Oberlin College

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2017

CN017
3197756

This document printed in March, 2017 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, 2017

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

HC-CER17  04-10  V1
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

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with Cigna, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Customer Service/Member Services at the toll-free phone number shown on your ID card, and ask an associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAgrievance@cigna.com or by writing to the following address: Cigna, Nondiscrimination Complaint Coordinator, P.O. Box 188016, Chattanooga, TN 37422.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; or by phone at 1-800-368-1019, 800-537-7697 (TDD).


Proficiency of Language Assistance Services

ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1-800-244-6224 (TTY: Dial 711).

Spanish

ATENCIÓN: tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1-800-244-6224 (los usuarios de TTY deben llamar al 711).

Chinese

注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1-800-244-6224 (聽障專線：請撥 711）。

Vietnamese

CHÚ Ý: Có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Dành cho khách hàng hiện tại của Cigna, gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1-800-244-6224 (TTY: Quay số 711).

Korean

주의: 언어 지원 서비스를 비용없이 이용하실 수 있습니다. 기존 Cigna 가입자의 경우, 가입자 ID 카드 뒷면에 있는 전화번호로 연락해 주십시오. 아니면 1-800-244-6224번으로 연락해 주십시오 (TTY: 711번으로 전화).

Tagalog

PAUNAWA: Makakakuha ka ng mga serbisyo sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1-800-244-6224 (TTY: I-dial ang 711).

Russian

ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1-800-244-6224 (TTY: 711).

Arabic

Cigna مبادئ المساواة منحة متاحة لكل العملاء الحاليين. يرجى الاتصال بالرقم المدون على ظهر بطاقة الأعضاء الشخصية. أو اتصل ب 1-800-244-6224 (TTY: 711).
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;
  • you are a unionized service employee who is appointed and scheduled to work at least 20 hours per week on either a full year or school year basis;
  • you are a unionized security employee who is appointed and scheduled to work at least 20 hours per week on either a full year or school year basis;
  • you are a unionized security employee who is appointed and scheduled to work 20 hours per week;
  • you are a faculty member who is appointed at least 4/9 of a full-time appointment;
  • you are an administrative or professional staff worker who is appointed to work at least half-time for nine (9) months per calendar year; or
  • you are an intern in active appointments of half-time or more; or
  • you are an eligible retiree; and
• you pay any required contribution.

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.

Waiting Period
First day of calendar month following the date that the Employee satisfies the eligibility requirement, the actively at work requirements and the enrollment requirements of the Plan.

Classes of Eligible Employees
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, but no earlier than the date you become eligible.

If you are a Late Entrant, you may elect the insurance only during an Open Enrollment Period. Your insurance will become effective on the first day of the month after the end of that Open Enrollment Period in which you elect it.

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

Late Entrant – Employee
You are a Late Entrant if:

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

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

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

Effective Date of Dependent Insurance
Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.
If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until Cigna agrees to insure that Dependent. Your Dependents will be insured only if you are insured.

**Late Entrant – Dependent**
You are a Late Entrant for Dependent Insurance if:

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

**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.

**Death of Employee While Still Active**
The Spouse or Same-Sex Partner of an active employee will be offered an extension of coverage that mirror 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; and
- Employee had worked for Oberlin College for at least ten (10) year; and
- Employee had reached the retirement age of at least 62; and
- Surviving spouse or partner does not have health coverage from their employer.

**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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Services Covered Under Your Dental Plan**

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

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

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

- **Clinical Oral Evaluations** – Up to a total of 4 evaluations (Periodic oral evaluations, and/or comprehensive oral evaluations, and/or comprehensive periodontal evaluations, and/or oral evaluations for patients under three years of age are covered during a 12 consecutive month period.

- If bleaching (tooth whitening) is listed as a covered service on your Patient Charge Schedule, the method covered is specific to the use of take-home bleaching gel with trays.

- When listed on your Patient Charge Schedule, general anesthesia, IV sedation and nitrous oxide are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. General Anesthesia and IV sedation when used for anxiety control or patient management do not meet the criteria of medical necessity.

- Services that meet commonly accepted dental standards and are listed on your Patient Charge Schedule.

- Consultations and/or evaluations associated with services that are covered endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a good or favorable periodontal prognosis.

- When listed on your Patient Charge Schedule, bone grafting and/or guided tissue regeneration is covered when performed for the treatment of periodontal disease at a tooth site other than the site of an extraction, apicoectomy or periradicular surgery.

- **Root canal treatment** in the presence of injury to, or disease of, the pulp (nerve tissue) of a tooth.

- **Restorative, fixed prosthodontic and removable prosthodontic services** when listed on your patient charge schedule and provided by your Network General Dentist.

- **Localized delivery of antimicrobial agents** when performed in conjunction with traditional periodontal therapy and less than nine (9) of these procedures are performed on the same date of service.

- **Infection control and/or sterilization.** Cigna Dental considers this to be incidental to and part of the charges for services provided.

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

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

- Services listed on your Patient Charge Schedule when performed for the treatment of pathology or disease not related to congenital conditions.

- When listed on your Patient Charge Schedule the replacement of an occlusal guard (night guard) once, every 24 months.

**Services Not Covered Under Your Dental Plan**

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

- services not listed on the Patient Charge Schedule.

- services provided by a non-network Dentist without Cigna Dental's prior approval (except in emergencies).

- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.

- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.

- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.

- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless the service is specifically listed on your Patient Charge Schedule.

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.

- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated run by the United States Government or by a state or municipal government if the person had no insurance.
• due to injuries which are intentionally self-inflicted.
• prescription medications.
• procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion.
• replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
• surgical placement of a dental implant, repair, maintenance or removal of a dental implant, implant abutment(s), or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
• services considered to be unnecessary or experimental in nature.
• procedures or appliances for minor tooth guidance or to control harmful habits.
• hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for network Dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
• the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
• the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
• crowns, bridges and/or implant supported prosthesis used solely for splinting.
• resin bonded retainers and associated pontics.

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

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

**Appointments**

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

**Broken Appointments**

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

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

**Office Transfers**

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

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

**Specialty Care**

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

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

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

**Specialty Referrals**

**In General**

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatric Dentistry and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.
When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in the Orthodontics section. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental’s authorization. If you are unable to obtain treatment within the 90-day period, please call Member Services to request an extension. Your coverage must be in effect when each procedure begins.

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

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

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

Orthodontics (This section is only applicable if Orthodontia 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.

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**Patient Charges**

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

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

**Additional Charges**

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

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

- orthognathic surgery and associated incremental costs;

- appliances to guide minor tooth movement;

- appliances to correct harmful habits; and

- services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

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

Coordination of Benefits

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

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

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

- a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder; and
- any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

Definitions

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

Plan

A plan is a form of coverage written on an expense-incurred basis with which coordination is allowed. The definition of Plan in a contract must state the types of coverage which will be considered in applying the COB provision of that contract. This section uses the term Plan. However, a contract may, instead, use program or some other term.

Plan shall not include individual or family:

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

Plan may include:

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

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

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

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

This Plan

In a COB provision, the term This Plan refers to the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced on account of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan.

A contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like
benefits, and may apply other separate COB provisions to coordinate other benefits.

**Primary Plan**

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

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

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

**Secondary Plan**

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

**Allowable Expense**

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

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

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

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

**Claim Determination Period**

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

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

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

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

**Reasonable Cash Value**

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

**Order of Benefit Determination Rules**

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

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

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

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

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

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

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

  - first, the Plan of the parent with custody of the child;

  - then, the Plan of the spouse of the parent with custody of the child;

  - finally, the Plan of the parent not having custody of the child; and

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

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

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

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

  - a change in the amount or scope of a Plan's benefits;

  - a change in the entity which pays, provides or administers the Plan's benefits; or

  - a change from one type of Plan to another (such as, from a single employer Plan to that of a multiple employer Plan).

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

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**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 benefits payments for unassigned claims should be made payable to the executor.

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

**Recovery of Overpayment**

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.
Miscellaneous

Clinical research has established an association between dental disease and complication of some medical conditions, such as the conditions noted below.

If you are a Cigna Dental plan member and you have one or more of the conditions listed below, you may apply for 100% reimbursement of your copayment or coinsurance for certain periodontal or caries-protection procedures (up to the applicable plan maximum reimbursement levels and annual plan maximums.)

For members with diabetes, cerebrovascular or cardiovascular disease:
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- periodontal maintenance

For members who are pregnant:
- periodic, limited and comprehensive oral evaluation.
- periodontal evaluation
- periodontal maintenance
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- treatment of inflamed gums around wisdom teeth.
- an additional cleaning during pregnancy.
- palliative (emergency) treatment – minor procedure

For members with chronic kidney disease or going to or having undergone an organ transplant or undergoing head and neck Cancer Radiation:
- topical application of fluoride
- topical fluoride varnish
- application of sealant
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- periodontal maintenance

Please refer to the plan enrollment materials for further details.

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:
- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.

- the last day for which you have made any required contribution for the insurance.
- the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least two opportunities to transfer to another Dental Office.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.
- the date you relocate to an area where the Dental plan is not offered.
- the date, as determined by Cigna, of a continuing lack of participating Dental Office in your area.
- the date upon a determination of fraud or misuse of dental services and/or dental facilities.

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

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer stops paying premium for you; or otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

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

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels your insurance.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:
- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- with respect to your Dental benefits, the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least one opportunity to transfer to another participating Dental Office.
the date Dependent Insurance is canceled.
The insurance for any one of your Dependents will cease on
the date that Dependent no longer qualifies as a Dependent.

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

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

Qualified Medical Child Support Order
(QMCSO)
Eligibility for Coverage Under a QMCSO
If a Qualified Medical Child Support Order (QMCSO) is
issued for your child, that child will be eligible for coverage as
required by the order and you will not be considered a Late
Entrant for Dependent Insurance.
You must notify your Employer and elect coverage for that
child, and yourself if you are not already enrolled, within 31
days of the QMCSO being issued.

Qualified Medical Child Support Order Defined
A Qualified Medical Child Support Order is a judgment,
decree or order (including approval of a settlement agreement)
or administrative notice, which is issued pursuant to a state
domestic relations law (including a community property law),
or to an administrative process, which provides for child
support or provides for health benefit coverage to such child
and relates to benefits under the group health plan, and
satisfies all of the following:
- the order recognizes or creates a child’s right to receive
  group health benefits for which a participant or beneficiary
  is eligible;
- the order specifies your name and last known address, and
  the child’s name and last known address, except that the
  name and address of an official of a state or political
  subdivision may be substituted for the child’s mailing
  address;
- the order provides a description of the coverage to be
  provided, or the manner in which the type of coverage is to
  be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed
  in accordance with the Child Support Performance and
  Incentive Act of 1998, such Notice meets the requirements
  above.
The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

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

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

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

B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

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

D. Medicare or Medicaid Eligibility/Entitlement

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

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

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

You may make a coverage election change if the plan of your spouse or Dependent:

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

G. Reduction in work hours

If an Employee’s work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer’s coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace’s annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning
Eligibility for Coverage for Adopted Children

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

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

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

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for 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 professional) 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 covered, 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 as applicable, and in the determination notices.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment 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 and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; 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, if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

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

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals’ coverage will terminate when your COBRA continuation coverage terminates. The sections titled “Secondary Qualifying Events” and “Medicare Extension For Your Dependents” are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for “Termination of COBRA Continuation” listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

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

Employer’s Notification Requirements
Your Employer is required to provide you and/or your Dependents with the following notices:
• An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
• A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  • if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  • if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  • in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage
The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?
Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

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

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

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

**You Must Give Notice of Certain Qualifying Events**

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

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

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

**Newly Acquired Dependents**

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

**COBRA Continuation for Retirees Following Employer’s Bankruptcy**

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

**Interaction With Other Continuation Benefits**

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

**ERISA Required Information**

The name of the Plan is:

The Oberlin College Health Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Oberlin College
173 West Lorain Street
Oberlin, OH 44074
440-775-8430

Employer Identification Number (EIN):
340714363

Plan Number:
506

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above
The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.
The Plan’s fiscal year ends on 12/31.
The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

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

Plan Type
The plan is a healthcare benefit plan.

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

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

Plan Modification, Amendment and Termination
The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

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

Your coverage under the Plan’s insurance policy(s) will end on the earliest of the following dates:
- the date you leave Active Service (or later as explained in the Termination Section);
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

Statement of Rights
As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
- examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage
- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.
Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

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

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

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

Grievances
Cigna Dental’s grievance procedure applies to any issue not relating to Medical Necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding Cigna Dental’s administrative policies or access to Dentists.

Filing a Grievance
You can contact Cigna Dental by phone at 1.800.Cigna24 or in writing to the address that appears on your explanation of benefits to file a grievance. You may submit an oral grievance in connection with a denial of a referral or a covered benefit determination. We may require that you sign a written acknowledgement of your oral grievance, prepared by us. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

When we receive your grievance, we will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry.

Grievance Determination
Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify you within the following timeframes:

<table>
<thead>
<tr>
<th>Type of Grievance</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited/Urgent</td>
<td>The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of your appeal.</td>
</tr>
<tr>
<td>Pre-Service</td>
<td>15 calendar days of receipt of your appeal.</td>
</tr>
<tr>
<td>Post-Service</td>
<td>30 calendar days of receipt of your appeal.</td>
</tr>
<tr>
<td>All Other</td>
<td>30 business days of receipt of all necessary information to make a determination.</td>
</tr>
</tbody>
</table>

Grievance Appeals
If you are not satisfied with the resolution of your grievance, you or your designee may file an appeal by phone at 1.800.Cigna24 or in writing. You have up to 60 business days from receipt of the grievance determination to file an appeal.

When we receive your appeal, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling your appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the appeal and notify you in writing within the following timeframes:

<table>
<thead>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>All Other</td>
<td>30 business days of receipt of all necessary information to make a determination.</td>
</tr>
</tbody>
</table>

Assistance
If you remain dissatisfied with our appeal determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov
If you need assistance filing a grievance or appeal, you may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
www.communityhealthadvocates.org

External Appeal

Your Right to an External Appeal

In some cases, you have a right to an external appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that a service does not meet our requirements for Medical Necessity (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the state to conduct these appeals.

In order for you to be eligible for an external appeal you must meet the following two requirements:

- the service, procedure, or treatment must otherwise be a Covered Service under the certificate; and
- in general, you must have received a final adverse determination through the first level of our internal appeal process. But, you can file an external appeal even though you have not received a final adverse determination through the first level of our internal appeal process if:
  - we agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal; or
  - you file an external appeal at the same time as you apply for an expedited internal appeal; or
  - we fail to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

Your Right to Appeal a Determination that a Service is Not Medically Necessary

If we have denied coverage on the basis that the service does not meet our requirements for Medical Necessity, you may appeal to an External Appeal Agent if you meet the requirements for an external appeal in the paragraph “Your Right to an External Appeal” above.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If we have denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the two requirements for an external appeal in the paragraph “Your Right to an External Appeal” above and your attending Physician must certify that your condition is one for which:

- standard health services are ineffective or medically inappropriate;
- there does not exist a more beneficial standard service or procedure covered by us; or
- there exists a clinical trial or rare disease treatment (as defined by law).

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

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – your attending Physician should contact the state for current information as to what documents will be considered or acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending Physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be your treating Physician.

Your Right to Appeal a Determination That a Service Is Out-of-Network

If we have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, you may appeal to an External Appeal Agent if you meet the two requirements for an external appeal in paragraph “Your Right to an External Appeal” above, and you have requested preauthorization for the out-of-network treatment.
In addition, your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat you for the health service.

You do not have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by you.

**The External Appeal Process**

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on our failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of our internal appeal process or our written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1.800.400.8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the state will forward the request to a certified External Appeal Agent.

You can submit additional documentation with your external appeal request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which we based our denial, the External Appeal Agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited external appeal (described below), we do not have a right to reconsider our 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 Physician, or us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending Physician certifies that a delay in providing the service has denied poses an imminent or serious threat to your health; or if your attending Physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must notify you and us by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, we will provide coverage subject to the other terms and conditions of this certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the cost of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under this certificate for non-experimental or non-investigational treatments provided in the clinical trial.

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

We will charge you a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if we determine that paying the fee would be a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to you.

**Your Responsibilities. It is your responsibility to start the external appeal process**

You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

**Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination or from receipt of**
determination, or the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

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

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

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

Relevant Information
Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action
If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

Definitions
Active Service
You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

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

- be consistent with the symptoms, diagnosis or treatment of the condition present;
- conform to commonly accepted standards of treatment;
- not be used primarily for the convenience of the member or provider of care; and
- not exceed the scope, duration or intensity of that level of care needed to provide safe and appropriate treatment.

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

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**Dental Office**

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

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**Dental Plan**

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

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**Dentist**

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

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**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, a foster child, or a child for whom you are the legal guardian who lives with you. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.
Benefits for a Dependent child 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 signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same 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.
**Employee**
The term Employee means a unionized security 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.

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

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

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

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

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

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

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

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

**Service Area**
The Service Area is the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.
Specialist
The term Specialist means any person or organization licensed as necessary: who delivers or furnishes specialized dental care services; and who provides such services upon approved referral to persons insured for these benefits.

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

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Usual Fee
The customary fee that an individual Dentist most frequently charges for a given dental service.

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