person was born;

- if two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - finally, the Plan of the parent not having custody of the child; and

  - if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;

- the benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this subparagraph is ignored;

- if none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

- to determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new Plan does not include:

  - a change in the amount or scope of a Plan's benefits;
  - a change in the entity which pays, provides or administers the Plan's benefits; or
  - a change from one type of Plan to another (such as, from a single employer Plan to that of a multiple employer Plan);

- the claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

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

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

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

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

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

Recovery of Overpayment
When an overpayment has been made by Cigna, Cigna will have the right at any time to: 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.
Miscellaneous
Clinical research has established an association between dental disease and complication of some medical conditions, such as the conditions noted below.
If you are a Cigna Dental plan member and you have one or more of the conditions listed below, you may apply for 100% reimbursement of your copayment or coinsurance for certain periodontal or caries-protection procedures (up to the applicable plan maximum reimbursement levels and annual plan maximums.)
For members with diabetes, cerebrovascular or cardiovascular disease:
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- periodontal maintenance
For members who are pregnant:
- periodic, limited and comprehensive oral evaluation.
- periodontal evaluation
- periodontal maintenance
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- treatment of inflamed gums around wisdom teeth.
- an additional cleaning during pregnancy.
- palliative (emergency) treatment – minor procedure
For members with chronic kidney disease or going to or having undergone an organ transplant or undergoing head and neck Cancer Radiation:
- topical application of fluoride
- topical fluoride varnish
- application of sealant
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- periodontal maintenance
Please refer to the plan enrollment materials for further details.

Termination of Insurance
Employees
Your insurance will cease on the earliest date below:
- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least two opportunities to transfer to another Dental Office.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.
- the date you relocate to an area where the Dental plan is not offered.
- the date, as determined by Cigna, of a continuing lack of participating Dental Office in your area.
- the date upon a determination of fraud or misuse of dental services and/or dental facilities.
Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence
If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: 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 Employer stops paying premium for you or otherwise cancels the insurance.

Retirement
If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels 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.
- with respect to your Dental benefits, the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least one opportunity to transfer to another participating Dental Office.
• the date Dependent Insurance is canceled.
The insurance for any one of your Dependents will cease on
the date that Dependent no longer qualifies as a Dependent.

Dental Benefits Extension
An expense incurred in connection with a Dental Service that
is completed after a person's benefits cease will be deemed to
be incurred while he is insured if:
• for fixed bridgework and full or partial dentures, the first
impressions are taken and/or abutment teeth fully prepared
while he is insured and the device installed or delivered to
him within 3 calendar months after his insurance ceases.
• for a crown, inlay or onlay, the tooth is prepared while he is
insured and the crown, inlay or onlay installed within 3
calendar months after his insurance ceases.
• for root canal therapy, the pulp chamber of the tooth is
opened while he is insured and the treatment is completed
within 3 calendar months after his insurance ceases.
• for Orthodontic Services, the treatment commenced while
the person was insured and the expenses are incurred within
60 days after his insurance ceases.
• post operative visits related to covered oral surgery or
periodontal services within 3 calendar months after his
insurance ceases.

There is no extension for any Dental Service not shown above.
This extension of benefits does not apply if insurance ceases
due to nonpayment of premiums.

Qualified Medical Child Support Order (QMCSO)
Eligibility for Coverage Under a QMCSO
If a Qualified Medical Child Support Order (QMCSO) is
issued for your child, that child will be eligible for coverage as
required by the order and you will not be considered a Late
Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that
child, and yourself if you are not already enrolled, within 31
days of the QMCSO being issued.

Qualified Medical Child Support Order Defined
A Qualified Medical Child Support Order is a judgment,
decree or order (including approval of a settlement agreement)
or administrative notice, which is issued pursuant to a state
domestic relations law (including a community property law),
or to an administrative process, which provides for child
support or provides for health benefit coverage to such child
and relates to benefits under the group health plan, and
satisfies all of the following:
• the order recognizes or creates a child’s right to receive
group health benefits for which a participant or beneficiary
is eligible;
• the order specifies your name and last known address, and
the child’s name and last known address, except that the
name and address of an official of a state or political
subdivision may be substituted for the child’s mailing
address;
• the order provides a description of the coverage to be
provided, or the manner in which the type of coverage is to
be determined;
• the order states the period to which it applies; and
• if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

**Payment of Benefits**

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to the child, the child’s custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

**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).

**A. 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 30 days of the following:

• the date you meet the criteria shown in the following Sections B through H.

**B. Change of Status**

A change in status is defined as:

• change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
• change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
• change in employment status of Employee, spouse or Dependent 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;
• changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
• change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and
• changes which cause a Dependent to become eligible or ineligible for coverage.

**C. Court Order**

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

**D. Medicare or Medicaid Eligibility/Entitlement**

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

**E. 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.

**F. Changes in Coverage of Spouse or Dependent Under Another Employer’s Plan**

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

**G. Reduction in work hours**

If an Employee’s work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer’s coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 15th day of the 2nd month following the month that includes the date the original coverage is revoked.

**H. Enrollment in Qualified Health Plan (QHP)**

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace’s annual open enrollment period; and the disenrollment from the group plan corresponds to the
intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the “Exception for Newborns” section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:
- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee’s military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.
For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any “Conversion Privilege” shown in your certificate.

**Reinstatement of Benefits (applicable to all coverages)**

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider’s network participation documents, and in the determination notices.

**Postservice Medical Necessity Determinations**

When you or your representative requests a Medical Necessity determination after services have been rendered, 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 or your representative 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. 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.

**Postservice Claim Determinations**

When you or your representative requests payment for services which have been rendered, Cigna will notify you of the claim payment 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 or your representative 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 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 pertain to the determination:

- 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;

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**Claim Determination Procedures Under ERISA**

**Procedures Regarding 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.

You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider’s network participation documents as applicable.
• a description of the plan’s review procedures and the time limits applicable, including a statement of a claimant’s rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal;
• 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 a Medical Necessity, experimental treatment or other similar exclusion or limit; and
• in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COBRA Continuation Rights Under Federal Law
For You and Your Dependents

What is COBRA Continuation Coverage?
Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?
For you and your Dependents, COBRA continuation is available 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; or
• 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 a loss of coverage under the Plan:
• your death;
• your divorce or legal separation; or
• for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?
Only a “qualified beneficiary” (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless 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 sections titled “Secondary Qualifying Events” and “Medicare Extension For Your 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) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their 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 discussed below. Under no circumstances will 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 coverage 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, all 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 covered persons 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” listed below will also apply to the period of disability extension.

**Medicare Extension for Your Dependents**

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

**Termination of COBRA Continuation**

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer’s policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- 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 under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

**Employer’s Notification Requirements**

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan 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 continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

**How to Elect COBRA Continuation Coverage**

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the 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. 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 continuation coverage 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.

How Much Does COBRA Continuation Coverage Cost?
Each qualified beneficiary may be required to pay the entire cost of 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 premium 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 coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums
First payment for COBRA continuation
If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments
After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments
Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation 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 your payment is received after the due date, your 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 payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events
If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “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.).

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. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy
If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your
covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits
You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

ERISA Required Information
The name of the Plan is:
The Oberlin College Health Plan
The name, address, ZIP code and business telephone number of the sponsor of the Plan is:
Oberlin College
173 West Lorain Street
Oberlin, OH 44074
440-775-8430
Employer Identification Number (EIN):
340714363
Plan Number:
506
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 person designated as agent for service of legal process is:
Employer named above
The office designated to consider the appeal of denied claims is:
The Cigna Claim Office responsible for this Plan
The cost of the Plan is shared by Employee and Employer.
The Plan’s fiscal year ends on 12/31.
The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees
A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type
The plan is a healthcare benefit plan.

Collective Bargaining Agreements
You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority
The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination
The Employer as Plan Sponsor 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 participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan’s insurance policy(s) will end on the earliest of the following dates:
• the date you leave Active Service (or later as explained in the Termination Section;)

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the date you are no longer in an eligible class;
• if the Plan is contributory, the date you cease to contribute;
• the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights
As a participant in the plan 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:

Receive Information About Your Plan and Benefits
• 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.
• obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
• receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage
• continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your 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 your 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. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a 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 domestic relations order or 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 your 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.

Dental Conversion Privilege
Any Employee or Dependent whose Dental Insurance ceases for a reason other than those listed below may be eligible for coverage under another Dental Insurance Policy underwritten by Cigna; provided that: he applies in writing and pays the
first premium to Cigna within 45 days after his insurance ceases; and he is not considered to be overinsured.

CDH or Cigna, as the case may be, or the Policyholder will give the Employee, on request, further details of the Converted Policy.

Conversion is not available if your insurance ceased due to:
- nonpayment of required premiums;
- selection of alternate dental insurance by your group;
- fraud or misuse of the Dental Plan.

Notice of an Appeal or a Grievance

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

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate a complaint about: a denial of, or failure to pay for, a referral; or a determination as to whether a benefit is covered under the Policy, we will get back to you on the same day we receive your complaint, or use the "Grievances and Appeals of Administrative and Other Matters" process described in the following section to provide a Grievance resolution if we cannot resolve your complaint on the same day.

If you have a concern which requires an expedited review as described in the following section, or if you submit a written concern about any matter in writing, we will use the "Grievances and Appeals of Administrative and Other Matters" process described in the following section to provide a Grievance resolution.

Concerns regarding the quality of care, choice of or access to providers, or provider network adequacy, will be forwarded to Cigna's Quality Management Staff for review, and Cigna will provide written acknowledgment of your concern within 15 days with appropriate resolution information to follow in a timely manner.

I. Grievance and Appeals of Administrative and Other Matters

Cigna has a two-step appeals procedure to review any dispute you may have with Cigna's decision, action or determination. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

We will acknowledge your appeal in writing within five working days after we receive the appeal. Acknowledgments include the name, address, and telephone of the person designated to respond to your appeal, and indicate what additional information, if any, must be provided.

Level One Administrative Appeal/Grievance

You or your representative, with your acknowledgment and consent, must submit your Level One Administrative Appeal in writing or by telephone:

Customer Services Toll-Free Number or Address that appears on your Benefit Identification 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 clinical appropriateness will be considered by a health care professional of the same or similar specialty as the care under consideration.

For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive the appeal.
This notification will include the reasons for the decision, including clinical rationale if applicable, as well as additional appeal rights, if any. You may request that the review process be expedited if, the time frames under this process would increase risk to your health or seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Dentist, would cause you severe pain which cannot be managed without the requested services. Cigna's Dentist reviewer, in consultation with the treating Dentist, will decide if an expedited review is necessary. When an appeal is expedited, we will respond orally with a decision within 48 hours after receiving all the necessary information, but in no event later than 72 hours after receiving the appeal. A written notice of the decision will be transmitted within two working days after rendering the decision.

**Level Two Administrative Appeal**

If you are dissatisfied with our level one grievance decision, you may request a second review. To start a level two grievance, follow the same process required for a level one Appeal.

Most requests for a second review will be conducted by the Administrative Appeal Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Dental reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You are not obligated to grant the Committee an extension or to provide the requested information. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the review process be expedited if, the time frames under this process would increase risk to your health or seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Dentist, would cause you severe pain which cannot be managed without the requested services. Cigna's Dentist reviewer, in consultation with the treating Dentist will decide if an expedited review is necessary. When a review is expedited, we will respond orally with a decision within two working days after receiving all the necessary information, but no later than 72 hours after receiving the appeal. A written notice of the decision will be transmitted within two working days after rendering the decision.

**II. Appeals Of Utilization Review Decisions**

Cigna has a two-step appeals procedure to review any dispute you may have regarding a Cigna utilization review determination. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal or ask for information about utilization review decisions by calling the toll-free number on your Benefit Identification card, explanation of benefits or claim form, Monday through Friday, during regular business hours. If calling after hours, follow the recorded instructions if you wish to leave a message.

We will acknowledge your appeal in writing within five working days after we receive the appeal. Acknowledgments include the name, address, and telephone of the person designated to respond to your appeal, and indicate what additional information, if any, must be provided.

If no decision is made within the applicable time frames described below regarding your appeal of an adverse utilization review determination, the adverse determination will be deemed to be reversed.

**Level One Appeal (Final Adverse Determination)**

You or your representative with your acknowledgment and consent must submit your Level One appeal in writing or by telephone to:

- Customer Services Toll-Free Number or Address that appears on your Benefit Identification 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 of the same or similar specialty as the care under consideration.

We will respond in writing with a decision within 15 calendar days after we receive an appeal. If more information is needed to make the determination, we will notify you in writing or request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You are not obligated to grant Cigna an extension or to provide the requested information.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Dentist would cause you severe pain
which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay; including non-authorization of home health care services following discharge from an inpatient hospital admission or your appeal involves continued or extended health care services, procedures or treatments or additional services for you or an insured undergoing a course of continued treatment prescribed by a health care provider or an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Cigna's Dentist reviewer, in consultation with the treating Dentist, will decide if a requested appeal is necessary. When an expedited appeal is requested, Cigna will provide reasonable access to its clinical peer reviewer within one working day after receiving the appeal. When an appeal is expedited, Cigna will respond orally with a decision within two working days after receiving all the necessary information, but no later than 72 hours after receiving the appeal.

A written notice of the decision will be transmitted within two working days after rendering the decision. If you are not satisfied with the result of the expedited appeal review, you may further appeal under the time frames above, or through the external appeal process described in the following paragraph.

If you remain dissatisfied with the Level One or Expedited Appeal decision of Cigna, you have the right to request an External Appeal as well as a Level Two Appeal as described in the following paragraphs. You may also request an External Appeal application from the New York Insurance Department toll-free at 800-400-8882, or its website (www.ins.state.ny.us); or the New York Department of Health at its website (www.health.state.us).

**Level Two Appeal**

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You are not obligated to grant the Committee an extension, or to provide the requested information. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Dentist would cause you severe pain, which cannot be managed without the requested services; your appeal involves non-authorization of an admission or continuing inpatient Hospital stay; including non-authorization of home health care services following discharge from an inpatient hospital admission; or your appeal involves continued or extended health care services, procedures or treatments or additional services for you or an insured undergoing a course of continued treatment prescribed by a health care provider or an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Cigna's Dentist reviewer, in consultation with the treating Dentist, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

**External Appeal**

**Your right to an external appeal**

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Cigna has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative, with your acknowledgment and consent, may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

**Your right to appeal a determination that a service is not medically necessary**

If Cigna has denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you satisfy the following criteria:

- The service, procedure or treatment must otherwise be a Covered Expenses under this Certificate; and
- You must have received a final adverse determination through the first level of the Plan's internal appeal process and Cigna must have upheld the denial or you and Cigna must agree in writing to waive any internal appeal.
Your rights to appeal a determination that a service is experimental or investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Expenses under this Certificate; and
- You must have received a final adverse determination through the first level of Cigna's internal appeal process and Cigna must have upheld the denial or you and Cigna must agree in writing to waive any internal appeal.

In addition, your Dentist must certify that you have a life threatening or disabling condition or disease. A life threatening condition or disease is one which according to the current diagnosis of your Dentist has a high probability of death. A disabling condition or disease is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

Your Dentist must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by Cigna or one for which there exists a clinical trial (as defined by law).

In addition, your Dentist must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Expenses (only certain documents will be considered in support of this recommendation - your Dentist should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your Dentist must be a licensed, board-certified or board eligible Dentist qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The External Appeal Process

If, through the first level of Cigna's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, you have four months from receipt of such notice to file a written request for an external appeal. If you and Cigna have agreed in writing to waive any internal appeal, you have four months from receipt of such waiver to file a written request for an external appeal. Cigna will provide an external appeal application with the final adverse determination issued through the first level of Cigna's internal appeal process or its written waiver of an internal appeal.

You will lose your right to an external appeal if you do not file an application for an external appeal within four months from your receipt of the final adverse determination from the first level plan appeal regardless of whether you choose to pursue a second level internal appeal with Cigna.

The External Appeal Program is a voluntary program.

You may also request an external appeal application from New York State at toll-free at 800-400-8882, or its website (www.ins.state.ny.us); or our Member Services department at the toll-free number on your Benefit ID card. Submit the completed application to State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Cigna based its denial, the External Appeal Agent will share this information with Cigna in order for it to exercise its right to reconsider its decision. If Cigna chooses to exercise this right, Cigna will have three working days to amend or confirm its decision. In the case of an expedited appeal as described in the following section, Cigna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your Dentist or Cigna. If the External Appeal Agent requests additional information, it will have five additional working days to make its decision. The External Appeal Agent must notify you in writing of its decision within two working days.

If your Dentist certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and Cigna by telephone, or facsimile of the decision. The External Appeal Agent must also notify you in writing of its decision.
If the External Appeal Agent overturns Cigna's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, Cigna will provide coverage subject to the other terms and conditions of this document. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Cigna will only cover the costs of services required to provide treatment to you according to the design of the trial. Cigna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this certificate for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and Cigna. The External Appeal Agent's decision is admissible in any court proceeding.

Cigna will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. Cigna will also waive the fee if Cigna determines that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Your Responsibilities

It is your responsibility to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If utilization review was initiated after health care services have been provided, your Dentist may file an external appeal by completing and submitting the "New York State External Appeal Application For Health Care Providers To Request An External Appeal Of A Retrospective Final Adverse Determination," which will require your signed acknowledgment of the provider's request and consent to release the medical records.

Under New York State law, your completed request for appeal must be filed within four months of either the date upon which you receive written notification from Cigna that it has upheld a first level denial of coverage or the date upon which you receive a written waiver of any internal appeal. Cigna has no authority to grant an extension of this deadline.

Complaints/Appeals To The State Of New York

At any time in the Grievance/Appeals process you may contact the Department of Health (for medically related issues) or the Department of Insurance (for billing/contract related issues) at the following address and telephone number to register your complaint.

New York Department of Health
Metropolitan Regional Area Office
5 Penn Plaza, 2nd Floor
New York, NY 10001
212-268-6306 or 800-206-8125

or

New Rochelle Area Office
145 Huguenot Street, 6th Floor
New Rochelle, NY 10810
914-654-7199 or 800-206-8125

New York State Insurance Department
One Commerce Plaza
Albany, NY 12257
800-342-3736

Notice Of Benefit Determination On Grievance Or Appeal

Every notice of a determination on grievance or appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination including clinical rationale; 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; a statement describing: the procedures to initiate the next level of appeal; any voluntary appeal procedures offered by the plan; and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

In addition, every notice of a utilization review final adverse determination must include: a clear statement describing the basis and clinical rationale for the denial as applicable to the insured; a clear statement that the notice constitutes the final adverse determination; Cigna's contact person and his or her telephone number; the insured's coverage type; the name and full address of Cigna's utilization review agent, if any; the utilization review agent's contact person and his or her telephone number; a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or Dentist proposed to
provide the treatment and the developer/manufacturer of the health care service; a statement that the insured may be eligible for an external appeal and the time frames for requesting an appeal; and a clear statement written in bolded text that the four month time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing the request a second level internal appeal, the time may expire for the insured to request an external appeal.

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

Relevant Information

Relevant Information is any document, record, or other information which 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; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

Definitions

Active Service

You will be considered in Active Service:

• on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.

• on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Adverse Determination

An Adverse Determination is a decision made by Cigna Dental that it will not authorize payment for certain limited specialty care procedures. Any such decision will be based on the necessity or appropriateness of the care in question. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and must meet the following requirements. It must:

• be consistent with the symptoms, diagnosis or treatment of the condition present;

• conform to commonly accepted standards of treatment;

• not be used primarily for the convenience of the member or provider of care; and

• not exceed the scope, duration or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the member at the dentist’s Usual Fees.

Cigna Dental Health (herein referred to as CDH)

CDH is a wholly-owned subsidiary of Cigna Corporation that, on behalf of Cigna, contracts with Participating General Dentists for the provision of dental care. CDH also provides management and information services to Policyholders and Participating Dental Facilities.
Contract Fees

Contract Fees are the fees contained in the Network Specialty Dentist agreement with Cigna Dental which represent a discount from the provider’s Usual Fees.

Covered Services

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

Dental Office

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

Dental Plan

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

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

Dependent

Dependents are:
- your lawful spouse; or
- your Domestic Partner; and
- any unmarried child of yours who is
  - less than 23 years old.
  - 23 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

A child includes a legally adopted child from the start of any waiting period prior to the finalization of the child's adoption. It also includes a newborn infant who is adopted by you from the moment you take physical custody of the child upon the child's release from the hospital prior to the finalization of the child's adoption. It also includes a stepchild who lives with you. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

Domestic Partner

A Domestic Partner is defined as a person of the same sex who:
- shares your permanent residence, as demonstrated by a driver’s license, tax return or other sufficient proof;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements:
  - a joint bank account;
  - a joint credit card or charge card;
  - joint obligation on a loan;
  - status as an authorized signatory on the partner’s bank account, credit card or charge card;
  - joint ownership of holdings or investments;
  - joint ownership of residence;
  - joint ownership of real estate other than residence;
  - listing of both partners as tenants on the lease of the shared residence;
• shared rental payments of residence (this need not be shared 50/50);
• listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
• a common household and shared household expenses, e.g. grocery bills, utility bills, telephone bills, etc. (this need not be shared 50/50);
• shared household budget for purposes of receiving government benefits;
• status of one as representative payee for the other’s government benefits;
• joint ownership of major items of personal property, e.g. appliances, furniture;
• joint ownership of a motor vehicle;
• joint responsibility for child care, e.g. school documents, guardianship;
• shared child-care expenses, e.g. babysitting, day care, school bills (this need not be shared 50/50);
• execution of wills naming each other as executor and/or beneficiary;
• designation as beneficiary under the other’s life insurance policy;
• designation as beneficiary under the other’s retirement benefits account;
• mutual grant of durable power of attorney;
• mutual grant of authority to make health care decisions, e.g. health care power of attorney;
• affidavit by creditor or other individual able to testify to partners’ financial interdependence; or
• such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
• is not a blood relative any closer than would prohibit legal marriage; and
• has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:
• has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
• is currently legally married to another person; or
• has any other Domestic Partner, spouse or spouse equivalent of the same sex.

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

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

Employee

• you are an administrative assistant who is appointed and scheduled to work at least 18 hours per week for at least nine (9) months per calendar year; or
• you are a unionized service employee who is appointed and scheduled to work at least 20 hours per week on either a full year or school year basis;
• you are a unionized security employee who is appointed and scheduled to work at least 20 hours per week on either a full year or school year basis;
• you are a unionized security employee who is appointed and scheduled to work 20 hours per week;
• you are a faculty member who is appointed at least 4/9 of a full-time appointment;
• you are an administrative or professional staff worker who is appointed to work at least half-time for nine (9) months per calendar year;
• you are an intern in active appointments of half-time or more.

Employer

The term Employer means the Policyholder and all Affiliated Employers.
**Group**
The term Group means the Employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

**Medicaid**
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

**Medically Necessary**
The term Medically Necessary means a service or supply which is determined by Cigna to be required for the treatment or evaluation of a medical condition, is consistent with the diagnosis and which would not have been omitted under generally accepted medical standards or provided in a less intensive setting.

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

**Network General Dentist**
A Network General Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide general dental care services to plan members.

**Network Specialty Dentist**
A Network Specialty Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide specialized dental care services to plan members.

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

**Service Area**
The Service Area is the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

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

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

**Usual Fee**
The customary fee that an individual Dentist most frequently charges for a given dental service.
Cigna Dental Care – Cigna Dental Health Plan

The certificate and the state specific riders listed in the next section apply if you are a resident of one of the following states: AZ, CO, DE, FL, KS/NE, MD, OH, PA, VA
Cigna Dental Companies

Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Delaware, Inc.
Cigna Dental Health of Florida, Inc. (a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)
Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska)
Cigna Dental Health of Kentucky, Inc.
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of Missouri, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of North Carolina, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Pennsylvania, Inc.
Cigna Dental Health of Virginia, Inc.
P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of dentists dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled “Disenrollment from the Dental Plan–Termination of Benefits.”

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.

PB09 12.01.12

myCigna.com
I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

A. be consistent with the symptoms, diagnosis or treatment of the condition present;
B. conform to commonly accepted standards throughout the dental field;
C. not be used primarily for the convenience of the customer or dentist of care; and
D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist’s Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

Contract Fees - the fees contained in the Network Dentist agreement with Cigna Dental.

Covered Services - the dental procedures listed on your Patient Charge Schedule.

Dental Office - your selected office of Network General Dentist(s).

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse, or your Domestic Partner; your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

(a) less than 23 years old; or
(b) less than 23 years old if he or she is both:
   i. a full-time student enrolled at an accredited educational institution, and
   ii. reliant upon you for maintenance and support; or
(c) any age if he or she is both:
   i. incapable of self-sustaining employment due to mental or physical disability, and
   ii. reliant upon you for maintenance and support.

For a dependent child 23 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child’s academic status to less than that of a full-time student.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist – a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Patient Charge Schedule - list of services covered under your Dental Plan and how much they cost you.

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

Service Area - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

Subscriber/You - the enrolled employee or customer of the Group.

Usual Fee - the customary fee that an individual dentist most frequently charges for a given dental service.

II. Introduction To Your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.
III. Eligibility/When Coverage Begins

To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

C. Other Charges – Patient Charges

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office’s payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under
age 7 by calling Customer Service at 1-800-Cigna24 to
get a list of network Pediatric Dentists in your Service
Area or if your Network General Dentist sends your child
under the age of 7 to a network Pediatric Dentist, the
network Pediatric Dentist’s office will have primary
responsibility for your child’s care. For children 7 years
and older, your Network General Dentist will provide
care. If your child continues to visit the Pediatric Dentist
upon the age of 7, you will be fully responsible for the
Pediatric Dentist’s Usual Fees. Exceptions for medical
reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot
provide your dental care, or if your Network General
Dentist terminates from the network, Cigna Dental will let
you know and will arrange a transfer to another Dental
Office. Refer to the Section titled “Office Transfers” if
you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our
website at myCigna.com, or call the Dental Office
Locator at 1-800-Cigna24. It is available 24 hours a day, 7
days per week. If you would like to have the list faxed to
you, enter your fax number, including your area code.
You may always obtain a current Dental Office Directory
by calling Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be
charged the fees listed on your Patient Charge Schedule.
For services listed on your Patient Charge Schedule at any
other dental office, you may be charged Usual Fees. For
non-Covered Services, you are responsible for paying
Usual Fees.

If, on a temporary basis, there is no Network General
Dentist in your Service Area, Cigna Dental will let you
know and you may obtain Covered Services from a non-
Network Dentist. You will pay the non-Network Dentist
the applicable Patient Charge for Covered Services. Cigna
Dental will pay the non-Network Dentist the difference, if
any, between his or her Usual Fee and the applicable
Patient Charge.

See Section IX, Specialty Referrals, regarding payment
responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists
state that you will not be liable to the Network Dentist for
any sums owed to the Network Dentist by Cigna Dental.

F. Emergency Dental Care - Reimbursement

An emergency is a dental condition of recent onset and
severity which would lead a prudent layperson possessing
an average knowledge of dentistry to believe the
condition needs immediate dental procedures necessary to
control excessive bleeding, relieve severe pain, or
eliminate acute infection. You should contact your

Network General Dentist if you have an emergency in
your Service Area.

1. Emergency Care Away From Home

If you have an emergency while you are out of your
Service Area or you are unable to contact your
Network General Dentist, you may receive
emergency Covered Services as defined above from
any general dentist. Routine restorative procedures or
definitive treatment (e.g. root canal) are not
considered emergency care. You should return to
your Network General Dentist for these procedures.
For emergency Covered Services, you will be
responsible for the Patient Charges listed on your
Patient Charge Schedule. Cigna Dental will
reimburse you the difference, if any, between the
dentist’s Usual Fee for emergency Covered Services
and your Patient Charge, up to a total of $50 per
incident. To receive reimbursement, send appropriate
reports and x-rays to Cigna Dental at the address
listed for your state on the front of this booklet.

2. Emergency Care After Hours

There is a Patient Charge listed on your Patient
Charge Schedule for emergency care rendered after
regularly scheduled office hours. This charge will be
in addition to other applicable Patient Charges.

G. Limitations on Covered Services

Listed below are limitations on services when covered by
your Dental Plan:

- **Frequency** - The frequency of certain Covered
  Services, like cleanings, is limited. Your Patient Charge
  Schedule lists any limitations on frequency.

- **Pediatric Dentistry** - Coverage for treatment by a
  Pediatric Dentist ends on your child’s 7th birthday.
  Effective on your child’s 7th birthday, dental services
  must be obtained from a Network General Dentist
  however, exceptions for medical reasons may be
  considered on an individual basis.

- **Oral Surgery** - The surgical removal of an impacted
  wisdom tooth may not be covered if the tooth is not
diseased or if the removal is only for orthodontic
  reasons. Your Patient Charge Schedule lists any
  limitations on oral surgery.

- **Periodontal (gum tissue and supporting bone)
  Services** – Periodontal regenerative procedures are
  limited to one regenerative procedure per site (or per
  tooth, if applicable), when covered on the Patient
  Charge Schedule.

  Localized delivery of antimicrobial agents is limited to
eight teeth (or eight sites, if applicable) per 12
consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

- **Prosthesis Over Implant** - When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. 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 5 calendar years old, is not serviceable and cannot be repaired.

**General Limitations Dental Benefits**

No payment will be made for expenses incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

**H. Services Not Covered Under Your Dental Plan**

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

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental’s prior approval (except emergencies, as described in Section IV.F).
- 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 war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or 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.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical
placement of a dental implant, unless specifically listed on your Patient Charge Schedule.

- 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.

- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)

- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)

- the completion of crowns, bridges, dentures, or root canal treatment, already in progress on the effective date of your Cigna Dental coverage?

- 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 Patient Charge Schedule.

- 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 Patient Charge Schedule.

- 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. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.

- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.

- 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 Patient Charge Schedule.

- crowns, bridges and/or implant supported prosthesis used solely for splinting.

- resin bonded retainers and associated pontics.

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

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

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.
If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers
If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. Specialty Care
Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists – children’s dentistry.
- Periodontists – treatment of gums and bone.
- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

See Section IV.D, Choice of Dentist, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals
A. In General

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental’s authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist’s Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist’s Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist’s Usual Fee.

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

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

a. Orthodontic Treatment Plan and Records – the preparation of orthodontic records and a treatment plan by the Orthodontist.

b. Interceptive Orthodontic Treatment – treatment prior to full eruption of the permanent
teeth, frequently a first phase preceding comprehensive treatment.

c. **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.

d. **Retention (Post Treatment Stabilization)** – the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. **Patient Charges**
The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist’s Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

3. **Additional Charges**
You will be responsible for the Orthodontist’s Usual Fees for the following non-Covered Services:

a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;

b. orthognathic surgery and associated incremental costs;

c. appliances to guide minor tooth movement;

d. appliances to correct harmful habits; and

e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. **Orthodontics In Progress**
If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. **Complex Rehabilitation/Multiple Crown Units**
Complex rehabilitation is extensive dental restoration involving 6 or more “units” of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a “unit” on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist’s treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. **What To Do If There Is A Problem**
For the purposes of this section, any reference to “you” or “your” also refers to a representative or dentist designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. **Start with Customer Service**
We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also
express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, 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.

B. Appeals Procedure

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

3. Independent Review Procedure

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas. Consult your State Rider for more details if applicable.

4. Appeals to the State

You have the right to contact your State’s Department of Insurance and/or Department of Health for assistance at any time. See your State Rider for further details.

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.
If you or your Dependents have dental coverage through your spouse’s employer or other sources such as an HMO or similar dental plan, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the sections titled “Extension/Continuation of Benefits” or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to Cigna Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. after voluntary disenrollment.

B. Effect on Dependents

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

XIV. Extension of Benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group’s Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group’s Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group’s Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group, or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group’s Dental Plan. Please call the Cigna Dental Conversion Department at 1-800-Cigna24 to obtain current rates and make arrangements for continuing coverage.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental’s confidentiality policies and procedures is made available to you during the enrollment process and/or as part...
of your customer plan materials. You may obtain additional
information about Cigna Dental’s confidentiality policies and
procedures by calling Customer Service at 1-800-Cigna24, or
via the Internet at myCigna.com.

XVIII. Miscellaneous
As a Cigna Dental plan customer, you may be eligible for
various discounts, benefits, or other consideration for the
purpose of promoting your general health and well being.
Please visit our website at myCigna.com for details.
As a Cigna Dental plan customer, you may also be eligible for
additional dental benefits during certain health conditions. For
example, certain frequency limitations for dental services may
be relaxed for pregnant women and customers participating in
certain disease management programs. Please review your
plan enrollment materials for details.

SEE YOUR STATE RIDER FOR ADDITIONAL
DETAILS.

State Rider
Cigna Dental Health Plan of Arizona, Inc.
Arizona Residents:
I. Definitions
Dependent
The following provision, included as the next to the last
sentence under the definition of “Dependent” in your Plan
Booklet, does not apply to Arizona residents:
Coverage for dependents living outside a Cigna Dental
service area is subject to the availability of an approved
network where the dependent resides.

III. Eligibility/When Coverage Begins
Employees may enroll within 31 days of becoming eligible.
If you have family coverage, a newborn child, newly adopted child,
or a child newly placed in your home for adoption by you, is
automatically covered during the first 31 days of life, adoption or
placement. If you wish to continue coverage beyond the first 31
days, you should enroll your child in the Dental Plan and you need
to begin to pay any additional Premiums during that period.

IV. Your Cigna Dental Coverage
F. Emergency Dental Care - Reimbursement
An emergency is a dental problem that requires
immediate treatment (includes control of bleeding, acute
infection, or relief of pain including local anesthesia).
Reimbursement for emergencies will be made by Cigna
Dental in accordance with your plan benefits, regardless
of the location of the facility providing the services.

H. Services Not Covered Under Your Dental Plan
The following bullet does not apply to Arizona residents.
• services to the extent you or your enrolled Dependent
  are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist
  policy. Arizona residents: Coverage for covered
  services to the extent compensated under group medical
  plan, no fault auto insurance policies or uninsured
  motorist policies is not excluded.

XI. What to Do if There is a Problem
Section B, “Appeals Procedure,” is hereby deleted and
replaced with the following:
B. Problems Concerning Denied Pre-authorizations or
   Denied Claims for Services Already Provided
If your problem concerns a specialty referral pre-
authorization that is not approved for payment or a claim
for services already provided that is denied by Cigna
Dental, you or your designated representative may request
a review as set out below by contacting Customer Service,
P.O. Box 188047, Chattanooga, TN 37422, Telephone 1-
800-Cigna24.

1. Expedited Review Process (Pre-authorizations
   Only)
   a. Expedited Review
      An Expedited Review is available if your
      Network Dentist certifies in writing that the time
to follow the Informal Reconsideration process,
as described below, would cause a significant
negative change in your medical condition. Cigna
Dental will notify you and your dentist of its
decision, by telephone and by mail within 1
business day after receipt of all documentation. If
Cigna Dental upholds the denial, the written
notice will include the criteria used, the clinical
reasons for the decision, references to any
supporting documentation, and notice of your
right to proceed to an Expedited Appeal.
b. Expedited Appeal
An Expedited Appeal is available if Cigna Dental upholds the denial of a pre-authorization at the Expedited Review level. To request an Expedited Appeal, your Network Dentist must immediately inform Cigna Dental, in writing, that you are requesting an Expedited Appeal. Cigna Dental will notify you and your dentist of its decision, by telephone and by mail, within 72 hours of receiving the request. If Cigna Dental upholds the denial, you may request an Expedited External Independent Review.

c. Expedited External Independent Review
An Expedited External Independent Review is available if Cigna Dental upholds the denial of a pre-authorization at the Expedited Appeal level. You have 5 business days from the date you receive written notice that your denial was upheld at the Expedited Appeal level to request an Expedited External Independent Review. You must send your request in writing to the Appeals Coordinator at the above address. Cigna Dental will notify the Director of Insurance and will acknowledge your request in writing within 1 business day. The Director of Insurance will advise you and your treating dentist of the decision.

2. Informal Reconsideration (Pre-authorizations Only)
An Informal Reconsideration is available if Cigna Dental denies a pre-authorization that does not qualify for Expedited Review. You have up to 2 years from the date your pre-authorization was denied to request Informal Reconsideration. Your coverage must be in effect at the time of the request. Cigna Dental will acknowledge your request for Informal Reconsideration in writing within 5 business days. An Appeals Information Packet will be included. Cigna Dental will notify you and your treating dentist of its decision in writing within 15 days. If Cigna Dental upholds the denial, the notice will include a description of the criteria used, the clinical reasons for the decision, references to any supporting documentation, and notice of your right to proceed to a Formal Appeal.

3. Formal Appeal (Pre-authorizations and Claims for Services Already Provided)
a. Denied Pre-authorizations: You have 60 days from the date you receive notice that your denial was upheld at the Informal Reconsideration level to request a Formal Appeal. Cigna Dental will notify you and your dentist of its decision in writing within 15 days.

b. Denied Claims for Services Already Provided:
You have 2 years from the date your claim was denied to request a Formal Appeal. Cigna Dental will notify you and your dentist of its decision in writing within 60 days.

You must send your request for a Formal Appeal in writing to the Appeals Coordinator at the above address. You or your Network Dentist must provide Cigna Dental with any material justification or documentation to support your request. Cigna Dental will acknowledge your appeal in writing within 5 business days of your request. If Cigna Dental upholds the denial, the written notice will include the criteria used, the clinical reasons for the decision, references to any supporting documentation, and your right to proceed to External Independent Review.

4. External Independent Review (Pre-authorizations and Claims for Services Already Provided)
If Cigna Dental upholds the denial of a pre-authorization or a claim for services already provided at the Formal Appeal level, you may seek an External Independent Review. You have 30 days from the date you receive notice that your denial was upheld at the Formal Appeal level to request an External Independent Review. You must send your request for an External Independent Review in writing to the Appeals Coordinator at the above address. Cigna Dental will notify the Director of Insurance and will acknowledge your request in writing within 5 business days. The Director of Insurance will notify you and your treating dentist of the Independent Review Organization’s decision.

Further information concerning the above Appeal Process is contained in the Appeals information Packet. You may obtain a replacement packet by contacting Customer Service at 1-800-Cigna24.

5. Appeals to the State
You have the right to contact the Arizona Department of Insurance and/or Department of Health for assistance at any time.

XII. Dual Coverage
If you are also an insured or a certificate holder under an indemnity health insurance policy that provides benefits for Covered Services provided by the Dental Plan, the indemnity health insurance policy will pay benefits without regard to the existence of the Cigna Dental Plan. Notwithstanding, the indemnity plan is not obligated to pay any amount for a
procedure provided under the Dental Plan at no charge or to pay in excess of the amount of the Patient Charge for any Covered Service. In the event the Patient Charge has been paid to the Network Dentist, then the Indemnity Plan must remit any payments due directly to you.

State Rider
Cigna Dental Health of Florida, Inc.
Florida Residents: This State Rider is attached to and made part of your Plan Booklet and contains information that either replaces, or is in addition to, information contained in your Plan Booklet.

I. Definitions
Dependent - A child born to or adopted by your covered family member may also be considered a Dependent if the child is pre-enrolled at the time of birth or adoption.

III. Eligibility/When Coverage Begins
There will be at least one open enrollment period of not less than 30 days every 18 months unless Cigna Dental Health and your Group mutually agree to a shorter period of time than 18 months.

If you have family coverage, your newly-born child, or a newly-born child of a covered family member, is automatically covered during the first 31 days of life if the child is pre-enrolled in the Dental Plan at the time of birth. If you wish to continue coverage beyond the first 31 days, you need to begin to pay Premiums, if any additional are due, during that period.

IV. Your Cigna Dental Coverage
B. Premiums/Prepayment Fees
Your Group Contract has a 31-day grace period. This provision means that if any required premium is not paid on or before the date is due, it may be paid subsequently during the grace period. During the grace period, the Group Contract will remain in force.

D. Choice of Dentist
You may receive a description of the process used to analyze the qualifications and credentials of Network Dentists upon request.

XI. What to Do If There is a Problem
The following is in addition to the Section XI of your Plan Booklet:

B. Appeals Procedure
The Appeals Coordinator can be reached at 1-800-Cigna24 (244.6224) or by writing to P.O. Box 188047, Chattanooga, TN 37422.

1. Level One Appeals
Your written complaint will be processed within 60 days of receipt unless the complaint involves the collection of information outside the service area, in which case Cigna Dental Health will have an additional 30 days to process the complaint. You may file a complaint up to 1 year from the date of occurrence.

If a meeting with you is necessary, the location of the meeting shall be at Cigna Dental Health’s administrative office at a location within the service area that is convenient for you.

4. Appeals to the State
You always have the right to file a complaint with or seek assistance from the Department of Insurance, 200 East Gaines Street, Tallahassee, Florida 32399, 1-800-342-2672.

XIII. Disenrollment from the Dental Plan/Termination
A. Causes for Disenrollment/Termination
3. Permanent breakdown of the dentist-patient relationship, as determined by Cigna Dental Health, is defined as disruptive, unruly, abusive, unlawful, or uncooperative behavior which seriously impairs Cigna Dental Health’s ability to provide services to customers, after reasonable efforts to resolve the problem and consideration of extenuating circumstances.

Forty-five days notice will be provided to you if Cigna Dental Health terminates enrollment in the dental plan.

XIV. Extension of Benefits
Coverage for all dental procedures in progress, including Orthodontics, is extended for 90 days after disenrollment.

XVI. Converting From Your Group Coverage
You and your enrolled Dependent(s) are eligible for conversion coverage unless benefits are discontinued because
you or your Dependent no longer resides in a Cigna Dental Health Service Area, or because of fraud or material misrepresentation in applying for benefits.

Unless benefits were terminated as previously listed, conversion coverage is available to your Dependents, only, as follows:

A. A surviving spouse and children at Subscriber’s death;
B. A former spouse whose coverage would otherwise end because of annulment or dissolution of marriage; or
C. A spouse or child whose group coverage ended by reason of ceasing to be an eligible family member under the Subscriber’s coverage.

Coverage and Benefits for conversion coverage will be similar to those of your Group’s Dental Plan. Rates will be at prevailing conversion levels.

In addition the following provisions apply to your plan:

**Expenses For Which A Third Party May Be Responsible**

This plan does not cover:

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

**Right Of Reimbursement**

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

**State Rider**

Cigna Dental Health of Maryland, Inc.

1571 Sawgrass Corporate Parkway,
Suite 140
Sunrise, FL 33323

Maryland Residents:

This State Rider contains information that either replaces, or is in addition to, information contained in your Plan Booklet.

**IV. Your Cigna Dental Coverage**

**D. Choice of Dentist**

If, due to circumstances beyond the control of Cigna Dental, such as complete or partial destruction of Dental Offices, war, riot, civil insurrection, labor disputes, or the disability of a significant number of Network Dentists, no Network Dentist can render Covered Services, then you may seek Covered Services from a non-Network Dentist and Cigna Dental will reimburse you as follows: 1. for no-charge services as listed on the applicable Patient Charge Schedule, to the extent that the non-Network Dentist’s fees are reasonable and customary for dentists in the same geographical area; and 2. for other Covered Services, the difference between the applicable Patient Charge Schedule and the non-Network Dentist’s reasonable and customary fee. This reimbursement will be made after you submit appropriate reports and x-rays to Cigna Dental.

**H. Services Not Covered Under Your Dental Plan**

The following bullet is amended for Maryland residents:

- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule.

When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

The following bullet:

- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.

Is replaced by:

- Services considered to be unnecessary in nature or do not meet commonly accepted dental standards.
The following bullet is amended for Maryland residents:
- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. Maryland residents: Services compensated under group medical plans are not excluded.

IX. Specialty Referrals
Your Network General Dentist may not refer you to a dental care entity in which your Network General Dentist and/or his or her immediate family owns a beneficial interest or has a compensation arrangement, unless the services are personally performed by your Network General Dentist or under his or her direct supervision. This provision does not prohibit a referral to another dentist in the same group practice as your Network General Dentist.

XI. What To Do If There Is A Problem
The following information replaces Section XI. of your Plan Booklet in its entirety.

For the purposes of this section, any reference to “you” or “your” also refers to a representative or provider designated by you to act on your behalf.

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. Start With Customer Service
We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to the address listed for your state on the cover page of your plan booklet. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible usually by the end of the next business day, but in any case within 30 days.

The Maryland Insurance Administration is also available to assist you with any complaint you may have against the Dental Plan. If your complaint concerns a Coverage Decision or an Adverse Determination, please refer to the appropriate section below. For all other issues, you may register your complaint with the Maryland Insurance Administration, Life and Health Inquiry and Investigation Unit, 525 St. Paul Place, Baltimore, Maryland, 21202-2272, telephone 410-468-2244.

B. Complaints Involving Coverage Decisions
1. Definitions - the following additional definitions apply to this Section:
   a. Appeal - a protest regarding a coverage decision filed under Cigna Dental’s internal appeal process.
   b. Appeal Decision - a final determination by Cigna Dental on an appeal of coverage decision filed under Cigna Dental’s internal appeal process.
   c. Coverage Decision - an initial determination by Cigna Dental that results in noncoverage of a dental procedure; a determination that an individual is not eligible for coverage under the plan; or, a determination that results in the recission of an individual’s coverage under the plan. It also includes nonpayment of all or any part of a claim. A coverage decision does not include an Adverse Determination, as defined in subsection C. “Complaints Involving Adverse Determinations” of this rider.
   d. Urgent Medical Condition - a condition that satisfies either of the following:
      1. A medical condition, including a physical or dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
         (a) Placing your life or health in serious jeopardy;
         (b) The inability to regain maximum function;
         (c) Serious impairment to bodily function;
         (d) Serious dysfunction of any bodily organ or part; or
      2. A medical condition, including a physical or dental condition, where the absence of medical attention within 72 hours, in the opinion of a health care provider with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.
2. Appeals Procedure

If you are not satisfied with the results of a Coverage Decision, you may start the Appeals Procedure. Cigna Dental has a two-step Appeals Procedure for Coverage Decisions. To initiate an Appeal, you must submit a request in writing to Cigna Dental, at the address listed for your state on the cover page of your plan booklet, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your Appeal should be approved and include any information to support your Appeal. If you are unable or choose not to write, you may ask Customer Service to register your Appeal by calling 1-800-Cigna24.

Following a coverage decision, the HAU is also available to assist in mediating and filing an appeal under the internal process. After an Appeal Decision, the Health Education and Advocacy Unit is available to assist the customer in filing a complaint with the Commissioner. You may contact the Health Education and Advocacy Unit at:

Office of the Attorney General
Consumer Protection Division
200 St. Paul Place, 16th floor
Baltimore MD 21202
Email: heau@oag.state.md.us
Phone: 410-576-6571
TTY: 1.800.576.6372

a. Level One Appeals

Your Level One Appeal will be reviewed and the decision made by someone not involved in the initial review. If your appeals concerns a denied pre-authorization, Cigna Dental will render a final decision in writing, to you and any provider acting on your behalf, within 15 calendar days after we receive your Appeal. For Appeals concerning all other Coverage Decisions, Cigna Dental will render a final decision in writing, to you and any provider acting on your behalf, within 30 calendar days after we receive your Appeal. If we need more time or information to complete the decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the Appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our Level One Appeal decision, you may either: (1) proceed to a Level Two Appeal or (2) register a complaint with the Maryland Insurance Administration (See “Appeals to the State” below).

b. Level Two Appeals

To initiate a Level Two Appeal, follow the same process required for a Level One Appeal. Level Two Appeals will be conducted by an Appeals Committee consisting of at least 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. If specialty care is in dispute, the Appeals Committee will consult with a dentist in the same or similar specialty as the care under review.

Cigna Dental will acknowledge your Appeal in writing within 5 business days and schedule an Appeals Committee review. The acknowledgment letter will include the name, address, and telephone number of the Appeals Coordinator. We may request additional information at that time. If your Appeal concerns a denied preauthorization, the Appeals Committee review will be completed within 15 calendar days.

For Appeals concerning all other coverage issues, the Appeals Committee review will be completed within 30 calendar days. If we need more time or information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeals Committee to complete the review.

You may present your Appeal to the Appeals Committee in person or by conference call. You must advise Cigna Dental 5 days in advance if you or your representative plan to attend in person. Cigna Dental will notify you, and any provider acting on your behalf, of the Appeals Committee’s final decision, in writing, within 5 business days after the meeting. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the Appeal resolution be expedited if the timeframes under the above
Complaints Involving Adverse Determinations

Not medically necessary, appropriate, or efficient; and service covered under the determination that a proposed or delivered health care service is or was not necessary, appropriate or efficient and which resulted in non-coverage of the health care service. A grievance may be filed by you or your designated representative, which may include your Network Dentist.

“Filing Date,” as used below, refers to the earlier of 5 days after the date of mailing or the date of receipt.

2. **Grievances Involving Preauthorization Requests and Covered Services Already Provided**

For grievances involving preauthorization requests, you or your Network Dentist may request a review in writing within 60 days of receipt of an Adverse Determination. Cigna Dental will render a final decision in writing within 30 working days after the date a grievance is filed unless:

a. the grievance involves an emergency. An emergency is a service necessary to treat a condition or illness that, without immediate dental attention, would:

   (1) seriously jeopardize the life or health of the customer or the customer’s ability to regain maximum function, or
   (2) cause the customer to be a danger to self or others.

   If your grievance involves an emergency, Cigna Dental will respond orally with a decision within 24 hours after the grievance is filed.

b. you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days;

c. the grievance involves Covered Services already provided.

For grievances involving Covered Services already provided, you or your Network Dentist may request a review in writing within 180 days of receipt of an Adverse Determination. Cigna Dental shall render a final decision in writing within 45 working days after the date a grievance is filed; unless you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days. If, within 5 days of the Filing Date, Cigna Dental does not have sufficient information to complete the grievance process, Cigna Dental will request additional information for review and will assist you or your Network Dentist in gathering information as required.

Cigna Dental will notify you or your designated representative orally of its grievance decision, followed up in writing to you and your designated representative, within 5 working days, and within 1

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A grievance may be filed by you or your designated representative, which may include your Network Dentist.

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b. you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days;

c. the grievance involves Covered Services already provided.

For grievances involving Covered Services already provided, you or your Network Dentist may request a review in writing within 180 days of receipt of an Adverse Determination. Cigna Dental shall render a final decision in writing within 45 working days after the date a grievance is filed; unless you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days. If, within 5 days of the Filing Date, Cigna Dental does not have sufficient information to complete the grievance process, Cigna Dental will request additional information for review and will assist you or your Network Dentist in gathering information as required.

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Cigna Dental will notify you or your designated representative orally of its grievance decision, followed up in writing to you and your designated representative, within 5 working days, and within 1

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a. the grievance involves an emergency. An emergency is a service necessary to treat a condition or illness that, without immediate dental attention, would:

   (1) seriously jeopardize the life or health of the customer or the customer’s ability to regain maximum function, or
   (2) cause the customer to be a danger to self or others.

   If your grievance involves an emergency, Cigna Dental will respond orally with a decision within 24 hours after the grievance is filed.

b. you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days;

c. the grievance involves Covered Services already provided.

For grievances involving Covered Services already provided, you or your Network Dentist may request a review in writing within 180 days of receipt of an Adverse Determination. Cigna Dental shall render a final decision in writing within 45 working days after the date a grievance is filed; unless you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days. If, within 5 days of the Filing Date, Cigna Dental does not have sufficient information to complete the grievance process, Cigna Dental will request additional information for review and will assist you or your Network Dentist in gathering information as required.

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a. the grievance involves an emergency. An emergency is a service necessary to treat a condition or illness that, without immediate dental attention, would:

   (1) seriously jeopardize the life or health of the customer or the customer’s ability to regain maximum function, or
   (2) cause the customer to be a danger to self or others.

   If your grievance involves an emergency, Cigna Dental will respond orally with a decision within 24 hours after the grievance is filed.

b. you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days;

c. the grievance involves Covered Services already provided.

For grievances involving Covered Services already provided, you or your Network Dentist may request a review in writing within 180 days of receipt of an Adverse Determination. Cigna Dental shall render a final decision in writing within 45 working days after the date a grievance is filed; unless you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days. If, within 5 days of the Filing Date, Cigna Dental does not have sufficient information to complete the grievance process, Cigna Dental will request additional information for review and will assist you or your Network Dentist in gathering information as required.

Cigna Dental will notify you or your designated representative orally of its grievance decision, followed up in writing to you and your designated representative, within 5 working days, and within 1

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A grievance may be filed by you or your designated representative, which may include your Network Dentist.

“Filing Date,” as used below, refers to the earlier of 5 days after the date of mailing or the date of receipt.

2. **Grievances Involving Preauthorization Requests and Covered Services Already Provided**

For grievances involving preauthorization requests, you or your Network Dentist may request a review in writing within 60 days of receipt of an Adverse Determination. Cigna Dental will render a final decision in writing within 30 working days after the date a grievance is filed unless:

a. the grievance involves an emergency. An emergency is a service necessary to treat a condition or illness that, without immediate dental attention, would:

   (1) seriously jeopardize the life or health of the customer or the customer’s ability to regain maximum function, or
   (2) cause the customer to be a danger to self or others.

   If your grievance involves an emergency, Cigna Dental will respond orally with a decision within 24 hours after the grievance is filed.

b. you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days;

c. the grievance involves Covered Services already provided.

For grievances involving Covered Services already provided, you or your Network Dentist may request a review in writing within 180 days of receipt of an Adverse Determination. Cigna Dental shall render a final decision in writing within 45 working days after the date a grievance is filed; unless you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days. If, within 5 days of the Filing Date, Cigna Dental does not have sufficient information to complete the grievance process, Cigna Dental will request additional information for review and will assist you or your Network Dentist in gathering information as required.

Cigna Dental will notify you or your designated representative orally of its grievance decision, followed up in writing to you and your designated representative, within 5 working days, and within 1
day if your grievance involves an emergency, after the decision is made. The notice shall include:

a. the specified factual basis for the decision;

b. the specific criteria and standards, including interpretive guidelines on which the grievance decision was based;

c. the name, business address and telephone number of the Cigna Dental Appeals Coordinator; and

d. the instructions and time frame for filing a complaint with the Maryland Insurance Commissioner, including the Commissioner’s address, telephone number and facsimile number.

3. Appeals to the State

The Maryland Health Education and Advocacy Unit is available to assist you in filing a grievance under Cigna Dental’s internal grievance process or in mediating a resolution to an Adverse Determination. However, it is not available to represent or accompany you during grievance proceedings. The Health Education and Advocacy Unit can be reached at: Consumer Protection Division, Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202; Phone (410) 528-1840 or 1-877-261-8807; TTY 1-800-576-6372; Fax (410) 576-6571; Email: heau@oag.state.md.us.

If you have exhausted Cigna Dental’s internal grievance process and are not satisfied with Cigna Dental’s decision, you may also file a written complaint with the Maryland Insurance Commissioner, within four months of receipt of Cigna Dental’s grievance decision, at Maryland Insurance Administration, Chief of Complaints, 525 St. Paul Place, Baltimore, MD 21202; Phone 1-800-492-6116; Fax (410) 468-2270; TTY 1-800-735-2258.

You may also file a complaint with the Insurance Commissioner if you do not receive a grievance decision on a timely basis as set out in Sections 2. and 3. above.

You or your Network Dentist may file a complaint with the Maryland Insurance Commissioner without first exhausting Cigna Dental’s internal grievance process, if you can demonstrate to the Commissioner a compelling reason why you should not proceed under Cigna Dental’s internal grievance process. A “compelling reason” demonstrates that the potential delay in receipt of a health care service until after the customer or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the customer remaining seriously mentally ill with symptoms that cause the customer to be a danger to self or others.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

The following supersedes the provisions of Section XIII, Subsection A.4. of your plan booklet.

4. After 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices. Cigna Dental may not terminate coverage for an entire family because a Dependent fraudulently uses the membership card; only the Dependent’s coverage may be terminated.

State Rider

Cigna Dental Health of Ohio, Inc.

Ohio Residents:

The following is in addition to the information on the first page of your Plan Booklet:

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

III. Eligibility/When Coverage Begins

You and your Dependents must live or work in the service area to be eligible for coverage.

Under Ohio law, if you divorce, you cannot terminate coverage for enrolled Dependents until the court determines that you are no longer responsible for providing coverage.
Cigna Dental does not require, make inquiries into, or rely upon genetic screening or testing in processing applications for enrollment or in determining insurability under the Dental Plan.

**Section IV is renamed:**

**IV. Your Cigna Dental Plan**

**E. Your Payment Responsibility (General Care)**

The following is in addition to the process described in Section IV. E. of your Plan Booklet:

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. There is no additional cost to you.

Cigna Dental is not a member of any Guaranty Fund. In the event of Cigna Dental’s insolvency, you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental. However, you may be financially responsible for services rendered by a non-network dentist whether or not Cigna Dental authorizes payment for a referral.

If you are undergoing treatment and the Dental Plan becomes insolvent, Cigna Dental will arrange for the continuation of services until the expiration of your Group Contract.

**XI. What To Do If There Is A Problem**

The following is in addition to the process described in Section XI of your Plan Booklet:

**A. Start With Member Services**

You can reach Member Services by calling 1-800-Cigna24 or by writing to Cigna Dental Health of Ohio, Inc., P.O. Box 453099, Sunrise, Florida 33345-3099, Attention: Member Services. You may also submit a complaint in person at any Cigna Dental Office.

**B. Appeals Procedure**

1. **Level One Appeals**

   Cigna Dental will provide a written response to your written complaint.

   Within 30 days of receiving a response from Cigna Dental, you may appeal a complaint resolution regarding cancellation, termination or non-renewal of coverage by Cigna Dental to the Ohio Superintendent of Insurance.

   The Ohio Department of Insurance is located at 50 W. Town Street, Suite 300, Columbus, Ohio 43215, Attention Consumer Services Division. The Department’s toll-free number is 1-800-686-1526 or (614) 644-2673.

**XII. Dual Coverage**

(This section is not applicable when Cigna Dental does not make payments toward specialty care as indicated by your Patient Charge Schedule. For those plans, Cigna Dental is always the primary plan.)

The following supersedes Section XII of your Plan Booklet.

**A. Coordination of Benefits**

“Coordination of benefits” is the procedure used to pay health care expenses when a person is covered by more than one plan. Cigna Dental follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills. Coordination of benefits applies only to Specialty Care.

When you or your family members are covered by another group plan in addition to this one, we will follow Ohio coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Cigna Dental pays for dental care when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

Cigna Dental will not reduce or exclude benefits payable to you or on your behalf because such benefits have also been paid under a supplemental, specified disease or limited plan of coverage for sickness and accident insurance which is entirely paid for by you, your family or guardian.

**B. Plans That Do Not Coordinate**

Cigna Dental will pay benefits without regard to benefits paid by the following kinds of coverage:

- Medicaid
- Group hospital indemnity plans which pay less than $100 per day
• School accident coverage
• Some supplemental sickness and accident policies

C. How Cigna Dental Pays As Primary Plan
When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

D. How Cigna Dental Pays as Secondary Plan
1. When we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.
2. We will pay only for health care expenses that are covered by Cigna Dental.
3. We will pay only if you have followed all of our procedural requirements, including: care is obtained from or arranged by your primary care dentist; preauthorized referrals are made to network specialists; coverage is in effect when procedures begin; procedures begin within 90 days of referral.
4. We will pay no more than the “allowable expenses” for the health care involved. If our allowable expense is lower than the primary plan’s, we will use the primary plan’s allowable expense. That may be less than the actual bill.

E. Which Plan is Primary?
To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following that applies:
1. Non-coordinating Plan
   If you have another group plan that does not coordinate benefits, it will always be primary.
2. Employee
   The plan that covers you as an employee (neither laid off nor retired) is always primary.
3. Children (Parents Divorced or Separated)
   If the court decree makes one parent responsible for health care expenses, that parent’s plan is primary. If the court decree gives joint custody and does not mention health care, we follow the birthday rule. If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.
4. Children & the Birthday Rule
   When your children’s health care expenses are involved, we follow the “birthday rule.” The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse’s birthday is in March, your plan will be primary for all of your children.
   However, if your spouse’s plan has some other coordination rule (for example, a “gender rule” which says the father’s plan is always primary), we will follow the rules of that plan.
5. Other Situations
   For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

F. Coordination Disputes
If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

G. Subrogation
If another source directly reimburses you more than your Patient Charge for Covered Services, you may be required to reimburse Cigna Dental. Where allowed by law, this section will apply to you or your Dependents who:
1. receive benefit payments under this Dental Plan as the result of a sickness or injury; and
2. have a lawful claim against another party or parties for compensation, damages, or other payment because of that same sickness or injury.
In those instances where this section applies, the rights of the Member or Dependent to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to Cigna Dental, but only to the extent of benefit payments made under this Dental Plan.

XIII. Disenrollment From The Dental Plan/Termination of Benefits

A. Causes For Disenrollment/Termination
3. Under Ohio law, you will not be terminated from the dental plan due to a permanent breakdown of the dentist-patient relationship. However, your Network Dentist has the right to decline services to a patient because of rude or abusive behavior.
   You or your Dependent may appeal any termination action by Cigna Dental by submitting a written complaint as set out in Section XI.
XVI. Conversion Coverage
You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

A. Nonpayment of Premiums/Prepayment Fees by the Subscriber;
B. Fraud or misuse of dental services and/or Dental Offices;
C. Selection of alternate dental coverage by your Group.

XVIII. Miscellaneous

A. Governing Law
The Group Contract shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with pertinent laws and regulations of the State of Ohio. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

B. Availability of Financial Statement
Cigna Dental Health of Ohio, Inc. will make available to you, upon request, its most recent financial statement.
The certificate(s) listed in the next section apply if you are a resident of one of the following states: CA, CT, IL, KY, MO, NJ, NC, TX
Cigna Dental Health of New Jersey, Inc.

P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. Please read the following information so you will know from whom or what group of dentists dental care may be obtained. This certificate is subject to the laws of the state of New Jersey.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information - Please Read the Provision Entitled “Disenrollment from the Dental Plan - Termination of Benefits.”

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at 1-800-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.
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XVIII. Miscellaneous
I. Definitions

Capitalized terms, unless otherwise defined, have the meanings listed below.

**Adverse Determination** - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

A. be consistent with the symptoms, diagnosis or treatment of the condition present;
B. conform to commonly accepted standards throughout the dental field;
C. not be used primarily for the convenience of the customer or dentist of care; and
D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist’s Usual Fees. A licensed dentist will make any such denial.

**Cigna Dental** - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

**Contract Fees** - the fees contained in the Network Dentist agreement with Cigna Dental.

**Covered Services** - the dental procedures listed on your Patient Charge Schedule.

**Dental Office** - your selected office of Network General Dentist(s).

**Dental Plan** - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

**Dependent** - your lawful spouse, civil union or your domestic partner (if established in New Jersey prior to February 19, 2007 or if established outside the state of New Jersey prior to or after February 19, 2007); your unmarried or unpartnered child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a Dependent child who resides in your home as a result of court order or administrative placement; or a Dependent child acquired through a civil union) who is:

A. less than 19 years old; or
B. less than 23 years old if he or she is both:
   1. a full-time student enrolled at an accredited educational institution, and
   2. reliant upon you for maintenance and support; or
C. any age if he or she is both:
   1. incapable of self-sustaining employment due to mental or physical disability, and
   2. reliant upon you for maintenance and support.

For a Dependent child 19 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child’s academic status to less than that of a full-time student.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for Dependents living outside a Cigna Dental Service Area is subject to the availability of an approved network where the Dependent resides.

This definition of “Dependent” applies unless modified by your Group Contract.

**Group** - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

**Network Dentist** - a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

**Network General Dentist** - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

**Network Specialty Dentist** - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to you.

**Patient Charge** - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

**Patient Charge Schedule** - list of services covered under your Dental Plan and how much they cost you.

**Premiums** - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

**Service Area** - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

**Subscriber/You** - the enrolled employee or customer of the Group.

**Usual Fee** - the customary fee that an individual dentist most frequently charges for a given dental service.
II. Introduction To Your Cigna Dental Plan
Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. Eligibility When Coverage Begins
To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. Your Cigna Dental Coverage
The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. Customer Service
If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. Premiums
Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

C. Other Charges – Patient Charges
Network General Dentists are reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services the amount you must pay for non-Covered Services and the Dental Office’s payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. Choice of Dentist
You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did
not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist’s office will have primary responsibility for your child’s care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist’s Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled “Office Transfers” if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

See Section IX, Specialty Referrals, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. Emergency Dental Care – Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

Emergency Care Away From Home - If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist’s Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed on the front of this booklet.

Emergency Care After Hours - There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

G. Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child’s 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Effective on your child’s 7th birthday, dental services must be obtained from a Network General Dentist.

- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.

- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations,
comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. 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 5 calendar years old, is not serviceable and cannot be repaired.

**General Limitations Dental Benefits**

No payment will be made for expenses incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. **Services Not Covered Under Your Dental Plan**

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

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental’s prior approval (except emergencies, as described in Section IV. F.).
- 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 war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or 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.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- 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.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be
submitted to the medical carrier for benefit determination.)

- the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- 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 Patient Charge Schedule.
- 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 Patient Charge Schedule.
- 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. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- 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 Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

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

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

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer, however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.
VIII. Specialty Care

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists - children’s dentistry.
- Periodontists - treatment of gums and bone.
- Oral Surgeons - complex extractions and other surgical procedures.
- Orthodontists - tooth movement.

There is no coverage for referrals to Prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

See Section IV.D., Choice of Dentist, regarding treatment by a Pediatric Dentist.

IX. Specialty Referrals

A. In General

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees for no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX. B. Orthodontics. Treatment by the Network Specialist must begin within 90 days from the date of Cigna Dental’s authorization. If you are unable to obtain treatment within the 90-day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist’s Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Customer Service. After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist’s Usual Fees.

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

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

- Orthodontic Treatment Plan and Records - the preparation of orthodontic records and a treatment plan by the Orthodontist.
- Interceptive Orthodontic Treatment - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- Comprehensive Orthodontic Treatment - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- Retention (Post Treatment Stabilization) - the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

Patient Charges

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

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist’s Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

Additional Charges

You will be responsible for the Orthodontist’s Usual Fees for the following non-Covered Services:

- incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- orthognathic surgery and associated incremental costs;
- appliances to guide minor tooth movement;
• appliances to correct harmful habits; and
• services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

Orthodontics in Progress
If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units
Complex rehabilitation is extensive dental restoration involving 6 or more “units” of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a “unit” on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist’s treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. What To Do If There Is A Problem
For the purposes of this section, any reference to “you” or “your” also refers to a representative or dentist designated by you to act on your behalf.

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. Start With Customer Service
We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 15 working days.

If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

B. Appeals Procedure
Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1-800-Cigna24.

Level-One Appeals
Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

We will respond with a decision within 15 working days after we receive your appeal. If we need more time or information to make the decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition.

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

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

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 15 working days. If we need more time or information to complete the review, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

Appeals to the State

You have the right to contact the New Jersey Department of Insurance and/or Department of Health for assistance at any time.

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. Dual Coverage

A. In General

“Coordination of benefits” is the procedure used to pay health care expenses when a person is covered by more than one plan. Cigna Dental follows rules established by New Jersey law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow New Jersey coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Cigna Dental pays for dental care when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

B. How Cigna Dental Pays As Primary Plan

When you receive care from a Network Specialty Dentist, Cigna Dental pays the Network Specialty Dentist a contracted fee amount less your copayment for the Covered Service. When we are primary, we will pay the full benefit allowed as if you had no other coverage. Cigna Dental pays for dental care when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

C. How Cigna Dental Pays As Secondary Plan

- If your primary plan pays on the basis of UCR, Cigna Dental will pay the difference between the provider’s billed charges and the benefits paid by the primary plan up to the amount Cigna Dental would have paid if primary. Cigna Dental’s payment will first be applied toward satisfaction of your copayment of your primary plan. You will not be liable for any billed charges in excess of the sum of the benefits paid by your primary plan, Cigna Dental as your secondary plan and the copayment you paid under either the primary or secondary plan. When Cigna Dental pays as secondary, you will never be responsible for paying more than your copayment for the Covered Service.

- When both your primary plan and Cigna Dental pay network providers on the basis of a contractual fee schedule and the provider is a network provider of both plans, the allowable expense will be considered to be the contractual fee of your primary plan. Your primary plan will pay the benefit it would have paid regardless of any other coverage you may have. Cigna Dental will pay the copayment for the Covered Service for which you are liable up to the amount Cigna Dental would have paid if primary and provided that the total amount received by the provider from the primary plan, Cigna Dental and you does not exceed the contractual fee of the primary plan. You will not be responsible for an amount more than your copayment.

- When your primary plan pays network providers on a basis of capitation or a contractual fee schedule or pays a benefit on the basis of UCR, and Cigna Dental pays network providers on the basis of capitation and a service or supply is provided by a network provider of Cigna Dental, we will not be obligated to pay to the network provider any amount other than the capitation payment required under the contract between Cigna and the primary plan.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

Appeals to the State

You have the right to contact the New Jersey Department of Insurance and/or Department of Health for assistance at any time.

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

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A. In General

“Coordination of benefits” is the procedure used to pay health care expenses when a person is covered by more than one plan. Cigna Dental follows rules established by New Jersey law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow New Jersey coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Cigna Dental pays for dental care when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

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- If your primary plan pays on the basis of UCR, Cigna Dental will pay the difference between the provider’s billed charges and the benefits paid by the primary plan up to the amount Cigna Dental would have paid if primary. Cigna Dental’s payment will first be applied toward satisfaction of your copayment of your primary plan. You will not be liable for any billed charges in excess of the sum of the benefits paid by your primary plan, Cigna Dental as your secondary plan and the copayment you paid under either the primary or secondary plan. When Cigna Dental pays as secondary, you will never be responsible for paying more than your copayment for the Covered Service.

- When both your primary plan and Cigna Dental pay network providers on the basis of a contractual fee schedule and the provider is a network provider of both plans, the allowable expense will be considered to be the contractual fee of your primary plan. Your primary plan will pay the benefit it would have paid regardless of any other coverage you may have. Cigna Dental will pay the copayment for the Covered Service for which you are liable up to the amount Cigna Dental would have paid if primary and provided that the total amount received by the provider from the primary plan, Cigna Dental and you does not exceed the contractual fee of the primary plan. You will not be responsible for an amount more than your copayment.

- When your primary plan pays network providers on a basis of capitation or a contractual fee schedule or pays a benefit on the basis of UCR, and Cigna Dental pays network providers on the basis of capitation and a service or supply is provided by a network provider of Cigna Dental, we will not be obligated to pay to the network provider any amount other than the capitation payment required under the contract between Cigna and the primary plan.
Dental and the network provider and we shall not be liable for any deductible, coinsurance or copayment imposed by your primary plan. You will not be responsible for the payment of any amount for eligible services.

- We will pay only for health care expenses that are covered by Cigna Dental.
- We will pay only if you have followed all of our procedural requirements, including: care is obtained from or arranged by your primary care dentist; coverage in effect when procedures begin; procedures begin within 90 days of referral.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames For Disenrollment/Termination

Except as otherwise provided in the sections titled “Extension/Continuation of Benefits” or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

- in which Premiums are not remitted to Cigna Dental;
- in which eligibility requirements are no longer met;
- after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office;
- after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices;
- after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area;
- after voluntary disenrollment.

B. Effect on Dependents

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

XIV. Extension of Benefits

Coverage for completion of a dental procedure which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

XV. Continuation of Benefits (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. Conversion Coverage

If you are no longer eligible for coverage under your Group’s Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three months after becoming ineligible for your Group’s Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group’s Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- permanent breakdown of the dentist-patient relationship;
- fraud or misuse of dental services and/or Dental Offices;
- nonpayment of Premiums by the Subscriber;
- selection of alternate dental coverage by your Group; or
- lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group’s Dental Plan. Please call the Cigna Dental Conversion Department at 1-800-Cigna24 to obtain current rates and make arrangements for continuing coverage.

XVII. Confidentiality/Privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental’s confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental’s confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at myCigna.com.

XVIII. Miscellaneous

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at myCigna.com for details.
If you are a Cigna Dental Care customer you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.
Cigna Dental Care – Cigna Dental Health Plan

The rider(s) listed in the next section are general provisions that apply to the residents of: AZ, CA, CO, CT, DE, FL, IL, KS/NE, KY, MD, MO, NJ, NC, OH, PA, TX, VA
Domestic Partner Rider

This definition of Domestic Partner applies to residents of: AZ, CA, CO, CT, DE, FL, IL, KS/NE, KY, MD, NC, OH, PA, TX, VA.

A. A person of the same or opposite sex who:
   1. shares your permanent residence;
   2. has resided with you for no less than one year;
   3. is no less than eighteen years of age;
   4. is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common lease hold interest in such property, common ownership of a motor vehicle, a joint bank account or a joint credit account, designation as a beneficiary for life insurance or retirement benefits or under your partner's will, assignment of durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;
   5. is not your blood relative any closer than would be prohibited for a legal marriage; and
   6. has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental Health which shall be made available to Cigna Dental Health upon request; or

B. A person of the same or opposite sex who has registered jointly with you as Domestic Partners with a governmental entity pursuant to a state or local law authorizing such registration and signed jointly with you a notarized affidavit of such registration which can be made available to Cigna Dental Health upon request.

The above definition applies so long as neither you nor your Domestic Partner hereunder:

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

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.

This insert contains Cigna Dental’s standard Domestic Partner definition. Your Group may have purchased one or both coverages (same/opposite sex partners). Consult your Group Contract for additional information.

Pennsylvania Residents: Domestic Partner coverage is available for persons of the same or opposite sex; same sex only coverage is not available.

Kentucky Residents: Coverage terminates (for the domestic partner and any dependents, if included) when the domestic partnership ends. Domestic Partners are entitled to Conversion rights upon termination of coverage.

Domestic Partner Rider

This definition of Domestic Partner applies to residents of: NJ.

A domestic partnership shall be established when all of the following requirements are met:

1. Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following:
   a. a joint deed, mortgage agreement or lease;
   b. a joint bank account;
   c. designation of one of the persons as a primary beneficiary in the other person's will; or
   d. designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
   e. joint ownership of a motor vehicle;
2. Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;
3. Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;
4. Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
5. Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older and not of the same sex may establish a domestic partnership if they meet the requirements set forth in this section;
6. Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
7. Both persons are at least 18 years of age.
(8) Both persons file jointly an Affidavit of Domestic Partnership; and

(9) Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and, in all cases in which a person registered a prior domestic partnership, the domestic partnership shall have been terminated in accordance with the provisions of section 10 of P.L. 2003, c. 246 (C. 26:8A-10).
Federal Requirements
The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks
If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with Cigna HealthCare or Cigna Dental Health.

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO
If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

B. Qualified Medical Child Support Order Defined
A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child’s right to receive group health benefits for which a participant or beneficiary is eligible;

2. the order specifies your name and last known address, and the child’s name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child’s mailing address;

3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

4. the order states the period to which it applies; and

5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

C. Payment of Benefits
Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to the child, the child’s custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

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).

A. 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 30 days of the date you meet the criteria shown in the following Sections B through F.

B. Change of Status
A change in status is defined as:
1. change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
2. change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
3. change in employment status of Employee, spouse or Dependent 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;
4. changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
5. change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and
6. changes which cause a Dependent to become eligible or ineligible for coverage.

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

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

E. 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.

F. Changes in Coverage of Spouse or Dependent Under Another Employer’s Plan
You may make a coverage election change if the plan of your spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

Eligibility for Coverage for Adopted Children
Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the “Exception for Newborns” section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Group Plan Coverage Instead of Medicaid
If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.
Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee’s military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

A. Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any “Conversion Privilege” shown in your certificate.

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

Claim Determination Procedures Under ERISA

Procedures Regarding 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.

You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the
Certificate, and in your provider's network participation documents as applicable.

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

**Postservice Medical Necessity Determinations**

When you or your representative requests a Medical Necessity determination after services have been rendered, 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 or your representative 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. 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.

**Postservice Claim Determinations**

When you or your representative requests payment for services which have been rendered, Cigna will notify you of the claim payment 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 or your representative 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 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 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 pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

**COBRA Continuation Rights Under Federal Law**

**For You and Your Dependents**

**What is COBRA Continuation Coverage?**

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under Basic Benefits which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

**When is COBRA Continuation Available?**

For you and your Dependents, COBRA continuation is available 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, or
- 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 a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.
Who is Entitled to COBRA Continuation?

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

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless 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 sections titled “Secondary Qualifying Events” and “Medicare Extension For Your 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) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their 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 discussed below. Under no circumstances will 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 coverage 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, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. 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 covered persons 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” listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.
provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or

- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

**Employer’s Notification Requirements**

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan 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 continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  
  a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  
  b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  
  c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

**How to Elect COBRA Continuation Coverage**

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the 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. 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 continuation coverage 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.

**How Much Does COBRA Continuation Coverage Cost?**

Each qualified beneficiary may be required to pay the entire cost of 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 premium 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 coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

**When and How to Pay COBRA Premiums**

**First payment for COBRA continuation**

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

**Subsequent payments**

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.
Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment is due 60 calendar days after the later of the date the qualifying event occurred; and supporting documentation has been received. If your payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that your COBRA coverage may be suspended if payment is missed. If any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period.

(Also refer to the section titled “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.).

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. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-626-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this
special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Interaction With Other Continuation Benefits
You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

ERISA Required Information
The name of the Plan is:

The Oberlin College Health Plan

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

Oberlin College
173 West Lorain Street
Oberlin, OH 44074
440-775-8430

Employer Identification Number (EIN)
340714363

Plan Number
506

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 person designated as agent for the service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

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

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees
A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type
The plan is a healthcare benefit plan.

Collective Bargaining Agreements
You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority
The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination
The Employer as Plan Sponsor 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. 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, is contained in the Employer’s Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependents’ total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).
Your coverage under the Plan’s insurance policy(s) will end on the earliest of the following dates:

- the last day of the calendar month in which you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights
As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan and 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.

- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage
- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your 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 your 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. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Receive Information About Your Plan and Benefits
- 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.
- examine without charge, or obtain for a reasonable charge, at the Plan Administrator’s office and at other specified locations, all copies of 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.

Enforce Your Rights
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a 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 domestic relations order or 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 your 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.