Oberlin College

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2014

CN013
3197756

This document printed in March, 2014 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, 2014

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; or
  - you are a unionized security employee who is appointed and scheduled to work 20 hours per week; or
  - you are a faculty member who is appointed at least 4/9 of a full-time appointment; or
  - you are an administrative or professional staff worker who is appointed to work at least half-time for nine (9) months per calendar year; or
  - 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.
- Spouses/partners with children/family” the person with the higher salary will carry the enrollments, effective January 1, 2002.
- 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 adoptive 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 the 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
Each Employee as reported to the insurance company by your Employer.

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 day 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 an extension of coverage that mirrors 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.

**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 www.cigna.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 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 - Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.
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.
- 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.
- Services listed on your Patient Charge Schedule when performed for the treatment of pathology or disease not related to congenital conditions.
- 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 (PCS).
- 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 drugs.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); diagnose or treat conditions or disorders of the temporomandibular joint (TMJ), when medical in nature or unless TMJ therapy is specifically listed on your Patient Charge Schedule; or if your Patient Charge Schedule ends in “-04” or higher; or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or d. 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.

• 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 and bridges, dentures, root canal treatment or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage.

• 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 www.cigna.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 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 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 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 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 Specialist 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 Orthodontics is listed on your Patient Charge Schedule.)

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.

- **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 Fee 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 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 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.
Coordination of Benefits

This section is intended to establish uniformity in the permissive use of overinsurance provisions and to avoid claims 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 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 other 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 on 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.

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 F.

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.

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: 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.

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:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the plan’s review procedures and the 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 date 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.

Although federal law does not extend COBRA continuation rights to domestic partners, this plan will extend these same continuation benefits to domestic partners (and their children if not legal children of the employee) to the same extent they are provided to spouses of the opposite sex and legal children of the employee.

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.

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 1-866-628-4282. 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.

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);
• 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.

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.
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.
- 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.

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 denying 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.

HC-FED65 02-14
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 healthcare 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 an expedited 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 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, 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.

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 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, 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 grievances 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.

**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 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, a foster child, or a child for whom you are the legal guardian 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.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

Domestic Partner
A Domestic Partner is defined as a person of the same or opposite 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 any other Domestic Partner, spouse or spouse equivalent of the same or opposite 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.

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Employee
The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

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Employer
The term Employer means the Policyholder and all Affiliated Employers.

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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.

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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.

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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.

Retiree
An employee who ceased to be a regular status employee of Oberlin College and who is at least 62 years of age. Must have been a regular status employee of Oberlin College and insured on the Oberlin College plan at the time of retirement. Ramp Retiree: Retirees prior to age 62, can continue to be covered under Preferred A Health Plan. For those who retire between the ages of 52 and 61 and have at least 10 years of full Service. At age 65 the retiree and dependent must enroll for both Medicare Part A & B.

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.