

**Brookhaven Science  
Associates, LLC**

CIGNA DENTAL CARE INSURANCE

**EFFECTIVE DATE: January 1, 2007**

CN003  
3210488

This document printed in January, 2007 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.



# Table of Contents

<b>Certification</b> .....	<b>6</b>
<b>Important Notices</b> .....	<b>9</b>
<b>Accident and Health Provisions</b> .....	<b>9</b>
<b>Eligibility – Effective Date</b> .....	<b>10</b>
Waiting Period.....	10
<b>Important Information about Your Dental Plan</b> .....	<b>11</b>
<b>Dental Benefits – CIGNA Dental Care</b> .....	<b>11</b>
<b>General Limitations</b> .....	<b>13</b>
<b>Coordination of Benefits</b> .....	<b>13</b>
<b>Expenses For Which A Third Party May Be Liable</b> .....	<b>15</b>
<b>Payment of Benefits</b> .....	<b>16</b>
<b>Termination of Insurance</b> .....	<b>16</b>
Employees .....	16
Dependents .....	16
<b>Dental Benefits Extension</b> .....	<b>16</b>
<b>Federal Requirements</b> .....	<b>17</b>
Notice of Provider Directory/Networks.....	17
Qualified Medical Child Support Order (QMCSO).....	17
Effect of Section 125 Tax Regulations on This Plan .....	18
Eligibility for Coverage for Adopted Children .....	18
Federal Tax Implications for Dependent Coverage .....	19
Group Plan Coverage Instead of Medicaid.....	19
Requirements of Medical Leave Act of 1993 (FMLA) .....	19
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) .....	19
Claim Determination Procedures Under ERISA .....	20
COBRA Continuation Rights Under Federal Law .....	21
ERISA Required Information .....	24
Provisions .....	26
Notice of an Appeal or a Grievance.....	26
<b>When You Have A Complaint Or An Appeal</b> .....	<b>26</b>
<b>Definitions</b> .....	<b>31</b>
<b>CIGNA Dental Care – CIGNA Dental Health Plan</b> .....	<b>34</b>
This section describes the CDC plan for residents of the following states: AZ, CO, DE, FL, KS/NE, KY, MD, MO, NC, OH, PA, VA .....	34
<b>State Rider CIGNA Dental Health Plan of Arizona, Inc.</b> .....	<b>45</b>

<b>State Rider CIGNA Dental Health of Colorado, Inc.</b> .....	<b>47</b>
<b>State Rider CIGNA Dental Health of Florida, Inc.</b> .....	<b>48</b>
<b>State Rider CIGNA Dental Health of Kentucky, Inc.</b> .....	<b>49</b>
<b>State Rider CIGNA Dental Health of Maryland, Inc.</b> .....	<b>49</b>
<b>State Rider CIGNA Dental Health of North Carolina, Inc.</b> .....	<b>53</b>
<b>State Rider CIGNA Dental Health of Ohio, Inc.</b> .....	<b>55</b>
<b>State Rider CIGNA Dental Health of Pennsylvania, Inc.</b> .....	<b>57</b>
<b>State Rider CIGNA Dental Health of Virginia, Inc.</b> .....	<b>57</b>
<b>CIGNA Dental Care – CIGNA Dental Health Plan</b> .....	<b>63</b>
This section describes the CDC plan for residents of the following states: CA, CT, NJ, TX .....	63
<b>CIGNA Dental Health of California, Inc.</b> .....	<b>66</b>
<b>CIGNA HealthCare of Connecticut, Inc.</b> .....	<b>83</b>
<b>CIGNA Dental Health of Texas, Inc.</b> .....	<b>94</b>
<b>CIGNA Dental Care – CIGNA Dental Health Plan</b> .....	<b>112</b>
This section describes the CDC Rider(s) for residents of the following states: AZ, CA, CO, CT, DE, FL, KS/NE, KY, MD, MO, NJ, NC, OH, PA, TX, VA .....	112
<b>Domestic Partner Rider</b> .....	<b>114</b>
<b>Your Rights Under Federal Law</b> .....	<b>115</b>



*Home Office: Bloomfield, Connecticut  
Mailing Address: Hartford, Connecticut 06152*

**CONNECTICUT GENERAL LIFE INSURANCE COMPANY**

a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy(s):

**POLICYHOLDER:** Brookhaven Science Associates, LLC

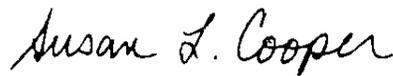
GROUP POLICY(S) — COVERAGE  
3210488 - DHMO CIGNA DENTAL CARE INSURANCE

**EFFECTIVE DATE:** January 1, 2007

**NOTICE**

Any insurance benefits in this certificate will apply to an Employee only if: a) he has elected that benefit; and b) he has a "Final Confirmation Letter," with his name, which shows his election of that benefit.

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.



*Corporate Secretary*

### **Explanation of Terms**

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





## Important Notices

### NOTICE

#### 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 your Member Services Representative.

NOT19

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.

GM6000 SPC40

#### New York Disclosure and Synopsis Statement

The accident and health insurance evidenced by this certificate provides dental insurance only.

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This Schedule highlights the benefits of the plan. The benefits shown may not always be payable because the plan contains certain limitations and exclusions. Dental Expense 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.

S14

## Accident and Health Provisions

### Claims

Notice of Claim, Claim Forms and Proof of Loss provisions do not apply to services received from, or upon referral by, a Participating Dental Facility or a Participating Dentist.

#### Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

#### Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

#### Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

#### Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

#### Legal Actions

Where CG has followed the terms of the policy, no action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

GM6000 PRO1V3CLA43V20



## Eligibility – Effective Date

### 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 20 hours a week.

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

None

### Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer excluding Illinois residents.

GM6000 EL 2V-32  
ELI6 M

### For Dental Insurance – Employees

This plan is offered to you as an Employee. To be insured, you must pay part of the cost.

### Effective Date of Your Insurance

You will become insured on the first day of the month after the later of: (a) the date you elect the insurance by signing an approved payroll deduction form; or (b) 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 the date you become eligible, including if you are not in Active Service on that date due to your health status. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

### Late Entrant

You are a Late Entrant if:

- you do not elect the insurance within 30 days after you become eligible;
- you again elect it after you cancel your payroll deduction.

CG may require evidence of good dental health at your expense if you are a Late Entrant.

### Open Enrollment Period

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

### Choice of Participating Dental Facility

When you elect Employee Insurance, you may select a Participating Dental Facility from the list provided by CDH. If your first choice of a Participating Dental Facility is not available, you will be notified by CDH of your designated Participating Dental Facility, based on your alternate selection. You and each of your insured Dependents may select your own designated Participating Dental Facility. No Dental Benefits are covered unless the Dental Service is received from your designated Participating Dental Facility, referred by a Participating Dentist at that Facility to a specialist approved by CDH, or otherwise authorized by CDH, except for Emergency Dental Treatment specified in the section, "DENTAL BENEFITS For You and Your Dependents." A transfer from one Participating Dental Facility to another Participating Dental Facility 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 Participating Dental Facility.

GM6000 EF 17 ELI63V9

### For Dental Insurance - Dependents

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

### Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the first day of the month after the later of: (a) the date you elect it by signing an approved payroll deduction form; or (b) 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, you may elect that insurance only during an Open Enrollment Period. The insurance for each of your Dependents will become effective on the first day of the month after the later of: (a) the end of that Open Enrollment Period; or (b) the date CG agrees in writing to insure that Dependent.

Your Dependents will be insured only if you are insured.

### Late Entrant

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.

CG may require evidence of your Dependent's good dental health at your expense if you are a Late Entrant.

GM6000 EF 2V-40  
ELI68

## Important Information about Your Dental Plan

When you elected Dental Insurance for yourself and your Dependents, you elected one of the two options offered:

- **CIGNA Dental Care; or**
- **CIGNA Dental Preferred Provider.**

Details of the benefits under each of the options are described in separate certificates/booklets.

When electing an option initially or when changing options as described below, the following rules apply:

- **You and your Dependents may enroll for only one of the options, not for both options.**
- **Your Dependents will be insured only if you are insured and only for the same option.**

### Change in Option Elected

If your plan is subject to Section 125 (an IRS regulation), you are allowed to change options only at Open Enrollment or when you experience a "Life Status Change."

If your plan is not subject to Section 125 you are allowed to change options at any time.

Consult your plan administrator for the rules that govern your plan.

### Effective Date of Change

If you change options during open enrollment, you (and your Dependents) will become insured on the effective date of the plan. If you change options other than at open enrollment (as allowed by your plan), you will become insured on the first day of the month after the transfer is processed.

GM6000 DEN198V6

## Dental Benefits – CIGNA Dental Care

### For You and Your Dependents

CG will pay for Covered Dental Services received by you or any one of your Dependents, excluding any dollar amounts listed in the Patient Charge Schedule.

Further, if you or any one of your Dependents, while insured

for these benefits, incurs expenses for charges made by a Dentist, other than a Participating General Dentist, for Emergency Dental Treatment, CG will pay for the expenses so incurred up to \$50, less any amount listed in the Patient Charge Schedule, for each emergency; provided that: (1) the need for treatment occurs at least 50 miles from the person's home; or (2) the person is unable to contact his designated Participating Dental Facility; and the treatment is performed during regular office hours.

For Emergency Dental Treatment received after regular office hours a fee will be charged as listed in the Patient Charge Schedule.

Emergency Dental Treatment means diagnostic and palliative procedures administered in the case of: (a) a dental emergency which involves acute pain; and (b) a dental condition which requires immediate treatment.

No Dental Benefits are covered unless the Dental Service is received from your designated Participating Dental Facility, referred by a Participating General Dentist at that Facility to a Specialist approved by CDH, or otherwise authorized by CDH, except as specified above for Emergency Dental Treatment.

### **Covered Dental Service**

The term Covered Dental Service means a Dental Service listed in the Patient Charge Schedule when that Dental Service:

- is performed by or under the direction of the designated Participating Dental Facility or upon referral by the Participating General Dentist to an approved Specialist and authorized by CDH; and
- is essential for the necessary care of the teeth and supporting structure (gums); and
- starts and is completed while the person is insured.

GM6000 DEN48 V25

A Dental Service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared.
- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

### **Frequency**

The frequency of certain Covered Services, such as cleanings, is limited. Your Patient Charge Schedule lists any limitations of frequency.



### Specialty Referrals

When specialized dental care services are required, a Participating General Dentist must initiate the referral process.

Covered specialists include:

- pediatric dentists – children's dentistry;
- endodontists – root canal treatment;
- periodontists – treatment of gums and bone;
- oral surgeons – complex extractions and other surgical procedures;
- orthodontists – tooth movement.

There is no coverage for prosthodontists or other specialists not listed above.

Upon payment approval by CDH, you and your Dependent will be liable for applicable fees including fees for any dental service rendered but not listed in the Patient Charge Schedule. All fees correspond to the Patient Charge Schedule in effect on the date the procedure is initiated. If CDH does not approve payment, you must pay the Dentist's Usual Fees.

A person must be insured for these benefits when treatment by a Specialist is rendered. Such treatment must occur no later than 90 days from the approval by CDH. The x-rays taken by the Participating General Dentist must be sent to the Specialist to avoid unnecessary expenses and exposure to radiation.

After completing specialty care, you should return to your Participating General Dentist for your general care. If you obtain additional specialized dental care services without a referral approved for payment after you have completed specialized care, you will be responsible for the Dentist's Usual Fees.

GM6000 DEN112V2

### Pediatric Dentistry

If your child up to age 7 needs to be treated by a Pediatric Dentist, contact your Participating General Dentist for a specialty referral. Upon appropriate referral, your child may continue under the care of the Specialist up to age 7 without additional referrals. If you need to change your child's Pediatric Dentist, you should return to your Participating General Dentist for a new referral up to the child's 7th birthday.

Your Pediatric Specialist must submit each specialty treatment plan to CDH for payment authorization. CDH's standard payment authorization process will apply.

For children age 7 and older, your Participating General Dentist will provide care. Exceptions for medical reasons may be considered on a case-by-case basis. For children over age 7, if you continue to visit the Pediatric Dentist without referral authorized for payment, you will be fully responsible for the

Pediatric Dentist's Usual Fees.

### Orthodontics

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

- **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist;
- **Interceptive Orthodontic Treatment** – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment;
- **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention; and
- **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.

The fees 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. This fee will apply unless (a) banding/appliance insertion does not occur within 90 days of such visit, (b) your treatment plan changes, or (c) there is an interruption in your coverage or treatment, in which case a later change in the Patient Charge Schedule may apply.

The 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, the Specialist may charge you an additional amount for each additional month of treatment. If you require less than 24 months of treatment, your fees will be reduced on a prorated basis.

GM6000 DEN113V1

**Additional Charges** – The following orthodontic services are not covered:

- 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, call CDH at 1-800-367-1037 to find out if you are entitled to any benefit under the Dental



Plan.

**Oral Surgery**

The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

**Complex Rehabilitation**

Complex Rehabilitation is extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. The crown and bridge charges listed in the Patient Charge Schedule are for each tooth (or "unit"). An additional amount is charged for each unit when Complex Rehabilitation is performed.

GM6000 DEN114

**Services Not Covered**

Covered Dental Services will not include or, where applicable, no payment will be made for any:

- services performed solely for cosmetic reasons.
- replacement of fixed and/or removal prosthodontic or orthodontic appliances that have been lost; stolen; or damaged due to patient abuse, misuse, or neglect.
- procedures, appliances or restorations if the main purposes is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ), unless TMJ therapy is specially listed on your Patient Charge Schedule; or (3) restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- prescription drugs.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule general anesthesia and IV Sedation are covered when Medically Necessary and provided in conjunction with Covered Dental Services performed by an Oral Surgeon or Periodontist.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- procedures or services associated with the placement or prosthodontic restoration of a dental implant.
- crowns or bridges used solely for splinting.
- resin bonded retainers and associated pontics.
- hospitalization, including any associated increment charges for dental services performed in a hospital.

GM6000 DEN128 (NY)

**General Limitations**

**Dental Benefits**

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

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by the United States Government: (a) unless there is a legal obligation to pay such charges whether or not there is insurance; or (b) such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- which the person would not be legally required to pay;
- when charges would not have been made if the person had no insurance;
- for care, treatment or surgery not prescribed as necessary by a Dentist;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- all clinical lab services, pharmacy services, x-ray or imaging services, if referred by a practitioner who has a financial relationship (or whose immediate family member has a financial relationship) with the provider of those services;
- due to Injuries that are intentionally self-inflicted.

GM6000 GEN344 NY

**Coordination of Benefits**

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

**Definitions**

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

**Plan**

Any of the following that provides benefits or services for dental care or treatment:

- (1) Group insurance and/or group-type coverage, whether insured or self-insured, including closed panel coverage which neither can be purchased by the general public, nor



is individually underwritten.

- (2) Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- (3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

#### **Primary Plan**

The Plan that provides or pays benefits without taking into consideration the existence of any other Plan.

#### **Secondary Plan**

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

GM6000 COB11 V10

#### **Allowable Expense**

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

#### **Claim Determination Period**

A calendar year or that part of a calendar year in which the person has been covered under this Plan.

GM6000 COB12V3

#### **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 rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area.

#### **Order of Benefit Determination Rules**

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- (1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- (2) For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent as an enrollee or employee whose birthday falls first in the calendar year;
- (3) For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - (a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - (b) then, the Plan of the parent with custody of the child;
  - (c) then, the Plan of the spouse of the parent with custody of the child;
  - (d) then, the Plan of the noncustodial parent.

GM6000 COB13V1



- (4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

**Effect on the Benefits of This Plan**

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14 V7

As each claim is submitted, CG will determine the following:

- (1) the Plan's obligation to provide services and supplies under this policy;
- (2) whether a benefit reserve has been recorded for you; and
- (3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, the Plan will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve shall be calculated for each new Claim Determination Period.

**Right of Recovery**

If the amount of payments made by an insurer is more than it should have paid under its COB provision, it may recover the excess from one or more of:

- (1) the persons it has paid or for whom it has paid;
- (2) insurance companies; or
- (3) other organizations.

**Right to Receive and Release Information**

The Plan, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits.

GM6000 COB15V2

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

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CG, another party may be liable:

- CG shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights.
- Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:
  - the amount actually paid for such Covered Expenses by CG; or
  - the amount you actually receive from the third party for such Covered Expenses;

at the time that the third party's liability for medical expenses is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

CG will only exercise its subrogation rights if the amount received by you is specifically identified in the settlement or judgment as amounts paid for medical expenses.

GM6000 CCP7  
CCL7V11



## Payment of Benefits

### To Whom Payable

The Policyholder and CG agree that, except in the case of Emergency Dental Treatment received from a non-Participating Dentist, all Dental Benefits will be paid directly to the person or institution providing the dental care. Any Dental Benefits for Emergency Dental Treatment received from a non-Participating Dentist will be paid, at the option of CG, either to you or to the person or institution providing the dental care.

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

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

GM6000 POB5V-10  
PMT121

### Miscellaneous

Certain Participating Dental Facilities may provide discounts on services not listed on the Patient Charge Schedule, including a 10% discount on bleaching services. You should contact your Participating Dental Facility to determine if such discounts are offered.

GM6000 POB2

## 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.
- 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 Facility.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

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

### Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) 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, the 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 the insurance.

GM6000 TRM15 V3 M

## Dependents

Insurance for all of your Dependents will cease on the earliest date below, except as modified by the Dental Benefits Extension provision:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.
- the date, as determined by CG, of a continuing lack of Participating Dental Facilities in your area.
- the date upon a determination of fraud or misuse of dental services and/or dental facilities.

Insurance for any one of your Dependents will cease:

- on the date he or she no longer qualifies as a Dependent.
- the date your Dependent relocates to an area where the Dental Plan is not offered.
- with respect to your CIGNA Dental Care benefits, the date upon permanent breakdown of your Dependent's relationship with his or her Dentist, as determined by CDH, after at least two opportunities to transfer to another Participating Dental Facility.

GM6000 TRM327V4

## Dental Benefits Extension

A Dental Service that is completed after a person's benefits



cease will be deemed to be completed while he is insured if:

- for fixed bridgework and full or partial dentures, the final impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted 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 ceased due to nonpayment of premiums.

GM6000 BEX188(NY)

## Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

FDRL1

## Notice of Provider Directory/Networks

### Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers.

You may also have access to a list of Providers who participate in the network by visiting [www.cigna.com](http://www.cigna.com); [mycigna.com](http://mycigna.com) or by calling the toll-free telephone number on your ID card.

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

FDRL32

## Qualified Medical Child Support Order (QMCSO)

### A. Eligibility for Coverage Under a QMCSO

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

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

### B. Qualified Medical Child Support Order Defined

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

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

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



### C. Payment of Benefits

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

FDRL2

### 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 Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through F.

#### B. Change of Status

A change in status is defined as:

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

### C. Court Order

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

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

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

#### E. Change in Cost of Coverage

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

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

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

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

FDRL5

### Eligibility for Coverage for Adopted Children

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

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

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

FDRL6



## Federal Tax Implications for Dependent Coverage

Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health insurance coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health insurance who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

FDRL7

## Group Plan Coverage Instead of Medicaid

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, 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.

FDRL10

## Requirements of Medical Leave Act of 1993 (FMLA)

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

### A. Continuation of Health Insurance During Leave

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

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

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

### B. Reinstatement of Canceled Insurance Following Leave

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

You will not be required to satisfy any eligibility or benefit

waiting period or the requirements of any Pre-existing Condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

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

FDRL13

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

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

### A. Continuation of Coverage

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

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

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

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

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

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

### B. Reinstatement of Benefits (applicable to all coverages)

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

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began.



However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

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

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

FDRL58

## **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.

Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

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

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

### **Concurrent Medical Necessity Determinations**

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, CG will notify you or your representative of the determination within 24 hours after receiving the request.

### **Postservice Medical Necessity Determinations**

When you or your representative requests a Medical Necessity determination after services have been rendered, CG 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 CG's control CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

FDRL35

### **Postservice Claim Determinations**

When you or your representative requests payment for services which have been rendered, CG will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

### **Notice of Adverse Determination**

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

FDRL36



## 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, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals’ coverage will terminate when your COBRA continuation coverage terminates. The

sections below titled “Secondary Qualifying Events” and “Medicare Extension for Your Dependents” are not applicable to these individuals.

FDRL20

#### Secondary Qualifying Events

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

#### Disability Extension

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

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

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

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

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



### Medicare Extension for Your Dependents

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

FDRL21

### 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: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

FDRL22

### Employer's Notification Requirements

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be

provided to you and/or your Dependents within the following timeframes:

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

### How to Elect COBRA Continuation Coverage

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

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

FDRL23

### How Much Does COBRA Continuation Coverage Cost

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



similarly situated active Employee or family member. For example:

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

### **When and How to Pay COBRA Premiums**

#### *First payment for COBRA continuation*

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

#### *Subsequent payments*

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

#### *Grace periods for subsequent payments*

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

FDRL24

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

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

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

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

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

### **Newly Acquired Dependents**

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

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

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



coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

FDRL25

**Trade Act of 2002**

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act\\_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above.

Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

**Interaction With Other Continuation Benefits**

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

FDRL26

**ERISA Required Information**

The name of the Plan is:

Brookhaven Science Associates, LLC Comprehensive Welfare Benefits Plan

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

Brookhaven Science Assoc., LLC  
P.O. Box 5000  
Upton, NY 11973  
(800)353-5321

Employer Identification Number (EIN)	Plan Number
113403915	501

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

Employer named above

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

Employer named above

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

The CG 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.

FDRL27

**Discretionary Authority**

The Plan Administrator delegates to CG 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 CG the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.



### Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part of all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your 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 last day of the calendar month in which you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

### Statement of Rights

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

FDRL28

### 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 copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.

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

### Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If you 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.

FDRL29



### Enforce Your Rights

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

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

FDRL30

### Provisions

#### 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 Group Dental Insurance Policy underwritten by CG; provided that: (a) he applies in writing and pays the first premium to CG within 45 days after his insurance ceases; and (b) he is not considered to be overinsured.

CDH or CG, 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;
- permanent breakdown of the dentist/patient relationship; or
- fraud or misuse of the Dental Plan.

GM6000 PRO78 NY

### 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.

GM6000 NOT90

### When You Have A Complaint Or An Appeal

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

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

#### Start With Member Services

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

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate a complaint about: (1) a denial of, or failure to pay for, a referral; or (2) a determination as to whether a benefit is covered under the Policy, we will get back to you on the same day we receive your complaint, or use the "Grievances and Appeals of Administrative and Other Matters" process described in the following section to provide a Grievance resolution if we cannot resolve your complaint on the same day.

If you submit a written concern about any matter in writing, we will use the "Grievances and Appeals of Administrative and Other Matters" process described in the following section to provide a Grievance resolution.

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

GM6000 APL685 V2



## **I. Grievance and Appeals of Administrative and Other Matters**

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

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

### **Level One Administrative Appeal/Grievance**

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

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

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving clinical appropriateness will be considered by a health care professional of the same or similar specialty as the care under consideration.

For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive the appeal.

GM6000 APL686 V1

This notification will include the reasons for the decision, including clinical rationale if applicable, as well as additional appeal rights, if any.

GM6000 APL748 V1

### **Level Two Administrative Appeal**

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

Most requests for a second review will be conducted by the Administrative Appeal Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving clinical appropriateness, the Committee will consult with at least one

Dentist reviewer in the same or similar specialty as the care under consideration, as determined by CG's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

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

GM6000 APL687 V2

## **II. Appeals of Utilization Review Decisions**

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

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

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

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

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

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



Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional of the same or similar specialty as the care under consideration.

GM6000 APL688

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

GM6000 APL747 V1

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

### **Level Two Appeal**

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

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

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

GM6000 APL689 V2

## **External Appeal**

### **1. Your Right To An External Appeal**

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

### **2. Your Right To Appeal A Determination That A Service Is Not Medically Necessary**

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

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

GM6000 APL690 V1

### **3. Your Rights To Appeal A Determination That A Service Is Experimental Or Investigational**

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

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



in writing to waive any internal appeal.

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

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

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

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

GM6000 APL691

For the 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 life-threatening or disabling condition or disease.

#### 4. The External Appeal Process

If, through the first level of CG's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and CG have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. CG will provide an external appeal application with the final adverse determination issued through the first level of CG's internal appeal process or its written waiver of an internal appeal.

**You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days from your receipt of the final adverse determination from the first level plan appeal regardless of whether you choose to pursue a second level internal appeal with CG.**

The External Appeal Program is a voluntary program.

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

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which CG based its denial, the External Appeal Agent will share this information with CG in order for it to exercise its right to reconsider its decision. If CG chooses to exercise this right, CG will have three working days to amend or confirm its decision.

GM6000 APL692 V1

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

If the External Appeal Agent overturns CG's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, CG will provide coverage subject to the other terms and conditions of this document. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, CG will only cover the costs of services required to provide treatment to you according to the design of the trial. CG shall not be responsible for the costs of investigational drugs or devices, the costs of nonhealth care services, the costs of managing research, or costs which would not be covered under this certificate for nonexperimental or noninvestigational treatments provided in such clinical trial.

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

CG will charge you a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in



which you must submit the fee. CG will also waive the fee if CG determines that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

GM6000 APL703 V2

**5. Your Responsibilities**

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

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from CG that it has upheld a first level denial of coverage or the date upon which you receive a written waiver of any internal appeal. CG has no authority to grant an extension of this deadline.

**Complaints/Appeals To The State Of New York**

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

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

or

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

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

GM6000 APL704

**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: (1) the specific reason or reasons for the adverse determination including clinical rationale; (2) reference to the specific plan provisions on which the determination is based; (3) 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; (4) a statement describing: (a) the procedures to initiate the next level of appeal; (b) any voluntary appeal procedures offered by the plan; and (c) the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your 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) a clear statement describing the basis and clinical rationale for the denial as applicable to the insured; (b) a clear statement that the notice constitutes the final adverse determination; (c) CG's contact person and his or her telephone number; (d) the insured's coverage type; (e) the name and full address of CG's utilization review agent, if any; (f) the utilization review agent's contact person and his or her telephone number; (g) 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 Physician proposed to provide the treatment and the developer/manufacturer of the health care service; (h) a statement that the insured may be eligible for an external appeal and the time frames for requesting an appeal; and (i) a clear statement written in bolded text that the 45-day 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.

GM6000 APL693

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 (a) was relied upon in making the benefit determination; (b) 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; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) 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 CG 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.

GM6000 APL746

## 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.

DFS1

## CIGNA Dental Health

### (herein referred to as CDH)

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

DFS592

### Dentist

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

DFS24

### Dependent

Dependents are:

- your lawful spouse;
- your Domestic Partner; and
- any unmarried child of yours who is
  - less than 19 years old.
  - 19 years but less than 23 years old, enrolled in school as a full-time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 23.
  - 19 years but less than 23 years old, enrolled in school as a full-time student and on leave of absence certified as medically necessary by the student's Physician. Coverage will continue for up to 12 months from the last day of school attendance or attainment of age 23.
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child from the start of any waiting period prior to the finalization of the child's adoption. It also includes a newborn infant who is adopted by you from the moment you take physical custody of the child upon the child's release from the hospital prior to the finalization of the



child's adoption. It also includes a stepchild who lives with you. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day before your Dependent child's birthday, in the year in which the limiting age is reached.

Benefits for a Dependent full-time student will continue until the last day of the calendar year in which the limiting age is reached.

Benefits for a Dependent student, that is no longer a full-time student and is under the limiting age, will continue until the last day in which your Dependent is no longer a full-time student.

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.

DFS1697 M

**Domestic Partner**

A Domestic Partner is defined as a person of the same sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by CG 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 which can be made available to CG 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 "Continuation Required By Federal Law" will not apply to your Domestic Partner and his or her Dependents.

DFS1222

**Employee**

The term Employee means a full-time employee of the Employer. 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.

DFS211

**Employer**

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

**Maximum Reimbursable Charge**

The Maximum Reimbursable Charge is the lesser of:

1. the provider's normal charge for a similar service or supply; or
2. the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

CG uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The percentile used to determine the Maximum Reimbursable Charge is listed in the Schedule.

Additional information about the Maximum Reimbursable Charge is available upon request.

GM6000 DFS1814V1 (DEN)

**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.

DFS192

### **Medically Necessary**

The term Medically Necessary means a service or supply which is determined by CG 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.

DFS1342

### **Medicare**

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

DFS149

### **Participating Dental Facility**

The term Participating Dental Facility means an approved dental care facility for the provision of ordinary and customary dental care; such care to be provided at predetermined fees as negotiated by CG and CDH.

The Participating Dental Facilities and Participating General Dentists may change from time to time. A list of the current Participating Dental Facilities will be provided to the Policyholder periodically by CDH for the purpose of Employee selection of a Participating Dental Facility.

DFS593

### **Participating General Dentist**

The term Participating General Dentist means a person practicing dentistry within the scope of his license at a Participating Dental Facility, under the terms of his provider contract with CDH.

DFS594

### **Patient Charge Schedule**

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

DFS1102

### **Specialist**

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

DFS598

### **Usual Fee**

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

DFS1834



## **CIGNA Dental Care – CIGNA Dental Health Plan**

**This section describes the CDC plan for residents of the following states: AZ, CO, DE, FL, KS/NE, KY, MD, MO, NC, OH, PA, VA**

CDO10 M



### **CIGNA Dental Companies**

CIGNA Dental Health Plan of Arizona, Inc.  
CIGNA Dental Health of Colorado, Inc.  
CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska)  
CIGNA Dental Health of Missouri, Inc.  
**P.O. Box 2125**  
**Glendale, California 91209-2125**

CIGNA Dental Health of California, Inc.  
**400 North Brand Boulevard, Suite 600**  
**Glendale, California 91203**

CIGNA Dental Health of Delaware, Inc.  
CIGNA Dental Health of Florida, Inc. **(a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)**

CIGNA Dental Health of Kentucky, Inc.  
CIGNA Dental Health of Maryland, Inc.  
CIGNA Dental Health of New Jersey, Inc.  
CIGNA Dental Health of North Carolina, Inc.  
CIGNA Dental Health of Ohio, Inc.  
CIGNA Dental Health of Pennsylvania, Inc.  
CIGNA Dental Health of Virginia, Inc.  
**P.O. Box 189060**  
**Plantation, Florida 33318-9060**

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

#### **NOTICE**

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

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

#### **READ YOUR PLAN BOOKLET CAREFULLY**

**Please call Member Services at 1-800-367-1037 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.**



## TABLE OF CONTENTS

- I. Definitions**
- II. Introduction to Your CIGNA Dental Plan**
- III. Eligibility/When Coverage Begins**
- IV. Your CIGNA Dental Coverage**
  - A. Member Services**
  - B. Premiums/Prepayment Fees**
  - C. Other Charges - Patient Charges**
  - D. Choice of Dentist**
  - E. Your Payment Responsibility (General Care)**
  - F. Emergency Dental Care - Reimbursement**
  - G. Limitations on Covered Services**
  - H. Services Not Covered Under Your Dental Plan**
- V. Appointments**
- VI. Broken Appointments**
- VII. Office Transfers**
- VIII. Specialty Care**
- IX. Specialty Referrals**
  - A. In General**
  - B. Pediatric Dentistry**
  - C. Orthodontics**
- X. Complex Rehabilitation/Multiple Crown Units**
- XI. What To Do If There Is A Problem**
  - A. Start With Member Services**
  - B. Appeals Procedure**
- XII. Dual Coverage**
- XIII. Disenrollment From the Dental Plan - Termination of Benefits**
  - A. Time Frames For Disenrollment/Termination**
  - B. Effect On Dependents**
- XIV. Extension of Benefits**
- XV. Continuation of Benefits (COBRA)**
- XVI. Conversion Coverage**
- XVII. Confidentiality/Privacy**
- XVIII. Miscellaneous**

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



## I. Definitions

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

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

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

Request 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. A licensed Dentist will make any such denial.

**CIGNA Dental** – The CIGNA Dental Health organization that provides dental benefits in your state as listed on the face page of this Booklet.

**Contract Fees** – The fees contained in the Network Specialty Dentist agreement with CIGNA Dental.

**Covered Services** – The dental procedures listed on your Patient Charge Schedule.

**Dental Office** – Your selected office of Network General Dentist(s).

**Dental Plan** – Managed dental care plan offered through the Group Contract between CIGNA Dental and your Group.

**Dependent** – Your lawful spouse;

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

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

2. reliant upon you for maintenance and support.

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

For a child who falls into category (B.) or (C.) above, you will need to furnish CIGNA Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter during his or her term of coverage.

Coverage for Dependents living outside a CIGNA Dental service area is subject to the availability of an approved network where the Dependent resides.

This definition of "Dependent" applies unless it is modified by your State Rider or Group Contract.

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

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

**Network General Dentist** – A licensed Dentist who has signed an agreement with CIGNA Dental under which he or she agrees to provide dental care services to you.

**Network Specialty Dentist** – A licensed Dentist who has signed an agreement with CIGNA Dental under which he or she agrees to provide specialized dental care services, as outlined in Section VIII., upon payment authorization by CIGNA Dental Health.

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

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

**Premiums/Prepayment Fees** – Fees that your Group remits to CIGNA Dental, on your behalf, during the term of your Group Contract.

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

**Subscriber/You** – The enrolled Employee or member of the Group.

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



## II. Introduction to Your CIGNA Dental Plan

Welcome to the CIGNA Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to CIGNA Dental or its designee for health plan operation purposes.

## III. Eligibility/When Coverage Begins

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

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

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

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

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

## IV. Your CIGNA Dental Coverage

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

Group Contract will be furnished to you upon your request.

### A. 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 1-800-367-1037. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

### B. Premiums/Prepayment Fees

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

### C. Other Charges - Patient Charges

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

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

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

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

### D. Choice of Dentist

You and your Dependents should have selected a Dental



Office when you enrolled in the Dental Plan. If you did not, you must advise CIGNA Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when CIGNA Dental authorizes a payment for out-of-networks benefits.

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

To obtain a list of Dental Offices near you, visit our website at [www.cigna.com](http://www.cigna.com) or call the Dental Office Locator at 1-800-367-1037. 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.

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

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

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

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

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

#### **F. Emergency Dental Care - Reimbursement**

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

#### **1. Emergency Care Away From Home**

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

#### **2. Emergency Care After Hours**

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

#### **G. Limitations on Covered Services**

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

- 1. Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- 2. Specialty Care** - Payment authorization is required for coverage of services by a Network Specialist Dentist.
- 3. Pediatric Dentistry** - Coverage for referral to a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 7th birthday.
- 4. Oral Surgery** - The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

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

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

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA's Dental's prior approval (except



emergencies, as described in Section IV.F.)

3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
7. general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist.
8. prescription drugs.
9. procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); or b. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) unless TMJ therapy is specifically listed on your Patient Charge Schedule; or if your Patient Charge Schedule ends in "-04" or a higher number; c. restore teeth which have been damaged by attrition, abrasion, erosion, and/or abfraction.
10. replacement of fixed and/or removable appliances that have been lost; stolen; or damaged due to patient abuse, misuse or neglect.
11. services associated with the placement or prosthodontic restoration of a dental implant.
12. services considered to be unnecessary or experimental in nature.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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 should be submitted to the medical carrier for benefit determination.)
15. services to the extent you or your enrolled Dependent is compensated under any group medical plan, no-fault auto insurance policy, or an uninsured motorist

policy.

16. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage.

In addition to the above, if your Patient Charge Schedule number ends in "-04" or a higher number, there is no coverage for the following.

17. crowns and bridges used solely for splinting.
18. resin bonded retainers and associated pontics.

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

## V. Appointments

To make an appointment with your Network General Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number (Social Security number or Employee ID number) and will check your eligibility.

## VI. Broken Appointments

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

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

## VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Member Services at 1-800-367-1037. To obtain a list of Dental Offices near your, visit our website at [www.cigna.com](http://www.cigna.com), or call the Dental Office Locator at 1-800-367-1037. Your transfer request will take about five days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

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

## VIII. Specialty Care

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care.



Because you may need specialty care, the CIGNA Dental Network includes the following types of Specialty Dentists:

Pediatric Dentists - Children's dentistry.

Endodontists – Root canal treatment.

Periodontists – Treatment of gums and bone.

Oral Surgeons – Complex extractions and other surgical procedures.

Orthodontists – Tooth movement.

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

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

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## IX. Specialty Referrals

### A. In General

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

When CIGNA Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.C, Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of CIGNA Dental's authorization. If you are unable to obtain treatment within the 90-day period, please call 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.

### B. Pediatric Dentistry

If your child up to age 7 needs to be treated by a Pediatric Dentist, contact your Network General Dentist for a specialty referral. Upon appropriate referral, your child may continue under the care of the Network Pediatric Dentist up to age 7 without additional referrals. If you need to change your child's Network Pediatric Dentist, you should return to your Network General Dentist for a new specialty referral up to the child's 7th birthday.

Your Network Pediatric Dentist must submit each specialty treatment plan to CIGNA Dental for payment authorization. CIGNA Dental's standard payment authorization process as set out above will apply for services rendered by the Network Pediatric Dentist.

For children 7 years and older, your Network General Dentist will provide care. Exceptions for medical reasons may be considered on a case-by-case basis. For children over 7, if you continue to visit the Pediatric Dentist without a referral authorized for payment, you will be fully responsible for the Pediatric Dentist's Usual Fees.

### C. Orthodontics

#### 1. Definitions

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

- a. **Orthodontic Treatment Plan and Records** - The preparation of orthodontic records and a treatment plan by the Orthodontist.
- b. **Interceptive Orthodontic Treatment** - Treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- c. **Comprehensive Orthodontic Treatment** - Treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.



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

**2. Patient Charges**

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

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

**3. Additional Charges**

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

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

**4. Orthodontics in Progress**

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call Member Services at 1-800-367-1037 to find out if you are entitled to any benefit under the Dental Plan.

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 and bridge 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 and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

**XI. What to Do if There is a Problem**

For the purpose of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your state. Consult your State Rider for further details.**

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

**A. Start with Member Services**

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you may call 1-800-367-1037 toll-free and explain your concern to one of our Member Services Representatives. You can also express that concern in writing to the address listed for your state on the cover page of this booklet. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

**B. Appeals Procedure**

CIGNA Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to CIGNA Dental, at the address on the cover page of this booklet, within 1 year from the date of the initial CIGNA Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Member Services to register your appeal by calling 1-

**X. Complex Rehabilitation/Multiple Crown Units**

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed bridges which are cemented in place, your Network General



800-367-1037.

### 1. Level One Appeals

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

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

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

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

### 2. Level Two Appeals

To initiate a level two appeal, follow the same process required for a level one appeal. Level two appeals will be conducted by an Appeals Committee consisting of at least 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the Appeals Committee will include at least one Dentist. If specialty care is in dispute, the Appeals Committee will consult with a Dentist in the same or similar specialty as the care under review.

CIGNA Dental will acknowledge your appeal in writing within 5 business days and schedule an Appeals Committee review. The acknowledgment letter will include the name, address, and telephone number of the Appeals Coordinator. We may request additional information at that time. If your appeal concerns a denied preauthorization, the Appeals Committee review will be completed within 15 working days. For appeals concerning all other coverage issues, the Appeals Committee review will

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

You may present your appeal to the Appeals Committee in person or by conference call. You must advise CIGNA Dental 5 days in advance if you or your representative plan to attend in person. You will be notified in writing of the Appeals Committee's decision within 5 business days after the meeting. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

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

### 3. Independent Review Procedure

If your appeal concerns a dental necessity issue and the Appeals Committee denies coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by CIGNA Dental or any of its affiliates.

In order to request a referral to an IRO, the reason for the denial must be based on a dental necessity determination by CIGNA Dental. Issues involving plan administration, eligibility, or benefit coverage limits are not eligible for review under this process.

There is no charge for you to initiate this independent review procedure; however, you must provide written authorization permitting CIGNA Dental to release the information to the IRO. CIGNA Dental will abide by the IRO's decision.

To request a referral to an IRO, you must notify the Appeals Coordinator within 60 days of your receipt of your level two appeal decision. CIGNA Dental will then forward the file to the IRO within 30 days.

The IRO will render an opinion within 30 days. When requested and when a delay would be detrimental to your dental condition, as determined by CIGNA Dental's Dental Director, the review shall be completed within 5 days.

The Independent Review Procedure is a voluntary



program arranged by the Dental Plan and is not available in all areas. Consult your State Rider for more details.

#### 4. Appeals to the State

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

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

### XII. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled separately, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

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

### XIII. Disenrollment from the Dental Plan - Termination of Benefits

#### A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the Sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan/Termination of benefits will occur on the last day of the month:

1. in which Premiums/Prepayment Fees are not remitted to CIGNA Dental;
2. in which eligibility requirements are no longer met;
3. after 30 days notice from CIGNA Dental due to permanent breakdown of the Dentist-patient relationship as determined by CIGNA Dental, after at least two opportunities to transfer to another Dental

Office;

4. after 30 days notice from CIGNA Dental due to fraud or misuse of dental services and/or Dental Offices;
5. after 60 days notice by CIGNA Dental, due to continued lack of a Dental Office in your Service Area;
6. after voluntary disenrollment.

#### B. Effect on Dependents

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

### XIV. Extension of Benefits

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

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

### XV. Continuation of Benefits (COBRA)

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

### XVI. Conversion Coverage

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

- permanent breakdown of the Dentist-patient relationship;
- fraud or misuse of dental services and/or Dental Offices;
- nonpayment of Premium/Prepayment Fees by the



Subscriber;

- selection of alternative dental coverage by your Group, or
- lack of network/service area.

Benefits and rates for CIGNA Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the CIGNA Dental Conversion Department at 1-800-367-1037 to obtain current rates and make arrangements for continuing coverage.

### XVII. Confidentiality/Privacy

CIGNA Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about CIGNA Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your member plan materials. You may obtain additional information about CIGNA Dental's confidentiality policies and procedures by calling Member Services at 1-800-367-1037, or via the Internet at [www.cigna.com](http://www.cigna.com).

### XVIII. Miscellaneous

As a CIGNA Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at [www.cigna.com](http://www.cigna.com) for details.

**SEE YOUR STATE RIDER FOR ADDITIONAL DETAILS**

CDCGEN06

## State Rider

### CIGNA Dental Health Plan of Arizona, Inc.

Arizona Residents:

#### I. Definitions

##### Dependent

The following provision, included as the next to the last sentence under the definition of "Dependent" in your Plan Booklet, does not apply to Arizona residents:

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

### III. Eligibility/When Coverage Begins

Employees may enroll within 31 days of becoming eligible.

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

### IV. Your CIGNA Dental Coverage

#### F. Emergency Dental Care - Reimbursement

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

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

Exclusion 15. does not apply to Arizona residents.

### XI. What to Do if There is a Problem

Section B, "Appeals Procedure," is hereby deleted and replaced with the following:

#### B. Problems Concerning Denied Preauthorizations or Denied Claims for Services Already Provided

If your problem concerns a specialty referral preauthorization that is not approved for payment or a claim for services already provided that is denied by CIGNA Dental, you or your designated representative may request a review as set out below by contacting Member Services, P.O. Box 19039, Plantation, Florida 33318-9039, Telephone 1-800-367-1037.

##### 1. Expedited Review Process (Preauthorizations Only)

###### a. Expedited Review

An Expedited Review is available if your Network Dentist certifies in writing that the time to follow the Informal Reconsideration process, as described below, would cause a significant negative change in your medical condition. CIGNA Dental will notify you and your Dentist of its decision, by telephone and by mail within 1 business day after receipt of all documentation. If CIGNA Dental upholds the denial, the written notice will include the criteria used, the clinical reasons for the decision, references to any supporting documentation, and notice of your right to proceed to an Expedited Appeal.



- b. Expedited Appeal  
An Expedited Appeal is available if CIGNA Dental upholds the denial of a preauthorization at the Expedited Review level. To request an Expedited Appeal, your Network Dentist must immediately inform CIGNA Dental, in writing, that you are requesting an Expedited Appeal. CIGNA Dental will notify you and your Dentist of its decision, by telephone and by mail, within 72 hours of receiving the request. If CIGNA Dental upholds the denial, you may request an Expedited External Independent Review.

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

### 2. Informal Reconsideration (Preauthorizations Only)

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

### 3. Formal Appeal (Preauthorizations and Claims for Services Already Provided)

- a. Denied Preauthorizations: You have 60 days from the date you receive notice that your denial was upheld at the Informal Reconsideration level to request a Formal Appeal. CIGNA Dental will notify you and your Dentist of its decision in writing within 15 days.

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

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

### 4. External Independent Review (Preauthorizations and Claims for Services Already Provided)

If CIGNA Dental upholds the denial of a preauthorization or a claim for services already provided at the Formal Appeal level, you may seek an External Independent Review. You have 30 days from the date you receive notice that your denial was upheld at the Formal Appeal level to request an External Independent Review. You must send your request for an External Independent Review in writing to the Appeals Coordinator at the above address. CIGNA Dental will notify the Director of Insurance and will acknowledge your request in writing within 5 business days. The Director of Insurance will notify you and your treating Dentist of the Independent Review Organization's decision.

Further information concerning the above Appeal Process is contained in the Appeals information Packet. You may obtain a replacement packet by contacting Member Services at 1-800-367-1037.

### 5. Appeals to the State

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

## XII. Dual Coverage

If you are also an insured or a certificate holder under an indemnity health insurance policy that provides benefits for Covered Services provided by the Dental Plan, the indemnity health insurance policy will pay benefits without regard to the existence of the CIGNA Dental Plan. Notwithstanding, the indemnity plan is not obligated to pay any amount for a procedure provided under the Dental Plan at no charge or to pay in excess of the amount of the Patient Charge for any



Covered Service. In the event the Patient Charge has been paid to the Network Dentist, then the Indemnity Plan must remit any payments due directly to you.

AZRIDER02

## State Rider

### CIGNA Dental Health of Colorado, Inc.

Colorado Residents:

#### IV. Your CIGNA Dental Coverage

##### D. Choice of Dentist

If you decide to obtain dental services from a non-network Dentist at your own cost, you may return to your Network Dentist to receive Covered Services without penalty.

#### IX. Specialty Referrals

If you have a dental emergency which requires Specialty Care, your Network Dentist will contact CIGNA Dental for an expedited referral.

Referrals approved by CIGNA Dental cannot be retrospectively denied except for fraud or abuse; however, your CIGNA Dental coverage must be in effect at the time your Network Specialist begins each procedure.

#### XI. What to Do if There is a Problem

The following is applicable only to Adverse Determinations and is in addition to the Appeals Procedure listed in Sections XI.B.1 and XI.B.2. of your Plan Booklet:

1. **Level One Appeals:** The reviewer will consult with a Dentist in the same or similar specialty as the care under consideration. A resolution to your written complaint will be provided to you and your Network Dentist, in writing, within 20 working days of receipt. The written decision will contain the name, title, and qualifying credentials of the reviewer and of any specialist consulted, a statement of the reviewer's understanding of the reason for your appeal, clinical rationale, a reference to the documentation used to make the determination, clinical criteria used, and instructions for requesting the clinical review criteria, and a description of the process for requesting a second level appeal.
2. **Level Two Appeals:** A majority of the Appeals Committee will consist of licensed Dentists who have appropriate expertise. The licensed Dentist may not have been previously involved in the care or decision under consideration, may not be members of the

board of directors or employees of CIGNA Dental, and may have no direct financial interest in either the case or its outcome.

The Appeals Committee will schedule and hold a review within 45 working days of receipt of your request. You will be notified in writing at least 15 working days prior to the review date of your right to: be present at the review; present your case to the Grievance Committee, in person or in writing; submit supporting documentation; ask questions of the reviewers prior to or at the review; and be represented by a person of your choice. If you wish to be present, the review will be held during regular business hours at a location reasonably accessible to you. If a face-to-face meeting is not practical for geographic reasons, you will have the opportunity to be present by conference call at CIGNA Dental's expense. Please notify CIGNA Dental within 5 working days prior to the review if you intend to have an attorney present.

The Appeals Committee's decision will include: the names, titles and qualifying credentials of the reviewers; a statement of the reviewer's understanding of the nature of the appeal and the pertinent facts; the rationale for the decision; reference to any documentation used in making the decision; instructions for requesting the clinical rationale, including the review criteria used to make the determination; additional appeal rights, if any; and the right to contact the Department of Insurance, including the address and telephone number of the Commissioner's office.

3. **Expedited Appeals:** Within 1 working day after your request, CIGNA Dental will provide reasonable access to the Dentist who will perform the expedited review.

The following process replaces Section XI.B.3. of your Plan Booklet, entitled "**Independent Review Procedure**":

If the Appeals Committee upholds a denial based on clinical necessity, and you have exhausted CIGNA Dental Appeals Process, you may request that your appeal be referred to an Independent Review Organization (IRO). In order to request a referral to an IRO, the reason for the denial must be based on a dental necessity determination by CIGNA Dental.

Administrative, eligibility or benefit coverage limits are not eligible for additional review under this process.

There is no charge for you to initiate this independent review process; however, you must provide written authorization permitting CIGNA Dental to release the information to the Independent Reviewer selected. The IRO is composed of persons who are not employed by CIGNA Dental or any of its affiliates. CIGNA Dental will abide by the decision of the



IRO. To request a referral to an IRO, you must notify the Appeals Coordinator within 60 days of your receipt of the Appeals Committee's level two appeal review denial. CIGNA Dental will then forward the file to the Colorado Department of Insurance within 2 working days, or within 1 working day for expedited reviews. We will send you descriptive information on the entity that the Department selects to conduct the review.

The IRO may request additional information to support the request for an independent review. Upon receipt of copies of any additional information, CIGNA Dental may reconsider its decision. If CIGNA Dental provides coverage, the independent review process will end.

The IRO will provide written notice of its decision to you, your provider and CIGNA Dental within 30 working days after CIGNA Dental receives your request for an independent review. When requested and when a delay would be detrimental to your dental condition as certified by your treating Dentist, the IRO will complete the review within 7 working days after CIGNA Dental receives your request. The IRO may request another 10 working days, or another 5 working days for expedited requests, to consider additional information.

If the IRO reverses the CIGNA Dental adverse decision, we will provide coverage within 1 working day for preauthorizations and within 5 working days for services already rendered.

### XVIII. Miscellaneous

In addition to the information contained in this booklet, CIGNA Dental Health maintains a written plan concerning accessibility of Network Dentists, quality management programs, procedures for continuity of care in the event of insolvency, and other administrative matters. Under Colorado law, these materials are available at CIGNA Dental Health administrative offices and will be provided to interested parties upon request.

CORIDER01

## State Rider

### CIGNA Dental Health of Florida, Inc.

#### Florida Residents:

#### I. Definitions

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

### III. Eligibility/When Coverage Begins

There will be at least one open enrollment period of not less than 30 days every 18 months unless CIGNA Dental Health and your Group mutually agree to a shorter period of time than 18 months.

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

### IV. Your CIGNA Dental Coverage

#### B. Premiums/Prepayment Fees

Your Group Contract has a 10-day grace period. This provision means that if any required premium is not paid on or before the date is due, it may be paid subsequently during the grace period. During the grace period, the Group Contract will remain in force.

#### D. Choice of Dentist

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

### XI. What to Do if There is a Problem

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

#### B. Appeals Procedure

The Appeals Coordinator can be reached at 1-800-367-1037 or by writing to 300 N.W. 82nd Avenue, Suite 700, P.O. Box 189060, Plantation, Florida 33318-9060.

##### 1. Level One Appeals

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

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

##### 4. Appeals to the State

You always have the right to file a complaint with or seek assistance from the Department of Insurance, 200 East Gaines Street, Tallahassee, Florida 32399,



### XIII. Disenrollment from the Dental Plan/Termination

#### A. Causes for Disenrollment/Termination

3. Permanent breakdown of the Dentist-patient relationship, as determined by CIGNA Dental Health, is defined as disruptive, unruly, abusive, unlawful, or uncooperative behavior which seriously impairs CIGNA Dental Health's ability to provide services to members, after reasonable efforts to resolve the problem and consideration of extenuating circumstances.

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

### XIV. Extension of Benefits

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

### XVI. Converting From Your Group Coverage

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

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

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

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

FLRIDER01

### State Rider

#### CIGNA Dental Health of Kentucky, Inc.

##### Kentucky Residents:

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

### IV. Your CIGNA Dental Coverage

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

15. Services compensated under no-fault auto insurance policies or insured motorist policies are not excluded.

KYRIDER02

### State Rider

#### CIGNA Dental Health of Maryland, Inc.

P.O. Box 189060

Plantation, FL 33318-9060

##### Maryland Residents:

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

### IV. Your CIGNA Dental Coverage

#### D. Choice of Dentist

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

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

7. General anesthesia is covered when medically necessary and authorized by your Physician.
12. For Maryland residents, this exclusion should read as follows: Services considered to be unnecessary.
15. This exclusion does not apply to Maryland residents.



## IX. Specialty Referrals

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

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

The following information replaces Section XI. of your Plan Booklet in its entirety.

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

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

### A. Start With Member Services

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-367-1037 toll-free and explain your concern to one of our Member Services Representatives. You can also express that concern in writing to the address listed for your state on the cover page of your plan booklet. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible usually by the end of the next business day, but in any case within 30 days.

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

### B. Complaints Involving Coverage Decisions

1. **Definitions** - the following additional definitions apply to this Section:
  - a. **Appeal** - a protest regarding a coverage decision filed under CIGNA Dental's internal appeal process.
  - b. **Appeal Decision** - a final determination by

CIGNA Dental on an appeal of coverage decision filed under CIGNA Dental's internal appeal process.

- c. **Coverage Decision** - an initial determination by CIGNA Dental that results in noncoverage of a dental procedure, including nonpayment of all or any part of a claim. A coverage decision does not include an Adverse Determination, as defined in Section I of your plan booklet.
- d. **Urgent Medical Condition** - a condition that satisfies either of the following:
  1. A medical condition, including a physical or dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
    - (a) Placing your life or health in serious jeopardy;
    - (b) The inability to regain maximum function;
    - (c) Serious impairment to bodily function; or
    - (d) Serious dysfunction of any bodily organ or part; or
  2. A medical condition, including a physical or dental condition, where the absence of medical attention within 72 hours, in the opinion of a health care provider with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

### 2. Appeals Procedure

If you are not satisfied with the results of a Coverage Decision, you may start the Appeals Procedure. CIGNA Dental has a two-step Appeals Procedure for Coverage Decisions. To initiate an Appeal, you must submit a request in writing to CIGNA Dental, at the address listed for your state on the cover page of your plan booklet, within 1 year from the date of the initial CIGNA Dental decision. You should state the reason you feel your Appeal should be approved and include any information to support your Appeal. If you are unable or choose not to write, you may ask Member Services to register your Appeal by calling 1-800-367-1037.



**a. Level One Appeals**

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

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

If you are not satisfied with our level one appeal decision, you may either: (1) proceed to a level two appeal or (2) register a complaint with the Maryland Insurance Administration (See "Appeals to the State" below).

**b. Level Two Appeals**

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

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

calendar days.

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

You may present your appeal to the Appeals Committee in person or by conference call. You must advise CIGNA Dental 5 days in advance if you or your representative plan to attend in person. You will be notified in writing of the Appeals Committee's final decision within 5 business days after the meeting. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

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

If you are not satisfied with our level two appeal Decision, you may register a complaint with the Maryland Insurance Administration by following the instructions below.

**3. Appeals to the State**

Before seeking the assistance of the Maryland Insurance Administration regarding the appeal of a Coverage Decision, you must first exhaust CIGNA Dental Level One Appeals Procedure. However, if your complaint involves an Urgent Medical Condition for which care has not yet been rendered, you may file a complaint with the Maryland Insurance Administration without first exhausting CIGNA Dental Level One Appeals Procedure.

If you are not satisfied with CIGNA Dental final resolution regarding your Coverage Decision, you may, within 60 working days of receipt of CIGNA Dental level one or level two appeals decision, file a written complaint with the Maryland Insurance Administration. Your complaint should be addressed to the Life and Health Inquiry and Investigation Unit, 525 St. Paul Place, Baltimore, MD 21202, telephone



(410) 468-2244, fax (410) 468-2260.

**C. Complaints Involving Adverse Determinations**

The following applies to decisions made by CIGNA Dental that a proposed or delivered Covered Service is or was not necessary, appropriate or efficient and which resulted in non-coverage of the service. For such Adverse Determinations, the complaint/appeal process is designated as a grievance process under Maryland law.

**1. In General**

The CIGNA Dental Appeals Coordinator is responsible for the internal grievance process and may be contacted at P.O. Box 189060, Plantation Florida 33318-9060; Phone 1-800-367-1037

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

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

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

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

- a. the grievance involves an emergency. An emergency is a service necessary to treat a condition or illness that, without immediate dental attention, would:
  - (1) seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or
  - (2) cause the member to be a danger to self or others.

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

- b. you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days;
- c. the grievance involves Covered Services already provided.

For grievances involving Covered Services already provided, you or your Network Dentist may request a review in writing within 180 days of receipt of an Adverse Determination. CIGNA Dental shall render a

final decision in writing within 45 working days after the date a grievance is filed; unless you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days.

If, within 5 days of the Filing Date, CIGNA Dental does not have sufficient information to complete the grievance process, CIGNA Dental will request additional information for review and will assist you or your Network Dentist in gathering information as required.

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

- a. the specified factual basis for the decision;
- b. the specific criteria and standards, including interpretive guidelines on which the grievance decision was based;
- c. the name, business address and telephone number of the CIGNA Dental Appeals Coordinator; and
- d. the instructions and time frame for filing a complaint with the Maryland Insurance Commissioner, including the Commissioner's address, telephone number and facsimile number.

**3. Appeals to the State**

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

If you have exhausted the CIGNA Dental internal grievance process and are not satisfied with the CIGNA Dental decision, you may also file a written complaint with the Maryland Insurance



Commissioner, within 30 working days of receipt of the CIGNA Dental grievance decision, at Maryland Insurance Administration, Chief of Complaints, 525 St. Paul Place, Baltimore, MD 21202; Phone 1-800-492-6116; Fax (410) 468-2270.

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

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

**XIII. Disenrollment From the Dental Plan – Termination of Benefits**

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

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

MDRIDER02

**State Rider  
CIGNA Dental Health of North Carolina,  
Inc.**

**North Carolina Residents:**

This State Rider contains information that either replaces, or is in addition to, information contained in your Evidence of Coverage.

**III. Eligibility When Coverage Begins**

The following is in addition to the information in Section III of your Plan Booklet:

Dependent children for whom you are required by a court or administrative order to provide dental coverage may be enrolled at any time. If your child is enrolled in the Dental Plan because of a court or administrative order, the child may not be disenrolled unless the order is no longer valid or the child is enrolled in another dental plan with comparable coverage.

If you have family coverage and have a new baby or if you are appointed as guardian or custodian of a foster child who is placed in your home, the newborn or foster child will be automatically covered for the first 31 days following birth or placement. If you wish to continue coverage beyond the first 31 days, you should enroll the child in the Dental Plan and you need to begin to pay Premiums/Prepayment Fees during the period, if any additional are due.

A life status change may also include placement for adoption. Evidence of good dental health is not required for late enrollees.

**IV. Your CIGNA Dental Coverage**

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

- 15. This exclusion does not apply to North Carolina residents.

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

**B. Appeals Procedure**

**1. Level One Appeals**

The following replaces the third sentence of paragraph 2:

If we need more information to make your Level One Appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

**2. Level Two Appeals**

The following replaces the last sentence of paragraph 2:

If we need more information to complete the Appeals Committee review, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeals Committee to complete the review.

The following is in addition to the information contained in your Plan Booklet:

The Appeals Committee decision will be provided to



you no later than 30 days after the date the appeal is made.

The Level Two Appeals process does not apply to resolutions made solely on the basis that the Dental Plan does not provided benefits for the service performed or requested.

**3. Independent Review Procedure**

The voluntary independent review process does not apply in North Carolina.

**XII. Dual Coverage**

"Other Sources," as used in the first sentence of the second paragraph, is defined as an HMO or similar dental plan.

**XIII. Disenrollment From the Dental Plan – Termination of Benefits**

**A. Time Frames For Disenrollment/Termination**

The following replaces Item 5 in section XIII.A. of your Plan Booklet:

- 5. For North Carolina residents, disenrollment due to a continued lack of a Dental Office in your Service Area occurs at the end of your plan year.

**XVIII. Miscellaneous**

The following provisions are in addition to the information contained in your Plan Booklet:

- A. From time to time, CIGNA Dental Health may offer or provide certain persons who enroll in the CIGNA Dental plan access to certain discounts, benefits or other consideration for the purpose of promoting general health and well being. Discounts arranged by our

CIGNA HealthCare affiliates may be offered in areas such as acupuncture, cosmetic dentistry, fitness club memberships, hearing care and hearing instruments, laser vision correction, vitamins and herbal supplements, and nonprescription health and wellness products.

In addition, our CIGNA HealthCare affiliates may arrange for third party service providers, such as chiropractors, massage therapists and optometrists, to provide discounted goods and services to those persons who enroll in the CIGNA Dental plan. While CIGNA HealthCare has arranged these goods, services and/or third party provider discounts, the third party service providers are liable to enrollees for the provisions of such goods and/or services. CIGNA HealthCare and CIGNA Dental Health are not responsible for the provision of such goods/or services, nor are we liable for the failure of the provision of the same. Further, CIGNA Health Care and CIGNA Dental

Health are not liable to enrollees for the negligent provision of such goods and/or services by third party service providers.

**B. Incontestability**

Under North Carolina law, no misstatements made by a Subscriber in the application for benefits can be used to void coverage after a period of two years from the date of issue.

**C. Willful Failure To Pay Group Insurance Premiums**

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER

AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THIER RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED A S A RESULT OF THE TERMINATION OF THE INSURANCE.

NCRIDER01



## State Rider CIGNA Dental Health of Ohio, Inc.

### Ohio Residents:

### III. Eligibility/When Coverage Begins

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

Under Ohio law, if you divorce, you cannot terminate coverage for enrolled Dependents until the court determines that you are no longer responsible for providing coverage.

CIGNA Dental does not require, make inquiries into, or rely upon genetic screening or testing in processing applications for enrollment or in determining insurability under the Dental Plan.

### IV. Your CIGNA Dental Coverage

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

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

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

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

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

#### A. Start With Member Services

You can reach Member Services by calling 1-800-367-1037 or by writing to CIGNA Dental Health of Ohio, Inc., P.O. Box 189060, Plantation, Florida, 33318-9060, Attention: Member Services. You may also submit a complaint in person at any CIGNA Dental Office.

#### B. Appeals Procedure

##### 1. Level One Appeals

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

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

The Ohio Department of Insurance is located at 2100 Stella Court, Columbus, Ohio 43215, Attention Consumer Services Division. The Department's toll-free number is 1-800-686-1526 or (614) 664-2673.

### XII. Dual Coverage (Coordination of Benefits/Subrogation)

The following supersedes Section XII of your Plan Booklet.

#### A. In General

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

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

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

#### B. Plans That Do Not Coordinate

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

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

#### C. How CIGNA Dental Pays As Primary Plan

When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

#### D. How CIGNA Dental Pays as Secondary Plan

1. When we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.



2. We will pay only for health care expenses that are covered by CIGNA Dental.
3. We will pay only if you have followed all of our procedural requirements, including: care is obtained from or arranged by your primary care dentist, preauthorized referrals are made to network specialists, coverage is in effect when procedures begin, procedures begin within 90 days of referral.
4. We will pay no more than the "allowable expenses" for the health care involved. If our allowable expense is lower than the primary plan's, we will use the primary plan's allowable expense. That may be less than the actual bill.

**E. Which Plan is Primary?**

To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following that applies:

1. Non-coordination Plan

If you have another group plan that does not coordinate benefits, it will always be primary.

2. Employee

The plan that covers you as an employee (neither laid off nor retired) is always primary.

3. Children (Parents Divorced or Separated)

If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, we follow the birthday rule. If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

4. Children & the Birthday Rule

When your children's health care expenses are involved, we follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children.

However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

5. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

**F. Coordination Disputes**

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

**G. Subrogation**

If another source directly reimburses you more than your Patient Charge for Covered Services, you may be required to reimburse CIGNA Dental. Where allowed by law, this section will apply to you or your Dependents who:

1. receive benefit payment under this Dental Plan as the result of a sickness or injury; and
2. have a lawful claim against another party or parties for compensation, damages, or other payment because of that same sickness or injury.

In those instances where this section applies, the rights of the Member or Dependent to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to CIGNA Dental, but only to the extent of benefit payments made under this Dental Plan.

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

**XIII. Disenrollment From The Dental Plan/Termination of Benefits**

**A. Causes For Disenrollment/Termination**

3. Under Ohio law, you will not be terminated from the dental plan due to a permanent breakdown of the Dentist-patient relationship. However, your Network Dentist has the right to decline services to a patient because of rude or abusive behavior.

You or your Dependent may appeal any termination action by CIGNA Dental by submitting a written complaint as set out in Section XI.

**XVI. Conversion Coverage**

You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- A. Nonpayment of Premiums/Prepayment Fees by the Subscriber;
- B. Fraud or misuse of dental services and/or Dental



Offices;

- C. Selection of alternate dental coverage by your Group.

### **XVIII. Miscellaneous**

#### **A. Governing Law**

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

#### **B. Availability of Financial Statement**

CIGNA Dental Health of Ohio, Inc. will make available to you, upon request, its most recent financial statement.

OHRIDER01

## **State Rider**

### **CIGNA Dental Health of Pennsylvania, Inc.**

**Pennsylvania Residents:**

#### **I. Definitions**

**Dependent** - A child born of a Dependent Child of a Subscriber shall also be considered a Subscriber's Dependent so long as such Dependent Child remains eligible for benefits.

#### **III. Eligibility/When Coverage Begins**

A Dependent child may be enrolled within 60 days of a court order.

If you have family coverage, a newborn child of a Dependent child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, the newborn needs to be enrolled in the Dental Plan and you need to begin to pay Premiums/Prepayment Fees during that period.

#### **IV. Your CIGNA Dental Coverage**

##### **D. Emergency Dental Care - Reimbursement**

If any emergency arises while you are unable to contact your Network General Dentist, the Dental Plan covers the cost of emergency dental services so that you are not liable for greater out-of-pocket expense than if you were attended by your Network General Dentist. You must submit appropriate reports and x-rays to CIGNA Dental Health.

#### **H. Services Not Covered Under Your Dental Plan Items 12 and 15 are amended as follows:**

- 12. Services considered to be experimental in nature.
- 15. Services compensated under any group medical plan, no-fault auto insurance policy or insured motorist policy are not excluded.

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

The following process is in addition to that described in your Plan Booklet:

You always have the right to file a complaint with or seek assistance from the Pennsylvania Department of Health, P.O. Box 90, Harrisburg, Pennsylvania, 17108-0090, (717-787-5193).

#### **XII. Dual Coverage**

All benefits provided under the Dental Plan shall be in excess of and not in duplication of first party medical benefits payable under the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. &secmrk; 1711, et. seq.

### **XVIII. Miscellaneous**

The Group Contract, including the Patient Charge Schedule, Pre-Contracting Application, and Coordination of Benefits provisions, and any amendments or additions thereto, represents the entire agreement between the parties with respect to the subject matter. The invalidity or unenforceability of any section or subsection of the contract will not affect the validity or enforceability of the remaining sections or subsections.

The Group Contract is construed for all purposes as a legal document and will be interpreted and enforced in accordance with the pertinent laws and regulations of the Commonwealth of Pennsylvania and with pertinent federal laws and regulations.

PARIDER02

## **State Rider**

### **CIGNA Dental Health of Virginia, Inc.**

**Virginia Residents:**

Your CIGNA Dental Care coverage is provided by CIGNA Dental Health of Virginia, Inc.

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



### III. Eligibility/When Coverage Begins

The following is added to paragraph 3, immediately after the first sentence:

An adopted child shall be eligible for coverage from the date of adoptive or parental placement in your home.

### IV. Your CIGNA Dental Coverage

#### F. Emergency Dental Care - Reimbursement

The following is in addition to the information listed in your Plan Booklet:

##### 1. Emergency Care Away From Home

CIGNA Dental will acknowledge your claim for emergency services within 15 days and will: accept, deny, or request additional information within 15 business days of receipt. If CIGNA Dental accepts your claim, reimbursement for all appropriate emergency services will be made within 5 days of acceptance.

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

The following replaces Section XI.B of your Plan Booklet:

#### B. Appeals Procedure

CIGNA Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to CIGNA Dental, at the address listed for your state on the cover page of this booklet, within 1 year from the date of the initial CIGNA Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Member Services to register your appeal by calling 1-800-367-1037. Complaints regarding adverse decisions are referred to as reconsiderations under Virginia law. Network dentists may request reconsiderations on your behalf, with your permission. Resolutions to requests for reconsideration of adverse decisions will be communicated to you within 10 business days of CIGNA Dental receiving the request.

##### 1. Level One Appeals

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

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we

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

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

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

##### 2. Level Two Appeals

To initiate a level two appeal, follow the same process required for a level one appeal. Level two appeals will be conducted by an appeals Committee consisting of at least 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the Appeals Committee will include at least one dentist. If specialty care is in dispute, the Appeals Committee will consult with a dentist in the same or similar specialty as the care under review.

CIGNA Dental will acknowledge your appeal in writing within 5 business days and schedule an Appeals Committee review. The acknowledgment letter will include the name, address, and telephone number of the Appeals Coordinator. We may request additional information at that time. If your appeal concerns a denied pre-authorization, the Appeals Committee review will be completed within 15 calendar days. For appeals concerning all other coverage issues, the Appeals Committee review will be completed within 30 calendar days. If we need more time or information to complete the review, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeals Committee to complete the review.

You may present your appeal to the Appeals Committee in person or by conference call. You must advise CIGNA Dental 5 days in advance if your or your representative plan to attend in person. You will be notified in writing of the Appeals Committee's decision within 5 business days after the meeting. The decision will include the specific contractual or



clinical reasons for the decision, as applicable.

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

### 3. Independent External Review Procedure

If you are not fully satisfied with the CIGNA Dental Level Two Appeals decision regarding a dental necessity or clinical appropriateness issue, you may appeal the decision to the Virginia Bureau of Insurance, provided the actual cost to you for the health services exceeds \$300. A decision to use the voluntary level of Independent External Review will not affect your rights to any other benefits under the Dental Plan.

To initiate the Independent External Review Procedure, you or your representative should, within 30 days of receipt of the CIGNA Dental written Level Two Appeals decision, file a request on the Virginia Bureau of Insurance form enclosed with the decision. The written request should include the \$50 filing fee. The Bureau of Insurance may waive or refund the filing fee if you can demonstrate that paying the fee will cause undue financial hardship or if the appeal is not accepted for review. If the Bureau of Insurance accepts your request for Independent External Review, the Bureau will assign an impartial Independent External Review entity to review your request. The entity will issue its recommendation within 30 working days of the date it receives all documentation and information necessary to complete its review. The Commissioner of Insurance will issue a written decision, based upon the entity's recommendation, within 10 working days after receipt of the entity's recommendation. If accepted by the Bureau of Insurance for expedited review, the entity will issue its recommendation as soon as possible, consistent with the medical exigencies of the case, but in no event more than 5 working days after receipt of the appeal. As soon as the Commissioner receives the entity's recommendation, the Commissioner will review the recommendation and notify you of his/her decision. The Commissioner's written decision shall bind you and CIGNA Dental to the same extent to which each would be bound by a judgment entered in an action

at law or in equity, with respect to the issues which the impartial Independent External Review entity may examine when reviewing a final adverse decision.

The Independent Review Program is a voluntary program arranged by CIGNA Dental.

### 4. Appeals to the State

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

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

## XII. Dual Coverage

The following is in addition to the information listed in your plan booklet:

Under Virginia law, CIGNA Dental may not subrogate your right to recover excess benefits.

Under Coordination of Benefits rules, when we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.

## XIII. Disenrollment From the Dental Plan - Termination of Benefits

The following replaces Section XIII. of your Plan Booklet:

### A. Time Frames For Disenrollment/Termination

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

1. in which Premiums are not remitted to CIGNA Dental.
2. there will be a 31-day grace period for the payment of any premium falling due after the first premium, during which coverage shall remain in effect. If payment is not received within the 31 days, coverage may be canceled after the 31st day and you may be liable for the cost of services received during the grace period.
3. after 31 days notice from CIGNA Dental due to failure to meet eligibility requirements.



- 4 after 31 days notice from CIGNA Dental due to permanent breakdown of the dentist-patient relationship as determined by CIGNA Dental, after at least two opportunities to transfer to another Dental Office.
- 5 after 31 days notice from CIGNA Dental due to fraud or misuse of dental services and/or Dental Offices.
- 6 after voluntary disenrollment.

**B. Effect On Dependents**

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

**XVIII. Miscellaneous**

The following is in addition to the information listed in your Plan Booklet:

- A. **Assignment** - Your Group Contract provides that the Group may not assign the Contract or its rights under the Contract, nor delegate its duties under the Contract without the prior written consent of CIGNA Dental.
- B. **Entire Agreement** - Your Group Contract, including the Evidence of Coverage, State Rider, Patient Charge Schedule, Pre-Contract Application, and any amendments thereto, constitutes the entire contractual agreement between the parties involved. No portion of the charter, bylaws or other document of CIGNA Dental Health of Virginia, Inc. shall constitute part of the contract unless it is set forth in full in the contract.
- C. **Incontestability** - In the absence of fraud, all statements contained in a written application made by a Subscriber are considered representations and not warranties. Coverage can be voided: 1. during the first two years for material misrepresentations contained in a written enrollment form; and 2. after the first two years, for fraudulent misstatement contained in a written enrollment form.
- D. **Regulation** - CIGNA Dental Health of Virginia, Inc. is subject to regulation by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1 of the Virginia Insurance laws.
- E. **Subscriber Input** - Subscriber enrollees shall have the opportunity to provide input into the plan's procedures and processes regarding the delivery of dental services. Input will be solicited in various ways:
  - On-going contacts between Customer Service representatives and enrollees;
  - On-going contacts with enrollees during open

enrollment meetings;

- Annual survey of enrollees regarding their experiences in the plan.

F. **Domestic Partner Coverage**- Domestic partner coverage is not available to Virginia residents.

**Member Rights and Responsibilities**

**Your Rights**

- You have the right to considerate, respectful care, with recognition of your personal dignity, regardless of race, color, religion, sex, age, physical or mental handicap or national origin.
- You have the right to participate in decision making regarding your dental care. With the CIGNA Dental Care plan, you and your Dentist make decisions about your recommended treatment.
- You have the right to know your costs in advance for routine and emergency care. You have the right to an explanation of the benefits listed in your Patient Charge Schedule. Your Dentist can answer questions or call Member Services at 1-800-367-1037.
- You have the right to tell us when something goes wrong.
  - Start with your Dentist. He/she is your primary contact.
  - If you have a problem that cannot be resolved with your Dentist, call Member Services. We have an established process to resolve issues that cannot be worked out in other ways.
  - You have the right to appeal the decision of your complaint through the CIGNA Dental Appeals Process.
- You have the right to know about CIGNA Dental, dental services, network providers, and your rights and responsibilities.
  - You have the right to schedule an appointment with your network dental office within a reasonable time.
  - You have the right to receive a recall for an appointment with your Dentist.
  - You have the right to see a Dentist within 24 hours for emergency care. Emergencies are dental problems that require immediate treatment, (including control of bleeding, acute infection, or relief of pain, including local anesthesia).
  - You have the right to information from your network Dentist regarding appropriate or necessary treatment options without regard to cost or benefit coverage.



- You have the right to select or change dental offices within the CIGNA Dental Care network. It is good dental practice, however, to complete any treatment in progress with your current Dentist before transferring.
- You have the right to receive advance notification if your network general Dentist leaves the CIGNA Dental Care network.
- You have the right to call Member Services if you need help choosing a Dentist or need more information to help you make that choice.
- You have the right to know who we are, what services we provide, which Dentists are part of our plan and your rights and responsibilities under the plan. If you have any questions or concerns, call Member Services.
- You have the right to receive a Patient Charge Schedule to determine benefits and covered services. If you do not receive one before your plan becomes effective, call Member Services to request one.
- You have the right to privacy and confidential treatment of information and dental records, as provided by law.

CIGNA Dental wants to hear from you if you believe your rights have been violated.

**Your Responsibilities**

- Read the details of your CIGNA Dental Care Plan Booklet and Patient Charge Schedule.
- Choose a primary care Dentist from the CIGNA Dental network.
- Provide information, to the extent possible, that your Dentist needs to provide appropriate dental care.
- Receive care only from the Network General Dentist office you have chosen, unless a transfer has been arranged.
- Be sure your primary care Dentist gives you a referral for any specialty care and gets any preauthorization required for the treatment.
- Ask CIGNA Dental to address any concerns you may have.
- Let your Dentist know whether you understand the treatment plan he/she recommends and follow the treatment plan and instructions for care.
- Pay your Patient Charges as soon as possible for the dental care received so your Dentist can continue to serve you.
- Be considerate of the rights of other patients and the dental office personnel.

- Keep appointments or cancel in time for another patient to be seen in your place.

**Important Information Regarding Your Dental Plan**

In the event you need to contact someone about this Dental Plan for any reason, please contact your Benefit Administrator. If you have additional questions you may contact CIGNA Dental at the following address and telephone number:

CIGNA Dental Health of Virginia, Inc.  
P.O. Box 189060  
Plantation, FL 33318-9060  
1-800-367-1037

**Note:** We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from CIGNA Dental or your Benefit Administrator, you may contact the Virginia State Corporation Commission Bureau of Insurance at:

ADDRESS: Life and Health Division  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218

TELEPHONE: In-State Call: 1-800-552-7945  
Out-of-State Calls: 1-804-371-9741

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your Benefits Administrator, company or the Bureau of Insurance, have your policy number available.

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by CIGNA Dental, you may contact the Office of the Managed Care Ombudsman for assistance at:

ADDRESS: Office of The Managed Care  
Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218

TELEPHONE: Toll-Free: 1-877-310-6560

E-MAIL: [ombudsman@scc.state.va.us](mailto:ombudsman@scc.state.va.us)  
<http://www.state.va.us/scc>

If you have quality of care concerns, you may contact the Center for Quality Health Care Services and Consumer Protection at any time, at the following:



**CIGNA HealthCare**

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ADDRESS: The Center For Quality Health Care  
Services  
Consumer Protection  
3600 West Broad Street, Suite 216  
Richmond, VA 23230-4920

TELEPHONE: Toll-Free: 1-800-955-1819  
Out-of-State Calls: 1-804-367-2106  
Fax Number: 1-800-367-2149

VARIDER02



## **CIGNA Dental Care – CIGNA Dental Health Plan**

**This section describes the CDC plan for residents of the following states: CA, CT, NJ, TX**

CDO11 M



CIGNA HealthCare

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CIGNA HealthCare

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## **CIGNA Dental Health of California, Inc.**

400 North Brand Boulevard, Suite 400  
Glendale, California 91203

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

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

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

The Dental Plan is subject to the requirements of Chapter 2.2 of Division 2 of the Health and Safety Code and of Division 1 of Title 28 of the California Code of Regulations. Any provision required to be in the Group Contract by either of the above will bind the Dental Plan, whether or not provided in the Group Contract.

*READ YOUR PLAN BOOKLET CAREFULLY*

Please call Member Services at 1-800-367-1037 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.



## TABLE OF CONTENTS

- I. Definitions**
- II. Introduction to Your CIGNA Dental Plan**
- III. Eligibility/When Coverage Begins**
  - A. In General**
  - B. New Enrollee Transition of Care**
  - C. Renewal Provisions**
- IV. Your CIGNA Dental Coverage**
  - A. Member Services**
  - B. Prepayment Fees**
  - C. Other Charges – Copayments**
  - D. Facilities - Choice of Dentist**
  - E. Your Payment Responsibility (General Care)**
  - F. Specialty Care**
  - G. Specialty Referrals**
- V. Covered Dental Services**
  - A. Categories of Covered Services**
  - B. Emergency Dental Care - Reimbursement**
- VI. Exclusions**
- VII. What To Do If There is a Problem/Grievances**
  - A. Your Rights To File Grievances with CIGNA Dental**
  - B. How To File A Grievance**
  - C. You Have Additional Rights Under State Law**
  - D. Voluntary Mediation**
- VIII. Coordination of Benefits**
- IX. Disenrollment From the Dental Plan – Termination of Benefits**
  - A. For the Group**
  - B. For You and Your Enrolled Dependents**
  - C. Termination Effective Date**
  - D. Effect on Dependents**
  - E. Right to Review**
  - F. Notice of Termination**
- X. Continuity of Care**
- XI. Continuation of Benefits (COBRA)**
- XII. Individual Continuation of Benefits**
- XIII. Confidentialty/Privacy**
- XIV. Miscellaneous**
  - A. Programs Promoting General Health**
  - B. Organ and Tissue Donation**
  - C. 911 Emergency Response System**





## I. Definitions

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

**Adverse Determination** - a decision by CIGNA Dental not to authorize payment for certain limited specialty care procedures on the basis of clinical necessity or appropriateness of care. Requests for payment authorizations that are declined by CIGNA Dental based upon clinical necessity or appropriateness of care will be the responsibility of the member at the dentist's Usual Fees. A licensed dentist will make any such denial. Adverse Determinations may be appealed as described in the Section entitled "What To Do If There Is A Problem."

**CIGNA Dental** - CIGNA Dental Health of California, Inc.

**Clinical Necessity** - To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

- A. be consistent with the symptoms, diagnosis or treatment of the condition present;
- B. conform to professionally recognized standards of dental practice;
- C. not be used primarily for the convenience of the member or provider of care; and
- D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

**COBRA** – Consolidated Omnibus Budget Reconciliation Act of 1986, as amended. The federal law that gives workers who lose their health benefits the right to choose to continue group health benefits provided by the plan under certain circumstances.

**Contract Fees** - The fees contained in the Network Specialty Dentist agreement with CIGNA Dental.

**Copayment** – The amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

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

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

**Dental Plan** – The plan of managed dental care benefits offered through the Group Contract between CIGNA Dental and your Group.

**Dependent** -

Your lawful spouse;

Your unmarried child (including newborns, children of the noncustodial parent, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order;

or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

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

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

For a child who falls into category B. or C. above, you will need to furnish CIGNA Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter during his or her term of coverage.

Coverage for dependents living outside a CIGNA Dental service area is subject to the availability of an approved network where the dependent resides; provided however, CIGNA Dental will not deny enrollment to your dependent who resides outside the CIGNA Dental service area if you are required to provide coverage for dental services to your dependent pursuant to a court order or administrative order.

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

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

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

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

**Network Specialty Dentist** - A licensed dentist who has signed an agreement with CIGNA Dental under which he or she agrees to provide specialized dental care services, as outlined in Section V, upon payment authorization by CIGNA Dental.

Network General Dentist and Network Specialty Dentist



include any dental clinic, organization of dentists, or other person or institution licensed by the State of California to deliver or furnish dental care services that has signed an agreement with CIGNA Dental to provide general dentistry or specialty care services to you.

**Patient Charge Schedule** - List of services covered under your Dental Plan and the associated Copayment.

**Prepayment Fees** – The premium or fees that your Group pays to CIGNA Dental, on your behalf, during the term of your Group Contract. These fees may be paid all or in part by you.

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

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

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

## II. Introduction to Your CIGNA Dental Plan

Welcome to the CIGNA Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to CIGNA Dental or its designee for dental plan operation purposes.

## III. Eligibility/When Coverage Begins

### A. In General

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

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

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

enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Prepayment Fees.

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

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

### B. New Enrollee Transition of Care

If you or your enrolled Dependents are new enrollees currently receiving services for any of the conditions described hereafter from a non-Network Dentist, you may request CIGNA Dental to authorize completion of the services by the non-Network Dentist. CIGNA Dental does not cover services provided by non-Network Dentists except for the conditions described hereafter that have been authorized by CIGNA Dental prior to treatment. Rare instances where prolonged treatment by a non-Network Dentist might be indicated will be evaluated on a case-by-case basis by the Dental Director in accordance with professionally recognized standards of dental practice. Authorization to complete services started by a non-Network Dentist before you or your enrolled Dependents became eligible for CIGNA Dental shall be considered only for the following conditions:

1. An acute condition. An acute condition is a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of the covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a dental condition due to a disease, illness, or other dental problem or disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to a Network Dentist consistent with good professional practice, but not to exceed 12 months



3. Performance of a surgery or other procedure that is authorized by CIGNA Dental and has been recommended and documented by the non-Network Dentist to occur within 180 days of the effective date of your CIGNA Dental coverage.

#### **C. Renewal Provisions**

Your coverage under the Dental Plan will automatically be renewed, except as provided in the section entitled "Disenrollment From The Dental Plan – Termination of Benefits." All renewals will be in accordance with the terms and conditions of your Group Contract. CIGNA Dental reserves any and all rights to change the Prepayment Fees or applicable Copayments during the term of the Group Contract if CIGNA Dental determines the Group's information relied upon by CIGNA Dental in setting the Prepayment Fees materially changes or is determined by CIGNA Dental to be inaccurate.

### **IV. Your CIGNA Dental Coverage**

CIGNA Dental maintains its principal place of business at 400 North Brand Boulevard, Suite 400, Glendale, CA 91203, with a telephone number of 1-800-367-1037. This section provides information that will help you to better understand your Dental Plan. Included is information about how to access your dental benefits and your payment responsibilities.

#### **A. 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, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Member Services from any location at 1-800-367-1037. If you have a question about your treatment plan, we can arrange a second opinion or consultation. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

#### **B. Prepayment Fees**

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

#### **C. Other Charges - Copayments**

Network General Dentists are typically reimbursed by CIGNA Dental through fixed monthly payments and supplemental payments for certain procedures. Network

Specialty Dentists are compensated based on a contracted fee arrangement for services rendered. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the Copayments that you pay, as set out in your Patient Charge Schedule. You may request general information about these matters from Member Services or from your Network Dentist.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan, subject to plan exclusions and limitations. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the Copayments 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 is instructed to tell you about Copayments for Covered Services, the amount you must pay for optional or 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 change in accordance with your Group Contract. CIGNA Dental will give written notice to your Group of any change in Copayments at least 30 days prior to such change. You will be responsible for the Copayments listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

#### **D. Facilities- Choice of Dentist**

##### **1. In General**

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.

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

To obtain a list of Dental Offices near you, visit our website at [www.cigna.com](http://www.cigna.com), or call the Dental Office Locator at 1-800-367-1037. 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.

**2. Appointments**

To make an appointment with your Network General 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.

**3. Office Transfers**

If you decide to change Dental Offices, we encourage you to complete any dental procedure in progress first. To arrange a transfer, call Member Services at 1-800-367-1037. To obtain a list of Dental Offices near you, visit our website at [www.cigna.com](http://www.cigna.com), or call the Dental Office Locator at [1-800-367-1037]. 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 Copayments which you owe to your current Dental Office must be paid before the transfer can be processed. Copayments for procedures not completed at the time of transfer may be required to be prorated between your current Dental Office and the new Dental Office, but will not exceed the amount listed on your Patient Charge Schedule.

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

For Covered Services at your Dental Office, you will be charged the Copayments listed on your Patient Charge Schedule, subject to applicable exclusions and limitations. For services listed on your Patient Charge Schedule provided 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 available in the Service Area to treat you, 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 Copayment for Covered Services. CIGNA Dental will pay the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. If you seek treatment for Covered Services from a non-Network Dentist without authorization from CIGNA Dental, you will be responsible for paying the non-Network Dentist his or her Usual Fee.

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

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

**F. Specialty Care**

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

- Pediatric Dentists - Children's dentistry.
- Endodontists - Root canal treatment.
- Periodontists - Treatment of gums and bone.
- Oral Surgeons - Complex extractions and other surgical procedures.
- Orthodontists - Tooth movement.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist. Payment authorization is required for coverage of services by a Network Specialty Dentist.

**G. Specialty Referrals**

**1. 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 prior to rendering the service. Prior authorization from CIGNA Dental is not required for specialty referrals for Endodontic services. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by CIGNA Dental before treatment begins.

When CIGNA Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section V.A.8, Orthodontics.

Treatment by the Network Specialty Dentist must begin within 90 days from the date of CIGNA Dental's authorization. If you are unable to obtain treatment within the 90-day period, please call Member Services to request an extension. Your coverage must be in effect when each procedure begins.

If CIGNA Dental makes an Adverse Determination of the requested referral (i.e. CIGNA Dental does not authorize payment to the Network Specialty Dentist for Covered Services), or if the dental services sought



are not Covered Services, you will be responsible to pay the Network Specialty Dentist's Usual Fee for the services rendered. If you have a question or concern regarding an authorization or a denial, contact Member Services.

Specialty referrals will be authorized by CIGNA Dental if the services sought are (a) Covered Services; (b) rendered to an eligible member; (c) within the scope of the Specialty Dentists skills and expertise; and (d) meet Clinical Necessity requirements. CIGNA Dental may request medical information regarding your condition and the information surrounding the dentist's determination of the Clinical Necessity for the request. CIGNA Dental shall respond in a timely fashion appropriate for the nature of your condition, not to exceed 5 business days from CIGNA Dental's receipt of the information reasonably necessary and requested by CIGNA Dental to make the determination. When you face imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to your life or health or could jeopardize your ability to regain maximum function, the decision to approve, modify, or deny requests shall be made in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request. Decisions to approve, modify, or deny requests for authorization prior to the provision of dental services shall be communicated to the requesting dentist within 24 hours of the decision. Decisions resulting in denial, delay, or modification of all or part of the requested dental service shall be communicated to the Member in writing within 2 business days of the decision. Adverse Determinations may be appealed as described in the Section entitled "What To Do If There Is A Problem/Grievances."

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 Copayment for Covered Services. CIGNA Dental will reimburse the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee. Or, if you seek treatment for Covered Services from a non-Network Dentist without authorization from CIGNA Dental, you will be responsible for paying the dentist's Usual Fee.

You may request from Member Services a copy of the process that CIGNA Dental uses to authorize, modify, or deny requests for specialty referrals and services.

## **2. Second Opinions**

If you have questions or concerns about your treatment plan, second opinions are available to you upon request by calling Member Services. Second opinions will generally be scheduled within 5 days. In the case of an imminent and serious health threat, as determined by CIGNA Dental clinicians, second opinions will be rendered within 72 hours. CIGNA Dental's policy statement on second opinions may be requested from Member Services.

## **3. Pediatric Dentistry**

If your child up to age 7 needs to be treated by a Pediatric Dentist, contact your Network General Dentist for a specialty referral. Upon appropriate referral, your child may continue under the care of the Network Pediatric Dentist up to age 7 without additional referrals. If you need to change your child's Network Pediatric Dentist, you should return to your Network General Dentist for a new specialty referral up to the child's 7th birthday.

Your Network Pediatric Dentist must submit each specialty treatment plan to CIGNA Dental for payment authorization. CIGNA Dental's standard payment authorization process as set out above will apply for services rendered by the Network Pediatric Dentist.

For children 7 years and older, your Network General Dentist will provide care. Exceptions for medical reasons may be considered on a case-by-case basis. For children over 7, if you continue to visit the Pediatric Dentist without a referral authorized for payment, you will be fully responsible for the Pediatric Dentist's Usual Fees.



## V. Covered Dental Services

### A. Categories of Covered Services

Dental procedures in the following categories of Covered Services are covered under your Dental Plan when listed on your Patient Charge Schedule and performed by your Network Dentist. Please refer to your Patient Charge Schedule for the procedures covered under each category and the associated Copayment.

#### 1. Diagnostic/Preventive

Diagnostic treatment consists of the evaluation of a patient's dental needs based upon observation, examination, x-rays and other tests. Preventive dentistry involves the education and treatment devoted to and concerned with preventing the development of dental disease. Preventive Services includes dental cleanings, oral hygiene instructions to promote good home care and prevent dental disease, and fluoride application for children to strengthen teeth.

##### a. Limitation

The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency. If your Network Dentist certifies to CIGNA Dental that, due to medical necessity you require certain Covered Services more frequently than the limitation allows, CIGNA Dental will waive the limitation.

#### 2. Restorative (Fillings)

Restorative dentistry involves materials or devices used to replace lost tooth structure or to replace a lost tooth or teeth.

#### 3. Crown and Bridge

An artificial crown is a restoration covering or replacing the major part, or the whole of the clinical crown of a tooth. A fixed bridge is a prosthetic replacement of one or more missing teeth cemented to the abutment teeth adjacent to the space. The artificial tooth used in a bridge to replace the missing tooth is called a pontic.

##### a. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed 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 and bridge charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit copayment for each unit of crown and/or bridge PLUS an additional charge for complex rehabilitation for each unit beginning with the 6th unit when 6 or more units are prescribed in your Network General Dentist's treatment plan. The additional charge for complex rehabilitation will not be applied to the first 5 units of crown or bridge.

##### b. Limitations

- (1) All charges for crown and bridge are per unit (each replacement or supporting tooth equals one unit).
- (2) Limit 1 every 5 years unless CIGNA Dental determines that replacement is necessary because the existing crown or bridge is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes in tooth structure or supporting tissues since the placement of the crown or bridge.

##### c. Exclusion

- (1) If your Patient Charge Schedule number ends in "04" or a higher number, there is no coverage for crowns and bridges used solely for splinting. This exclusion will not apply if a crown or bridge is determined by CIGNA Dental to be the treatment most consistent with professionally accepted standards of care.
- (2) If your Patient Charge Schedule number ends in "04" or a higher number, there is no coverage for resin bonded retainers and associated pontics.

#### 4. Endodontics

Endodontics is root canal treatment, which may be required when the nerve of a tooth is damaged due to trauma, infection, or inflammation. Treatment consists of removing the damaged nerve from the root of the tooth and filling the root canal with a



rubber-like material. Following endodontic treatment, a crown is usually needed to strengthen the weakened tooth.

## 5. Periodontics

Periodontics is treatment of the gums and bone which support the teeth. Periodontal disease is chronic. It progresses gradually, sometimes without pain or other symptoms, destroying the support of the gums and bone. The disease is a combination of deterioration plus infection.

### a. Preliminary Consultation

This consultation by your Network General Dentist is the first step in the care process. During the visit, you and your Network General Dentist will discuss the health of your gums and bone.

### b. Evaluation, Diagnosis and Treatment Plan

If periodontal disease is found, your Network General Dentist or Network Specialty Dentist will develop a treatment plan. The treatment plan consists of mapping the extent of the disease around the teeth, charting the depth of tissue and bone damage and listing the procedures necessary to correct the disease.

Depending on the extent of your condition, your Network General Dentist or Network Specialty Dentist may recommend any of the following procedures:

(1) **Non-Surgical Program** - This is a conservative approach to periodontal therapy. Use of this program depends upon how quickly you heal and how consistently you follow instructions for home care. This program may include:

- Scaling and Root Planning
- Oral Hygiene Instruction
- Full Mouth Debridement

(2) **Scaling and Root Planning**- This periodontal therapy procedure combines scaling of the crown and root surface with root planning to smooth rough areas of the root. This procedure may be performed by the dental hygienist or your Network General Dentist.

(3) **Osseous Surgery** - Bone (osseous) surgery is a procedure used in advanced cases of periodontal disease to restructure the supporting gums and bone. Without this surgery, tooth or bone loss may occur. Two checkups by the Periodontist are covered within the year after osseous surgery.

(4) **Occlusal Adjustment** - Occlusal adjustment requires the study of the contours of the teeth, how they bite (occlude) and their position in the arch. It consists of a recontouring of biting surfaces so that direct biting forces are along the long axis of the tooth. If the biting forces are not properly distributed, the bone, which supports the teeth, may deteriorate.

(5) **Bone Grafts and other regenerative procedures** - This procedure involves placing a piece of tissue or synthetic material in contact with tissue to repair a defect or supplement a deficiency.

### c. Exclusion

General anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, IV sedation is covered when medically necessary and provided in conjunction with Covered Services performed by a Periodontist. General anesthesia is not covered when provided by a Periodontist.

## 6. Prosthodontics

Prosthodontics is treatment dealing with the replacement of missing teeth and other oral structures with removable appliances like dentures or partial dentures.

### a. Exclusion

- (1) Services associated with the placement (i.e., surgically placing the implant into the bone) or prosthodontic restoration of a dental implant.
- (2) Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect.

## 7. Oral Surgery

Oral surgery involves the surgical removal of teeth or associated surgical procedures by your Network General Dentist or Network Specialty Dentist.

### a. Limitation

The surgical removal of a wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Temporary pain from normal eruption is not considered disease.

### b. Exclusion

General anesthesia, sedation and nitrous oxide are not covered unless specifically listed on your



Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon.

## 8. Orthodontics

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

- (1) **Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the Orthodontist.
- (2) **Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- (3) **Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- (4) **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.

### b. Copayments

The Copayment for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Orthodontic Treatment Plan and Records. However, if (1) banding/appliance insertion does not occur within 90 days of such visit, (2) your treatment plan changes, or (3) there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Copayment 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 Copayment will be reduced on a prorated basis.

### c. Additional Charges

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

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

### d. Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call Member Services at [1-800-367-1037] to find out the benefit to which you are entitled based upon your individual case and the remaining months of treatment.

### e. Exclusion

Replacement of fixed and/or removable orthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

## B. 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. Emergency dental care services may include examination, x-rays, sedative fillings, dispensing of antibiotics or pain relief medication or other palliative services prescribed by the treating dentist. You should contact your Network General Dentist if you have an emergency in your Service Area.

### 1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Copayments listed on your Patient Charge Schedule. CIGNA Dental will reimburse you the difference between the dentist's usual fee for emergency Covered Services and your Copayment, up to a total of \$50 per incident. To receive reimbursement, send the dentist's itemized statement



to CIGNA Dental at the address listed for your state on the front of this booklet.

## 2. Emergency Care After Hours

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

## VI. Exclusions

In addition to the exclusions and limitations listed in Section V, listed below are the services or expenses which are also NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- A. services not listed on the Patient Charge Schedule.
- B. services provided by a non-Network Dentist without CIGNA Dental's prior approval (except emergencies, as described in Section V.B.).
- C. services to the extent you, or your Dependent, are compensated for them under any group medical plan.
- D. services considered to be unnecessary in accordance with professionally recognized standards of dental practice.
- E. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
- F. prescription drugs.
- G. 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. If special circumstances arise where a Network Dentist is not available, the Plan will make special arrangements for the provision of covered benefits as necessary for the dental health of the member.)
- H. procedures, appliances or restorations if the main purpose is to:
  - 1. change vertical dimension (degree of separation of the jaw when teeth are in contact);
  - 2. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or if your Patient Charge Schedule ends in "04" or a higher number,
  - 3. restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion,

erosion and/or abfraction and the primary purpose of the restoration is:

- a. to change the vertical dimension of occlusion;
  - b. to diagnose or treat abnormal condition of the temporomandibular joint; or
  - c. for cosmetic purposes.
- I. procedures or appliances for minor tooth guidance or to control harmful habits.
  - J. charges by dental offices for failing to cancel an appointment or canceling an appointment with less than 24 hours notice (i.e. a broken appointment). You will be responsible for paying any broken appointment fee unless your broken appointment was unavoidable due to emergency or exigent circumstances.

As noted in Section V, the following exclusions also apply:

- K. if your Patient Charge Schedule number ends in "04" or a higher number, there is no coverage for crowns and bridges used solely for splinting. This exclusion will not apply if a crown or bridge is determined by CIGNA Dental to be the treatment most consistent with professionally accepted standards of care.
- L. if your Patient Charge Schedule number ends in "04" or a higher number, there is no coverage for resin bonded retainers and associated pontics.
- M. general anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule.
- N. replacement of fixed and/or removable orthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

## VII. What To Do If There Is A Problem/Grievances

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

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

### A. Your Rights to File Grievances With CIGNA Dental

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



resolving your problems.

Grievances include both complaints and appeals. Complaints can include concerns about people, quality of service, quality of care, benefit interpretations or eligibility. Appeals are requests to reverse a prior denial or modified decision about your care. You can contact us by telephone or in writing with a grievance.

## B. How to File a Grievance

To contact us by phone, call us toll-free at 1-800-367-1037 or the toll-free telephone number on your CIGNA identification card. The hearing impaired may call the state TTY toll-free service listed in their local telephone directory.

Send written grievances to:

CIGNA Dental Health of California, Inc.  
Member Services Department  
400 North Brand Blvd., Suite 400  
Glendale, CA 91203

We will provide you with a grievance form upon request, but you are not required to use the form in order to make a written grievance.

You may also submit a grievance online through the following CIGNA website:

<http://www.cigna.com/consumer/services/healthcare/state/ca.html>

If the Member is a minor, is incompetent or unable to exercise rational judgment or give consent, the parent, guardian, conservator, relative, or other legal representative acting on behalf of the Member, as appropriate, may submit a grievance to CIGNA Dental or the California Department of Managed Health Care (DMHC or "Department"), as the agent of the Member. Also, a participating provider may join with or assist you or your agent in submitting a grievance to CIGNA Dental or the DMHC.

### 1. Complaints

If you are concerned about the quality of service or care you have received, a benefit interpretation, or have an eligibility issue, you should contact us to file a verbal or written complaint. If you contact us by telephone to file a complaint, we will attempt to document and/or resolve your complaint over the telephone. If we receive your complaint in writing, we will send you a letter confirming that we received the complaint within 5 calendar days of receiving your notice. This notification will tell you whom to contact should you have questions or would like to submit additional information about your complaint. We will investigate your complaint and will notify you of the outcome within 30 calendar days.

### 2. Appeals

If your grievance does not involve a complaint about the quality of service or care, a benefit interpretation or an eligibility issue, but instead involves dissatisfaction with the outcome of a decision that was made about your care and you want to request CIGNA Dental to reverse the previous decision, you should contact us within one year of receiving the denial notice to file a verbal or written appeal. Be sure to share any new information that may help justify a reversal of the original decision. Within 5 calendar days from when we receive your appeal, we will confirm with you, in writing, that we received it. We will tell you whom to contact at CIGNA Dental should you have questions or would like to submit additional information about your appeal. We will make sure your appeal is handled by someone who has authority to take action and who was not involved in the original decision. We will investigate your appeal and notify you of our decision, within 30 calendar days. You may request that the appeal process be expedited, if there is an imminent and serious threat to your health, including severe pain, potential loss of life, limb or major bodily function. A Dental Director for CIGNA Dental, in consultation with your treating dentist, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA Dental will respond orally and in writing with a decision within 72 hours.

### C. You Have Additional Rights Under State Law

CIGNA Dental is regulated by the California Department of Managed Health Care (DMHC or the "Department"). If you are dissatisfied with the resolution of your complaint or appeal, the law states that you have the right to submit the grievance to the department for review as follows:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-367-1037 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for



treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

You may file a grievance with the DMHC if CIGNA Dental has not completed the complaint or appeal process described above within 30 days of receiving your grievance. You may immediately file an appeal with CIGNA Dental and/or the DMHC in a case involving an imminent and serious threat to the health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the DMHC determines that an earlier review is warranted.

#### **D. Voluntary Mediation**

If you have received an appeal decision from CIGNA Dental that you are not satisfied with, you may also request voluntary mediation with us before exercising the right to submit a grievance to the DMHC. In order for mediation to take place, you and CIGNA Dental each have to voluntarily agree to the mediation. CIGNA Dental will consider each request for mediation on a case by case basis. Each side will equally share the expenses of the mediation. To initiate mediation, please submit a written request to the CIGNA Dental address listed above. If you request voluntary mediation, you may elect to submit your grievance directly to the DMHC after participating in the voluntary mediation process for at least 30 days.

For more specific information regarding these grievance procedures, please contact our Member Services Department.

### **VIII. Coordination of Benefits**

Coordination of benefit rules explain the payment process when you are covered by more than one dental plan. You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Coordination

of Benefits should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

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

### **IX. Disenrollment From the Dental Plan – Termination of Benefits**

Except for extensions of coverage as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan/termination of benefits and coverages will be as follows:

#### **A. For the Group**

The Dental Plan is renewable with respect to the Group except as follows:

1. for nonpayment of the required Prepayment Fees;
2. for fraud or other intentional misrepresentation of material fact by the Group;
3. low participation (i.e. fewer than ten enrollees);
4. if the Dental Plan ceases to provide or arrange for the provision of dental services for new Dental Plans in the state; provided, however, that notice of the decision to cease new or existing dental plans shall be provided as required by law at least 180 days prior to discontinuation of coverage; or
5. if the Dental Plan withdraws a Group Dental Plan from the market; provided, however, that notice of withdrawal shall be provided as required by law at least 90 days prior to the discontinuation and that any other Dental Plan offered is made available to the Group.

#### **B. For You and Your Enrolled Dependents**

The Dental Plan may not be canceled or not renewed except as follows:

1. failure to pay the charge for coverage if you have been notified and billed for the charge and at least 15 days have elapsed since the date of notification.
2. fraud or deception in the use of services or Dental Offices or knowingly permitting such fraud or deception by another.
3. your behavior is disruptive, unruly, abusive or uncooperative to such an extent that the Dental Plan or the Network Dental Office is materially impaired in its ability to provide services to you or another Member. CIGNA Dental will provide reasonable opportunities to transfer to another Dental Office prior to such termination. In the event of such



termination, CIGNA Dental will cooperate as needed to help you establish a relationship with a non-participating dental office.

4. you threaten the life or well-being of any Dental Plan employee, Network Dentist, Dental Office employee or another Member and the Dental Office is materially impaired in its ability to provide services to you. CIGNA Dental will provide reasonable opportunities to transfer to another Dental Office prior to such termination.

#### C. Termination Effective Date

The effective date of the termination shall be as follows:

1. In the case of nonpayment of Prepayment Fees, enrollment will be canceled as of the last day of the month in which payment was received, subject to compliance with notice requirements.
2. In the case of failure to meet eligibility requirements or for disruptive or threatening behavior described above, enrollment will be canceled as of the date of termination specified in the written notice, provided that at least 15 days have expired since the date of notification.
3. On the last day of the month after voluntary disenrollment.
4. Termination of Benefits due to fraud or deception shall be effective immediately upon receipt of notice of cancellation.

#### D. Effect on Dependents

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

For you and your Dependents, disenrollment will be effective the last day of the month in which Prepayment Fees are not paid to CIGNA Dental. CIGNA Dental will provide at least 15 days notice to your Group as to the date your coverage will be discontinued.

#### E. Right to Review

If you believe that your termination from the Dental Plan is due to your dental health status or requirements for dental care services, you may request review of the termination by the Director of the Department of Managed Health Care.

#### F. Notice of Termination

If the Group Contract is terminated for any reason described in this section, the notice of termination of the Group Contract or your coverage under the Group Contract shall be mailed by the Dental Plan to your Group or to you, as applicable. Such notice shall be dated and shall state:

1. the cause for termination, with specific reference to the applicable provision of the Group Contract or Plan Booklet;
2. the cause for termination was not the Subscriber's or a Member's health status or requirements for health care services;
3. the time the termination is effective;
4. the fact that a Subscriber or Member alleging that the termination was based on health status or requirements for health care services may request a review of the termination by the Director of the California Department of Managed HealthCare;
5. In instances of termination of the Group Contract for non-payment of fees, that receipt by the Dental Plan of any such past due fees within 15 days following receipt of notice of termination will reinstate the Group Contract as though it had never been terminated; if payment is not made within such 15 day period a new application will be required and the Dental Plan shall refund such payment within 20 business days;
6. any applicable rights you may have under the "Continuation of Benefits" Section.

#### X. Continuity of Care

If you are receiving care from a Network Dentist who has been terminated from the CIGNA Dental network, CIGNA Dental will arrange for you to continue to receive care from that dentist if the dental services you are receiving are for one of the following conditions:

- A. an acute condition. An acute condition is a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of the covered services shall be provided for the duration of the acute condition.
- B. a serious chronic condition. A serious chronic condition is a dental condition due to a disease, illness, or other dental problem or disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to a Network Dentist consistent with good professional practice, but not to exceed 12 months.
- C. performance of a surgery or other procedure that is



authorized by CIGNA Dental and has been recommended and documented by the terminated dentist to occur within 180 days of the effective date of termination of the dentist's contract.

CIGNA Dental is not obligated to arrange for continuation of care with a terminated dentist who has been terminated for medical disciplinary reasons or who has committed fraud or other criminal activities.

In order for the terminated Participating Provider to continue to care for you, the terminated dentist must comply with the CIGNA Dental's contractual and credentialing requirements and must meet the CIGNA Dental's standards for utilization review and quality assurance. The terminated dentist must also agree with CIGNA Dental to a mutually acceptable rate of payment. If these conditions are not met, CIGNA Dental is not required to arrange for continuity of care.

If you meet the necessary requirements for continuity of care as described above, and would like to continue your care with the terminated Dentist, you should call Member Services.

If you do not meet the requirements for continuity of care or if the terminated dentist refuses to render care or has been determined unacceptable for quality or contractual reasons, CIGNA Dental will work with you to accomplish a timely transition to another qualified Network Dentist.

## **XI. Continuation of Benefits (COBRA)**

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

## **XII. Individual Continuation of Benefits**

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

- permanent breakdown of the dentist-patient relationship,
- fraud or misuse of dental services and/or Dental Offices,
- nonpayment of Prepayment Fees by the Subscriber,
- selection of alternate dental coverage by your Group, or
- lack of network/service area.

Benefits and rates for CIGNA Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the CIGNA Dental Conversion Department at [1-800-367-1037] to obtain current rates and make arrangements for continuing coverage.

## **XIII. Confidentiality/Privacy**

CIGNA Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about CIGNA Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your member plan materials. You may obtain additional information about CIGNA Dental's confidentiality policies and procedures by calling Member Services at [1-800-367-1037], or via the Internet at [www.cigna.com](http://www.cigna.com).

**A STATEMENT DESCRIBING CIGNA DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.**

## **XIV. Miscellaneous**

### **A. Programs Promoting General Health**

As a CIGNA Dental plan member, you may be eligible for various benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at [www.cigna.com](http://www.cigna.com) for details.

### **B. Organ and Tissue Donation**

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. The California Health and Safety Code states that an anatomical gift may be made by one of the following ways:

- a document of gift signed by the donor.
- a document of gift signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the donor and of each other and state that it has been so signed.
- a document of gift orally made by a donor by means of a tape recording in his or her own voice.

One easy way individuals can make themselves eligible for organ donation is through the Department of Motor Vehicles (DMV). Every time a license is renewed or a new one is issued to replace one that was lost, the DMV will automatically send an organ donor card. Individuals



may complete the card to indicate that they are willing to have their organs donated upon their death. They will then be given a small dot to stick on their driver's license, indicating they have an organ donor card on file. For more information, contact your local DMV office and request an organ donor card.

**C. 911 Emergency Response System**

You are encouraged to use appropriately the '911' emergency response system, in areas where the system is established and operating, when you have an emergency medical condition that requires an emergency response.



## **CIGNA HealthCare of Connecticut, Inc.**

**CIGNA HealthCare of Connecticut, Inc.  
900 Cottage Grove Road  
Hartford, CT 06152-1118**

**CIGNA Dental Health, Inc.  
P.O. Box 189060  
Plantation, FL 33324-9060  
Phone: 1-800-367-1037**

**This Plan Booklet is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between CIGNA HealthCare of Connecticut, Inc. and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change.**

### **READ YOUR PLAN BOOKLET CAREFULLY**

**Please call Member Services at 1-800-367-1037 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.**

## **TABLE OF CONTENTS**

- I. Definitions**
- II. Introduction to Your CIGNA Dental Plan**
- III. Eligibility/When Coverage Begins**
- IV. Your CIGNA Dental Coverage**
  - A. Member Services**
  - B. Premiums/Prepayment Fees**
  - C. Other Charges - Patient Charges**
  - D. Choice of Dentist**
  - E. Your Payment Responsibility (General Care)**
  - F. Emergency Dental Care - Reimbursement**
  - G. Limitations on Covered Services**
  - H. Services Not Covered Under Your Dental Plan**
- V. Appointments**
- VI. Broken Appointments**
- VII. Office Transfers**



- VIII. Specialty Care**
- IX. Specialty Referrals**
  - A. In General**
  - B. Pediatric Dentistry**
  - C. Orthodontics**
- X. Complex Rehabilitation/Multiple Crown Units**
- XI. What To Do If There Is A Problem**
  - A. Start With Member Services**
  - B. Appeals Procedure**
- XII. Dual Coverage**
- XIII. Disenrollment From the Dental Plan - Termination of Benefits**
  - A. Time Frames For Disenrollment/Termination**
  - B. Effect On Dependents**
- XIV. Extension of Benefits**
- XV. Continuation of Benefits (COBRA)**
- XVI. Conversion Coverage**
- XVII. Confidentiality/Privacy**
- XVIII. Miscellaneous**

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## I. Definitions

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

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

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

Request 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. A licensed Dentist will make any such denial.

**CIGNA Dental** - CIGNA Dental Health, Inc., on behalf of CIGNA HealthCare of Connecticut, Inc. (said corporations are affiliates and are herein after referred to as "CIGNA Dental"), contracts with participating general dentists for the provision of dental care. CIGNA Dental Health, Inc. also provides management and information services to members and participating dental offices.

**Contract Fees** - The fees contained in the Network Specialty Dentist agreement with CIGNA Dental.

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

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

**Dental Plan** - Managed dental care plan offered through the Group Contract between CIGNA HealthCare of Connecticut, Inc. and your Group.

**Dependent** - Your lawful spouse;

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

- A. less than 19 years old; or
- B. less than 23 years old if he or she is both:
  1. a full-time student enrolled at an accredited educational institution, and

2. reliant upon you for maintenance and support; or
- C. any age if he or she is both:
1. incapable of self-sustaining employment due to mental or physical disability; and
  2. reliant upon you for maintenance and support.

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

For a child who falls into category (B.) or (C.) above, you will need to furnish CIGNA Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 19 and once a year thereafter during his or her term of coverage.

Coverage for Dependents living outside a CIGNA Dental service area is subject to the availability of an approved network where the Dependent resides.

This definition of "Dependent" applies unless it is modified by your State Rider or Group Contract.

**Group** - Employer, labor union or other organization that has entered into a Group Contract with CIGNA HealthCare of Connecticut, Inc. for managed dental services on your behalf.

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

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

**Network Specialty Dentist** - A licensed Dentist who has signed an agreement with CIGNA Dental under which he or she agrees to provide specialized dental care services, as outlined in Section VIII., upon payment authorization by CIGNA Dental Health.

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

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

**Premiums** - Fees that your Group remits to CIGNA HealthCare of Connecticut, Inc., on your behalf, during the term of your Group Contract.

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



**Subscriber/You** - The enrolled Employee or member of the Group.

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

## II. Introduction To Your CIGNA Dental Plan

Welcome to the CIGNA Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to CIGNA Dental or its designee for health plan operation purposes.

## III. Eligibility/When Coverage Begins

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

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

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order.

You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. CIGNA Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility, (except during open enrollment), or after disenrollment because of nonpayment of Premiums.

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

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

Additional information is available through your Benefits Representative.

## IV. Your CIGNA Dental Coverage

The information below outlines your coverage and will help

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

### A. 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 1-800-367-1037. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

### B. Premiums

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

### C. Other Charges - Patient Charges

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

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

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

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



#### D. Choice of Dentist

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

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

To obtain a list of Dental Offices near you, visit our website at [www.cigna.com](http://www.cigna.com) or call the Dental Office Locator at 1-800-367-1037. 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.

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

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

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

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

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

#### F. Emergency Dental Care - Reimbursement

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

your Service Area.

##### 1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or 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 Charges. To receive reimbursement, send appropriate reports and x-rays to CIGNA Dental at the address listed at the front of this booklet.

##### 2. Emergency Care After Hours

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

#### G. Limitations on Covered Services

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

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

2. **Specialty Care** - Payment authorization is required for coverage of services by a Network Specialist Dentist.

3. **Pediatric Dentistry** - Coverage for referral to a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 7th birthday.

4. **Oral Surgery** - The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

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

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

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA Dental prior approval (except emergencies,



as described in Section IV.F.)

3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. 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.
6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
7. general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist.
8. prescription drugs.
9. procedures, appliances or restorations if the main purpose is to:
  - a. change vertical dimension (degree of separation of the jaw when teeth are in contact);
  - b. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) unless TMJ therapy is specifically listed on your Patient Charge Schedule or if your Patient Charge Schedule ends in "-04" or a higher number; or
  - c. restore teeth which have been damaged by attrition, abrasion, erosion, and/or abfraction.
10. replacement of fixed and/or removable appliances that have been lost; stolen; or damaged due to patient abuse, misuse or neglect.
11. services associated with the placement or prosthodontic restoration of a dental implant.
12. services considered to be unnecessary or experimental in nature.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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 should be submitted to the medical carrier for benefit determination.)
15. services to the extent you or your enrolled Dependent is compensated under any group medical plan, no-fault auto insurance policy, or an insured motorist

policy.

16. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage.

In addition to the above, if your Patient Charge Schedule number ends in "-04" or a higher number, there is no coverage for the following.

17. crowns and bridges used solely for splinting.
18. resin bonded retainers and associated pontics.

## V. Appointments

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

## VI. Broken Appointments

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

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

## VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Member Services at 1-800-367-1037. To obtain a list of Dental Offices near your, visit our website at [www.cigna.com](http://www.cigna.com), or call the Dental Office Locator at 1-800-367-1037.

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

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

## VIII. Specialty Care

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



- Pediatric Dentists - Children's dentistry.
- Endodontists - Root canal treatment.
- Periodontists - Treatment of gums and bone.
- Oral Surgeons - Complex extractions and other surgical procedures.
- Orthodontists - Tooth movement.

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

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

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## IX. Specialty Referrals

### A. In General

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

When CIGNA Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.C, Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of CIGNA Dental's authorization. If you are unable to obtain treatment within the 90-day period, please call 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.

### B. Pediatric Dentistry

If your child up to age 7 needs to be treated by a Pediatric Dentist, contact your Network General Dentist for a specialty referral. Upon appropriate referral, your child may continue under the care of the Network Pediatric Dentist up to age 7 without additional referrals. If you need to change your child's Network Pediatric Dentist, you should return to your Network General Dentist for a new specialty referral up to the child's 7th birthday.

Your Network Pediatric Dentist must submit each specialty treatment plan to CIGNA Dental for payment authorization. CIGNA Dental standard payment authorization process as set out above will apply for services rendered by the Network Pediatric Dentist.

For children 7 years and older, your Network General Dentist will provide care. Exceptions for medical reasons may be considered on a case-by-case basis. For children over 7, if you continue to visit the Pediatric Dentist without a referral authorized for payment, you will be fully responsible for the Pediatric Dentist's Usual Fees.

### C. Orthodontics

#### 1. Definitions

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

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



and stabilize the new position of the teeth.

## 2. Patient Charges

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

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

## 3. Additional Charges

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

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

## 4. Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call Member Services at 1-800-367-1037 to find out if you are entitled to any benefit under the Dental Plan.

## X. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed 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 and bridge 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 and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

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

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

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

### A. Start With Member Services

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you may call 1-800-367-1037 toll-free and explain your concern to one of our Member Services Representatives. You can also express that concern in writing to CIGNA Dental at P.O. Box 189060, Plantation, FL 33318. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

### B. Appeals Procedure

CIGNA Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to CIGNA Dental within 1 year from the date of the initial CIGNA Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Member Services to register your appeal by calling 1-800-367-1037.

#### 1. Level One Appeals

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



consideration, under the authority of a Connecticut licensed dentist.

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

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, CIGNA Dental will respond orally with a decision within the lesser of 72 hours after the appeal is received, or 2 business day after the required information is received, followed up in writing.

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

## **2. Level Two Appeals**

To initiate a level two appeal, follow the same process required for a level one appeal. For postservice claim or administrative appeals, your request must be received before the 14th calendar day following our mailing of the level one determination. Level two appeals will be conducted by an Appeals Committee consisting of at least 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the Appeals Committee will include at least one Dentist. If specialty care is in dispute, the Appeals Committee will consult with a Dentist in the same or similar specialty as the care under review.

CIGNA Dental will acknowledge your appeal in writing and schedule an Appeals Committee review. The acknowledgment letter will include the name, address, and telephone number of the Appeals Coordinator. We may request additional information at that time. If your appeal concerns a denied preauthorization, the Appeals Committee review will be completed within 15 calendar days. For appeals concerning all other coverage issues, the Appeals Committee review will be completed within 60 calendar days after receipt of your original level one

request for appeal, unless you request an extension. If we receive a request for a Level Two appeal post service claim appeal on or after the 14th calendar day following our mailing of the level one determination: a. it will be deemed as a request by you for an extension; and b. the 60 day review period will be suspended on the 14th day we receive no Level Two appeal, then resume on the day we receive your Level Two appeal.

You may present your appeal to the Appeals Committee in person or by conference call. You must advise CIGNA Dental 5 days in advance if you or your representative plan to attend in person. You will be notified in writing of the Appeals Committee's decision within 5 business days after the meeting. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within the lesser of 72 hours or 2 business day after the required information is received, followed up in writing.

## **3. Appeals to the Commissioner of Insurance**

If coverage has been denied on the basis of dental necessity and you have exhausted the CIGNA Dental appeals process, you or a provider acting on your behalf, may within 30 days of receiving CIGNA Dental's final written determination, file a written appeal with the Connecticut Commissioner of Insurance. You may contact the Commissioner at the Connecticut Insurance Department, P.O. Box 816, Hartford, CT 06142-0816, Telephone 860-297-3910. Instructions and filing forms are available from the Connecticut Insurance Department at the above address or from the Department's website: [www.state.ct.us/cid](http://www.state.ct.us/cid). The appeal must include a \$25 filing fee and general release signed by you for all clinical records pertinent to the appeal. The Commissioner may waive the filing fee if you are unable to pay.

The Connecticut Insurance Department will assign an impartial external review entity to make a determination within 30 days (or longer if a review extension is granted by the Department and communicated to you). The external review decision



is binding on CIGNA Dental.

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

## **XII. Dual Coverage**

If you and your spouse are employed by the same employer and by reason of that employment are participating in this Dental Plan, you may be covered as an employee under this plan in addition to being covered as a Dependent.

If you or your Dependents have dental coverage through your spouse's employer or other sources, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

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

## **XIII. Disenrollment From the Dental Plan – Termination of Benefits**

### **A. Time Frames For Disenrollment/Termination**

Except as otherwise provided in the Sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan/Termination of benefits will occur on the last day of the month:

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

Area.

6. After voluntary disenrollment.

### **B. Effect on Dependents**

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

## **XIV. Extension of Benefits**

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

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

## **XV. Continuation of Benefits (COBRA)**

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

## **XVI. Conversion Coverage**

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

- permanent breakdown of the Dentist-patient relationship;
- fraud or misuse of dental services and/or Dental Offices;
- nonpayment of Premium/Prepayment Fees by the Subscriber;
- selection of alternative dental coverage by your Group, or
- lack of network/service area.

Benefits and rates for CIGNA Dental conversion coverage and



any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the CIGNA Dental Conversion Department at 1-800-367-1037 to obtain current rates and make arrangements for continuing coverage.

### **XVII. Confidentiality/Privacy**

CIGNA Dental is committed to maintaining the confidentiality of your personal and sensitive information. You may obtain additional information about CIGNA HealthCare's privacy policies and procedures by calling Member Services at 1-800-367-1037, or via the Internet at [www.cigna.com](http://www.cigna.com).

### **XVIII. Miscellaneous**

As a CIGNA Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at [www.cigna.com](http://www.cigna.com) for details.

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## **CIGNA Dental Health of Texas, Inc.**

6600 Campus Circle Drive East  
Suite 100  
Irving, Texas 75063

This Certificate of Coverage is intended for your information; and is included as a part of the agreement between CIGNA Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also be changed. Please read the following information so you will know from whom or what group of providers dental care may be obtained.

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

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

### **READ YOUR PLAN BOOKLET CAREFULLY**

**Please call Member Services at 1-800-367-1037 if you have any questions.**

**If you have a hearing or speech disability, please use your state Telecommunications Relay Service to call us. This service makes it easier for people who have hearing or speech disabilities to communicate with people who do not. Check your local telephone directory for your Relay Service's phone number.**



**CIGNA HealthCare**

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**IMPORTANT NOTICE**

To obtain information to make a complaint;

You may call CIGNA Dental Health's toll-free telephone number for information or to make a complaint at:

**1-800-367-1037**

You may also write to:

CIGNA Dental Health of Texas, Inc.  
6600 Campus Circle Drive, East.  
Suite 100  
Irving, TX 75063

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

**1-800-252-3439**

You may write the Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104, Fax No. (512) 475-1771.

**Claim Disputes:**

Should you have a dispute about a claim, you should contact CIGNA Dental Health first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

**Attach This Notice to Your Policy:**

This notice is for information only and does not become a part or condition of the attached document.



**AVISO IMPORTANTE**

Para obtener información o para someter una queja;

Usted pueda llamar al número de teléfono gratis de CIGNA Dental Health para información o para someter una queja al:

**1-800-367-1037**

Usted también puede escribir a:

CIGNA Dental Health of Texas, Inc.  
6600 Campus Circle Drive, East  
Suite 100  
Irving, TX 75063

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, de-rechos o quejas al:

**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas, P.O. Box 149104, Austin, TX 78714-9104, Fax No. (512) 475-1771.

**Disputas sobre reclamos:**

Si tiene una disputa concerniente a un reclamo, debe comunicarse primero con CIGNA Dental Health. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

**Adjunte este aviso a su póliza:**

Este aviso es sólo para propósito de información y no se convierte en parte o condición del documento adjunto.



TABLE OF CONTENTS

- I. Definitions**
- II. Introduction to Your CIGNA Dental Plan**
- III. Eligibility/When Coverage Begins**
- IV. Your CIGNA Dental Coverage**
  - A. Member Services**
  - B. Premiums**
  - C. Other Charges - Patient Charges**
  - D. Choice of Dentist**
  - E. Your Payment Responsibility (General Care)**
  - F. Emergency Dental Care - Reimbursement**
  - G. Limitations on Covered Services**
  - H. Services Not Covered Under Your Dental Plan**
- V. Appointments**
- VI. Broken Appointments**
- VII. Office Transfers**
- VIII. Specialty Care**
- IX. Specialty Referrals**
  - A. In General**
  - B. Pediatric Dentistry**
  - C. Orthodontics**
- X. Complex Rehabilitation/Multiple Crown Units**
- XI. What To Do If There Is A Problem**
  - A. Start With Member Services**
  - B. Appeals Procedure**
- XII. Dual Coverage**
- XIII. Disenrollment From the Dental Plan - Termination of Benefits**
  - A. Termination of Your Group**
  - B. Termination of Benefits For You and/or Your Dependents**
- XIV. Extension of Benefits**
- XV. Continuation of Benefits (COBRA)**
- XVI. Conversion Coverage**
- XVII. Confidentiality/Privacy**
- XVIII. Miscellaneous**



## I. Definitions

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

**Adverse Determination** - a determination that the dental care services furnished or proposed to be furnished to you or your Dependents are not clinically necessary or are not appropriate. Adverse Determinations do not affect services rendered by a Network General Dentist but apply only to limited specialty referral procedures. To be considered clinically necessary, the Specialty Referral Procedure must be reasonable and appropriate and meet the following requirements:

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

Requests for payment authorizations that are declined by CIGNA Dental based upon the above criteria will be the responsibility of the member at the Dentist's Usual Fees. A licensed Dentist will make any such denial.

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

**Contract Fees** - The fees contained in the Network Specialty Dentist Agreement with CIGNA Dental.

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

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

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

### **Dependent** -

Your lawful spouse;

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

- A. less than 25 years old; or
- B. any age if he or she is both:
  1. incapable of self sustaining employment due to mental or physical disability; and
  2. reliant upon you for maintenance and support.

A Dependent includes your grandchild if the child is your Dependent for federal income tax purposes at the time of application, or a child for whom you must provide medical support under a court order.

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

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

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

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

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

**Network Specialty Dentist** - A licensed Dentist who has signed an agreement with CIGNA Dental under which he or she agrees to provide specialized dental care services, as outlined in Section VIII, upon payment authorization by CIGNA Dental Health.

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

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

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

**Service Area** - The geographical area designated by CIGNA Dental within which it shall provide benefits and arrange for dental care services, as set out in the attached list of service areas.

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

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

## II. Introduction To Your CIGNA Dental Plan

Welcome to the CIGNA Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to CIGNA Dental or its designee for health plan operation purposes.



### III. Eligibility/When Coverage Begins

To enroll in the Dental Plan, you and your Dependents must live or work within the CIGNA Dental Service Area. Other eligibility requirements are determined by your Group.

If the legal residence of an enrolled Dependent is different from that of the Subscriber, the Dependent must:

- A. reside in the Service Area with a person who has temporary or permanent guardianship, including adoptees or children subject to adoption, and the Subscriber must have legal responsibility for that Dependent's health care; or
- B. reside in the Service Area, and the Subscriber must have legal responsibility for that Dependent's health care; or
- C. reside in the Service Area with the Subscriber's spouse; or
- D. reside anywhere in the United States when the Dependent's coverage is required by a medical support order.

If you or your Dependent becomes eligible for Medicare, you may continue coverage so long as you or your Medicare-eligible Dependent meet all other group eligibility requirements.

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

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order.

You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. CIGNA Dental may require evidence of good dental health to be provided at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

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

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which

you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

### IV. Your CIGNA Dental Coverage

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

#### A. 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 1-800-367-1037. The hearing impaired may contact Member Services through the State Relay Service located in your local telephone directory.

#### B. Premiums

Your Group sends a monthly fee to CIGNA Dental for members participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group. Your Premium is subject to annual change in accordance with your Group Contract. CIGNA Dental will give written notice to your Group of any change in Premiums at least 60 days before any change.

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#### C. Other Charges – Patient Charges

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

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



covered by your Dental Plan.

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

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

#### **D. Choice of Dentist**

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

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

To obtain a list of Dental Offices near you, visit our website at [www.cigna.com](http://www.cigna.com), or call the Dental Office Locator at 1-800-367-1037. 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.

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

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

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

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

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

#### **F. Emergency Dental Care - Reimbursement**

Emergency Dental Services are limited to procedures administered in a dental office, dental clinic or other comparable facility to evaluate and stabilize emergency dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson with average knowledge of dentistry to believe that immediate care is needed. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. **Emergency Care Away From Home** - If you have an emergency while you are out of your Service Area or 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.

To receive reimbursement, send appropriate reports and x-rays to CIGNA Dental at the address listed on the front of this booklet. CIGNA Dental Health will acknowledge your claim for emergency services within 15 days and will accept, deny, or request additional information within 15 business days of receipt. If CIGNA Dental Health accepts your claim, reimbursement for all appropriate emergency services will be made within 5 days of acceptance.

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

#### **F. ATENCIÓN DENTAL DE EMERGENCIA - REEMBOLSO**

Los servicios dentales de emergencia están limitados a procedimientos proporcionados en un consultorio dental, una clínica dental u otra instalación similar para evaluar y estabilizar condiciones dentales de emergencia de inicio reciente y de gravedad acompañadas por hemorragia



excesiva, dolor intenso o infección aguda que una persona con un nivel promedio de conocimientos en odontología considere que la atención inmediata es necesaria. Usted debe comunicarse con su Dentista general en la red si usted tiene una en su Área de servicio.

1. **Emergencia Lejos del Hogar** - Si se presenta una emergencia mientras usted está fuera de su Área de servicio o no le es posible comunicarse con su Dentista general en la red, usted puede recibir Servicios cubiertos de emergencia como se definen anteriormente de cualquier dentista general. Los procedimientos rutinarios de restauración o el tratamiento definitivo (es decir, tratamientos de la raíz del diente) no se consideran una atención de emergencia. Usted debe regresar a su Dentista general de la red para estos procedimientos. Para Servicios cubiertos de emergencia usted será responsable por los Cargos al paciente de su Tabla de cargos al paciente. CIGNA Dental le reembolsará la diferencia, si la hay, entre los Honorarios usuales del dentista por Servicios cubiertos de emergencia y su cargo al paciente.

Para recibir el reembolso, envíe los reportes y radiografía y lacudefias apropiados a CIGNA Dental a la dirección que aparece en la portada de este folleto. CIGNA Dental Health acusará recibo de su reclamación adicional dentro de un plazo de 15 días y aceptará, negará o solicitará información adicional dentro de un plazo de 15 días laborables. Si CIGNA Dental Health acepta su reclamación, el reembolso por todos los servicios de emergencia apropiados se realizará en un plazo de 5 días después de haberla recibido.

2. **Atención de emergencia después de horas asignadas** - Hay un Cargo al paciente indicado en su Tabla de cargos al paciente para atención de emergencia después de las horas asignadas del consultorio. Este cargo será además de cualquier otro Cargo al paciente.

#### G. Limitations on Covered Services

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

1. **Frequency** - The frequency of certain Covered Services, such as cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency. If your Network General Dentist certifies to CIGNA Dental that, due to medical necessity, you require certain Covered Services more frequently than the limitation allows, CIGNA Dental may waive the applicable limitation.
2. **Specialty Care** - Payment authorization is required for coverage of services by a Network Specialty

Dentist.

3. **Pediatric Dentistry** - Coverage for referral to a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 7th birthday.
4. **Oral Surgery** - The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

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

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

1. services not listed on the Patient Charge Schedule;
2. services provided by a non-Network Dentist without CIGNA Dental prior approval (except emergencies, as described in Section IV, F.);
3. services related to an occupational disease, injury or illness paid under workers' compensation or similar laws;
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid;
5. 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.
6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
7. general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and are provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist.
8. prescription drugs.
9. procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or c.\* restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.



10. replacement of fixed and/or removable appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. services associated with the placement or prosthodontic restoration of a dental implant.
12. services considered to be unnecessary or experimental in nature.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. 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.)
15. services to the extent you, or your enrolled Dependent, are compensated for them under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.
16. crowns and bridges used solely for splinting.\*
17. resin bonded retainers and associated pontics.\*

Preexisting conditions are not excluded if otherwise covered under your Patient Charge Schedule.

\*If you are on an "-03" Patient Charge Schedule, these exclusions do not apply.

## V. Appointments

To make an appointment with your Network General Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number (Social Security number or Employee ID number) and will check your eligibility.

## VI. Broken Appointments

The time your Network General 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 must change your appointment, please contact your Dentist at least 24 hours before the scheduled time.

## VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer at no charge. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Member Services at 1-800-367-1037. To obtain a list of Dental Offices near you, visit our

website at [www.cigna.com](http://www.cigna.com), or call the Dental Office Locator at 1-800-367-1037.

Your transfer will take about 5 days to process. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

Network Dentists are Independent Contractors. CIGNA Dental cannot require that you pay your Patient Charges before processing of your transfer request; however, it is suggested that all Patient Charges owed to your current Dental Office be paid prior to transfer.

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## VIII. Specialty Care

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

- Pediatric Dentists - Children's dentistry.
- Endodontists - Root canal treatment.
- Periodontists - Treatment of gums and bone.
- Oral Surgeons - Complex extractions and other surgical procedures.
- Orthodontists - Tooth movement.

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

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

## IX. Specialty Referrals

### A. In General

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

When CIGNA Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX, C, Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of CIGNA Dental's authorization. If you are unable to obtain treatment within the 90-day period, please call



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, you must 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 not pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the Dentist's Usual Fee.

## B. Pediatric Dentistry

If your child up to age 7 needs to be treated by a Pediatric Dentist, contact your Network General Dentist for a specialty referral. Upon appropriate referral, your child may continue under the care of the Network Pediatric Dentist up to age 7 without additional referrals. If you need to change your child's Network Pediatric Dentist, you should return to your Network General Dentist for a new specialty referral up to the child's 7th birthday.

Your Network Pediatric Dentist must submit each specialty treatment plan to CIGNA Dental for payment authorization. CIGNA Dental's standard payment authorization process as set out above will apply for services rendered by the Network Pediatric Dentist.

For children 7 years and older, your Network General Dentist will provide care. Exceptions for medical reasons may be considered on a case-by-case basis. For children over 7, if you continue to visit the Pediatric Dentist without a referral authorized for payment, you will be fully responsible for the Pediatric Dentist's Usual Fees.

## C. Orthodontics

1. **Definitions** - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the

following definitions apply:

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

### 2. Patient Charges

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

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

### 3. Additional Charges

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

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



4. **Orthodontics in Progress** - If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call Member Services at 1-800-367-1037 to find out if you are entitled to any benefit under the Dental Plan.

## **X. Complex Rehabilitation/Multiple Crown Units**

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown and/or bridge in the same treatment plan. Using full crowns (caps) and/or fixed 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 and bridge 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 and/or bridge PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

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

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

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

### **A. Start With Member Services**

We are here to listen and to help. If you have a question about your Dental Office or the Dental Plan, you can call the toll-free number to reach one of our Member Services Representatives. We will do our best to respond upon your initial contact or to get back to you as soon as possible, usually by the end of the next business day. You may call Member Services at 1-800-367-1037 or you may write P.O. Box 152266, Irving Texas 75015.

### **B. Appeals Procedure**

#### **1. Problems Concerning Plan Benefits, Quality of**

#### **Care, or Plan Administration**

The Dental Plan has a two-step procedure for complaints and appeals.

##### **a. Level One Review ("Complaint")**

For the purposes of this section, a complaint means a written or oral expression of dissatisfaction with any aspect of the Dental Plan's operation. A complaint is not (1) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up a misunderstanding to your satisfaction; nor (2) your or your provider's dissatisfaction or disagreement with an Adverse Determination.

To initiate a complaint, submit a request in writing to the Dental Plan stating the reason why you feel your request should be approved and include any information supporting your request. If you are unable or choose not to write, you may ask Member Services to register your request by calling the toll-free number.

Within 5 business days of receiving your complaint, we will send you a letter acknowledging the date the complaint was received, a description of the complaint procedure and time frames for resolving your complaint. For oral complaints, you will be asked to complete a complaint form to confirm the nature of your problem or to provide additional information.

Upon receipt of your written complaint or complaint form, Member Services will review and/or investigate your problem. Your complaint will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving clinical appropriateness will be considered by a dental professional. A written resolution will be provided to you within 30 calendar days. If applicable, the written resolution will include a statement of the specific dental or contractual reasons for the resolution, the specialization of any dentist consulted, and a description of the appeals process, including the time frames for the appeals process and final decision of the appeal. If you are not satisfied with our decision, you may request an appeal.

##### **b. Level Two Review ("Appeals")**

CIGNA Dental will acknowledge your appeal in writing within 5 business days. The acknowledgment will include the name, address,



and telephone number of the Appeals Coordinator. The review will be held at CIGNA Dental Health's administrative offices or at another location within the Service Area, unless you agree to another site.

Additional information may be requested at that time. Second level reviews will be conducted by an Appeals Committee, which will include:

- (1) An employee of CIGNA Dental Health;
- (2) A Dentist who will preside over the Appeals Panel; and,
- (3) An enrollee who is not an employee of CIGNA Dental Health.

Anyone involved in the prior decision may not vote on the Appeals Committee. If specialty care is in dispute, the Committee will include a Dentist in the same or similar specialty as the care under consideration, as determined by CIGNA Dental. The review will be held and you will be notified in writing of the Committee's decision within 30 calendar days.

CIGNA Dental will identify the Committee members to you and provide copies of any documentation to be used during the review no later than 5 business days before the review, unless you agree otherwise. You, or your designated representative if you are a minor or disabled, may appear in person or by conference call before the Appeals Committee; present expert testimony; and, request the presence of and question any person responsible for making the prior determination that resulted in your appeal. Please advise CIGNA Dental 5 days in advance if you or your representative plans to be present. CIGNA Dental will pay the expenses of the Appeals Committee; however, you must pay your own expenses, if any, relating to the Appeals process including any expenses of your designated representative.

The appeal will be heard and you will be notified in writing of the Committee's decision within 30 calendar days from the date of your request. Notice of the Appeals Committee's decision will include a statement of the specific clinical determination, the clinical basis and contractual criteria used, and the toll-free telephone number and address of the Texas Department of Insurance.

## **2. Problems Concerning Adverse Determinations**

### **a. Appeals**

For the purposes of this section, a complaint

concerning an Adverse Determination constitutes an appeal of that determination. You, your designated representative, or your provider may appeal an Adverse Determination orally or in writing. We will acknowledge the appeal in writing within 5 working days of receipt, confirming the date we received the appeal, outlining the appeals procedure, and requesting any documents you should send to us. For oral appeals, we will include a one-page appeal form.

Appeal decisions will be made by a licensed Dentist; provided that, if the appeal is denied and your Dentist sends us a letter showing good cause, the denial will be reviewed, by a specialty Dentist in the same or similar specialty as the care under review. The specialty review will be completed within 15 working days of receipt.

We will send you and your Dentist a letter explaining the resolution of your appeal as soon as practical but in no case later than 30 calendar days after we receive the request. If the appeals is denied, the letter will include:

- (1) the clinical basis for the denial;
- (2) the specialty of the Dentist making the denial; and
- (3) notice of the rights to seek review of the denial by an independent review organization and the procedure for obtaining that review.

### **b. Independent Review Organization**

If the appeal of an Adverse Determination is denied, you, your representative, or your provider have the right to request a review of that decision by an Independent Review Organization ("IRO".) The written denial outlined above will include information on how to appeal the denial to an IRO, and the forms that must be completed and returned to us to begin the independent review process.

In life-threatening situations, you are entitled to an immediate review by an IRO without having to comply with our procedures for internal appeals of Adverse Determinations. Call Member Services to request the review by the IRO if you have a life-threatening condition and we will provide the required information.

In order to request a referral to an IRO, the reason for the denial must be based on a dental necessity determination by CIGNA Dental. Administrative, eligibility or benefit coverage limits are not eligible for additional review under



this process.

**c. Expedited Appeals**

You may request that the above complaint and appeal process be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary.

Investigation and resolution of expedited complaints and appeals will be concluded in accordance with the clinical immediacy of the case but will not exceed 1 business day from receipt of the complaint. If an expedited appeal involves an ongoing emergency, you may request that the appeal be reviewed by a dental professional in the same or similar specialty as the care under consideration.

**d. Filing Complaints with the Texas Department of Insurance**

Any person, including persons who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may file a complaint in writing with the Texas Department of Insurance at P.O. Box 149091, Austin, Texas 78714-9091, or you may call their toll-free number, 1-800-252-3439.

The Department will investigate a complaint against CIGNA Dental to determine compliance with Insurance laws within 60 days after the Department receives your complaint and all information necessary for the Department to determine compliance. The Department may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- (1) additional information is needed;
- (2) an on-site review is necessary;
- (3) we, the Physician or provider, or you do not provide all documentation necessary to complete the investigation; or
- (4) other circumstances occur that are beyond the control of the Department.

CIGNA Dental cannot retaliate against a Network General Dentist or Network Specialty Dentist for filing a complaint or appealing a decision on your behalf. CIGNA Dental will not

cancel or refuse to renew coverage because you or your Dependent has filed a complaint or appealed a decision made by CIGNA Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a Dentist.

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**XII. Dual Coverage**

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

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

**XIII. Disenrollment From the Dental Plan - Termination of Benefits**

Except as otherwise provided in the Sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan/termination of benefits and coverages will be as follows:

**A. Termination of Your Group**

- 1. Due to nonpayment of Premiums, coverage shall remain in effect for 30 days after the due date of the Premium. If the late payment is received within the 30-day grace period, a 20% penalty will be added to the Premium. If payment is not received within the 30 days, coverage will be canceled on the 31st day and the terminated members will be liable for the cost of services received during the grace period.
- 2. Either the Group or CIGNA Dental Health may terminate the Group Contract, effective as of any renewal date of the Group Contract, by providing at least 60 days prior written notice to the other party.

**B. Termination of Benefits For You and/or Your**



### Dependents

1. The last day of the month in which premiums are not paid to CIGNA Dental.
2. The last day of the month in which eligibility requirements are no longer met.
3. The last day of the month after voluntary disenrollment.
4. Upon 15 days written notice from CIGNA Dental due to intentional material misrepresentation or fraud in the use of services or dental offices.
5. Immediately for misconduct detrimental to safe plan operations and delivery of services.
6. For failure to establish a satisfactory patient-dentist relationship, CIGNA Dental will give 30 days written notification that it considers the relationship unsatisfactory and will specify necessary changes. If you fail to make such changes, coverage may be canceled at the end of the 30-day period.
7. Upon 30 days notice, due to neither residing nor working in the Service Area. Coverage for a Dependent child who is the subject of a medical support order cannot be canceled solely because the child does not reside or work in the Service Area.

When coverage for one of your Dependents ends, you and your other Dependents may continue to be enrolled. When your coverage ends, your Dependents coverage will also end.

### XIV. Extension of Benefits

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

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

### XV. Continuation of Benefits (COBRA)

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

Under Texas law you may also choose continuation coverage for you and your Dependents if coverage is terminated for any

reason except your involuntary termination for cause and if you or your Dependent has been continuously covered for 3 consecutive months prior to the termination. You must request continuation coverage from your Group in writing and you must pay the monthly Premiums, in advance, within 31 days of the date your termination ends or the date your Group notifies you of your rights to continuation. If you elect continuation coverage, it will not end until the earliest of:

- A. 6 months after the date you choose continuation coverage;
- B. the date you and/or your Dependent becomes covered under another dental plan;
- C. the last day of the month in which you fail to pay Premiums; or
- D. the date the Group Contract ends.

You must pay your Group the amount of premiums plus 2% in advance on a monthly basis.

### XVI. Conversion Coverage

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

- A. permanent breakdown of the Dentist-patient relationship;
- B. fraud or misuse of dental services and/or Dental Offices;
- C. nonpayment of Premiums/Prepayment Fees by the Subscriber; or
- D. selection of alternate dental coverage by your Group.

Benefits for conversion coverage will be based on the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Premiums will be the CIGNA Dental conversion premiums in effect at the time of conversion. Conversion premiums may not exceed 200% of CIGNA Dental's premiums charged to groups with similar coverage. Please call the CIGNA Dental Conversion Department at 1-800-367-1037 to obtain current rates and to make arrangements for continuing coverage.

### XVII. Confidentiality/Privacy

CIGNA Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about CIGNA Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your member plan materials. You may obtain additional information about CIGNA Dental's confidentiality



policies and procedures by calling Member Services at 1-800-367-1037, or via the Internet at [www.cigna.com](http://www.cigna.com).

## XVIII. Miscellaneous

- A. As a CIGNA Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at [www.cigna.com](http://www.cigna.com).
- B. **Notice:** Any notice required by the Group Contract shall be in writing and shall be mailed with postage fully prepaid and addressed to the entities named in the Group Contract.
- C. **Incontestability:** All statements made by a Subscriber on the enrollment application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of the Subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, or refuse to renew an enrollee's coverage or to reduce benefits unless it is in a written enrollment application signed by you and a signed copy of the enrollment application is or has been furnished to you or your personal representative.
- This Certificate of Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.
- D. **Entire Agreement:** The Contract, Pre-Contract Application, amendments and attachments thereto represent the entire agreement between CIGNA Dental Health and your Group. Any change in the Group Contract must be approved by an officer of CIGNA Dental Health and attached thereto; no agent has the authority to change the Group Contract or waive any of its provisions. In the event this Certificate contains any provision not in conformity with the Texas Health Maintenance Organization Act (the Act) or other applicable laws, this Certificate shall not be rendered invalid but shall be construed and implied as if it were in full compliance with the Act or other applicable laws.

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**CIGNA Dental Health  
Texas Service Areas**

**Amarillo Area:**

Armstrong  
Briscoe  
Carson  
Castro  
Childress  
Collingsworth  
Dallam  
Deaf Smith  
Donley  
Gray  
Hall  
Hansford  
Hartley  
Hemphill  
Hutchinson  
Lipscomb  
Moore  
Ochiltree  
Oldham  
Parmer  
Potter  
Randall  
Roberts  
Sherman  
Swisher  
Wheeler

**Austin Area:**

Bastrop  
Caldwell  
Fayette  
Hays  
Travis  
Williamson

**Houston-Beaumont Area:**

Austin  
Brazoria  
Chambers  
Colorado  
Fort Bend  
Galveston  
Grimes  
Hardin  
Harris  
Jasper  
Jefferson  
Liberty  
Montgomery  
Newton  
Orange  
Polk  
San Jacinto  
Tyler  
Walker  
Waller  
Washington  
Wharton

**San Angelo Area:**

Coke  
Concho  
Irion  
Menard  
Runnels  
Schleicher  
Sterling  
Tom Greene

**Lubbock Area:**

Bailey  
Borden  
Cochran  
Cottle  
Crosby  
Dawson  
Dickson  
Floyd  
Gaines  
Garza  
Hale  
Hockley  
Kent  
King  
Lamb  
Lubbock  
Lynn  
Motley  
Scurry  
Stonewall  
Terry  
Yoakum

**Lufkin Area:**

Angelina  
Houston  
Leon  
Madison  
Nacogdoches  
Sabine  
San Augustine  
Shelby  
Trinity

**Fort Worth Area:**

Clay  
Collin  
Cooke  
Dallas  
Denton  
Ellis  
Fannin  
Grayson  
Hill  
Hood  
Hunt  
Jack  
Johnson  
Kaufman  
Montague  
Navarro  
Parker  
Rockwall  
Somerville  
Tarrant  
Wise

**Brownsville, McAllen,**

**Laredo Area:**

Cameron  
Dimmit  
Hidalgo  
Jim Hogg  
LaSalle  
Starr  
Web  
Willacy  
Zapata



**Tyler/Longview Area:**

Anderson  
Cherokee  
Camp  
Cass  
Franklin  
Gregg  
Harrison  
Henderson  
Hopkins  
Marion  
Morris  
Panola  
Rains  
Rusk  
Smith  
Titus  
Upshur  
Van Zandt  
Wood

**Victoria Area:**

Aransas  
Bastrop  
Calhoun  
DeWitt  
Jackson  
Lavaca  
Lee  
Matagorda  
Victoria

**College Station-Bryan Area:**

Brazos  
Burlison  
Madison

**Abilene Area:**

Brown  
Callahan  
Coleman  
Comanche  
Eastland  
Fisher  
Hamilton  
Llano  
Jones  
Mason  
McCulloch  
Mills  
Mitchell  
Nolan  
San Saba  
Shackelford  
Taylor

**Waco Area:**

Bell  
Bosque  
Burnet  
Coryell  
Falls  
Freestone  
Lampasas  
Limestone  
McClennan  
Milam  
Robertson

**Texarkana Area:**

Bowie  
Delta  
Lamar  
Red River

**San Antonio Area:**

Atascosa  
Bandera  
Bexar  
Blanco  
Comal  
Frio  
Gillespie  
Gonzales  
Guadalupe  
Karnes  
Kendall  
Kerr  
Medina  
Wilson

**Corpus Christi Area:**

Bee  
Brooks  
Duval  
Goliad  
Jim Wells  
Kennedy  
Kleberg  
Live Oak  
McMullen  
Nueces  
Refugio  
San Patricio

**El Paso Area:**

Culberson  
El Paso  
Hudspeth  
Jeff Davis  
Reeves

**Wichita Falls Area:**

Archer  
Baylor  
Erath  
Foard  
Hardeman  
Haskell  
Knox  
Palo Pinto  
Stephins  
Throckmorton  
Wichita  
Wilbarger  
Young

**Midland Odessa Area:**

Andrews  
Crane  
Ector  
Glasscock  
Howard  
Loving  
Martin  
Midland  
Reagan  
Upton  
Ward  
Winkler





## **CIGNA Dental Care – CIGNA Dental Health Plan**

This section describes the CDC Rider(s) for residents of the following states: AZ, CA, CO, CT, DE, FL, KS/NE, KY, MD, MO, NJ, NC, OH, PA, TX, VA

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## Domestic Partner Rider

The following definition of Domestic Partner applies:

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

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

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

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

This insert contains CIGNA Dental's standard Domestic

Partner definition. Your Group may have purchased one or both coverages (same/opposite sex partners). Consult your Group Contract for additional information.

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

Virginia Residents: Domestic Partner coverage is not available.

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## **Your Rights Under Federal Law**

As a participant in your CIGNA Dental plan, you are entitled to certain rights and protections under federal laws. This is a summary of those laws and the things you need to know.

Please call Member Services at 1-800-367-1037 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.



**TABLE OF CONTENTS**

**I. Employee Retirement Income Security Act of 1974 (ERISA)**

- What is ERISA?
- ERISA Entitles You to Receive Information About Your Plan and Benefits
- ERISA Allows you and/or Your Dependent(s) to Continue Group Dental Plan Coverage
- ERISA Requires Prudent Actions by Plan Fiduciaries
- ERISA Allows You to Enforce Your Rights
- ERISA Requires Disclosure About Your Plan
- The Plan Sponsor Has the Right to Modify, Amend or Terminate your Plan
- Effect of Plan Termination
- Procedures Regarding Medical Necessity Determinations
- Preservice Medical Necessity Determinations
- Postservice Medical Necessity and Postservice Claim Determination
- Notice of Adverse Determination
- Assistance With Your Questions

**II. Notice of Federal Requirements Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

- What is USERRA?
- USERRA Allows You to Reinstate Your Benefits
- USERRA Sets Time Frames for Requesting Reemployment

**III. Requirements of the Family and Medical Leave Act of 1993 (FMLA)**

- What is FMLA?
- Continuation of Dental Insurance During Leave
- Reinstatement of Canceled Insurance Following Leave

**IV. Continuation Required by the Consolidated Omnibus Budget Reconciliation Act (COBRA)**

- What is COBRA?
- Employees and Dependents Continuation Provision
- Dependent Continuation Provision
- Subsequent Events Affecting Dependent Coverage
- Disabled Individuals Continuation Provisions
- Effect of Employer Chapter 11 Proceedings on Retiree Coverage
- Payment of Premium
- Providing Notification of Status to Providers During the Grace Period
- Notification Requirements
- Conversion Available Following Continuation
- Notification Requirements
- Conversion Available Following Continuation
- Interaction With Other Continuation Benefits
- Newly Acquired Dependents

**V. Notice of Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93)**



What is OBRA?

What is a Qualified Medical Child Support Order?

When Your Natural Child is Eligible for Coverage

When Your Adopted/Placed for Adoption Child is Eligible for Coverage

Payment of Benefits

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## **I. Employee Retirement Income Security Act of 1974 (ERISA)**

**The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.**

### **What is ERISA?**

ERISA is a federal law which governs different aspects of health and welfare plans including:

- Summary Plan Descriptions;
- Claim payments;
- Appeals procedures; and
- Reporting requirements.

Although most plans are subject to ERISA, some plans which are exempt include: (1) tax-exempt church employee groups; (2) state, local and federal government employee groups; (3) trust and association plans not funded by employers and plans maintained outside the U.S. for nonresident aliens. Exempt plans may also choose to be subject to ERISA. To be sure your plan is subject to ERISA, you should check with your Plan Administrator.

If your plan is subject to ERISA, you are afforded the following rights:

### **ERISA Entitles You to Receive Information About Your Plan and Benefits**

- to examine all documents governing the Plan at the Plan Administrator's office and at other specified locations, such as worksites and union halls, 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 Pension and Welfare Benefit Administration. This is available at no charge.
- to obtain, upon written request to the Plan Administrator, copies of all documents governing the Plan. There may be a charge for copies.
- to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

### **ERISA Allows You and/or Your Dependent(s) to Continue Group Dental Plan Coverage**

- to continue dental care coverage for yourself, your spouse or your 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.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group dental plan. You should be provided a certificate of creditable coverage, free of charge, from your group dental plan or issuer when you lose coverage under the Plan, when you

become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **ERISA Requires 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 other 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, in whole or in part, you have the 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.

### **ERISA Allows You to Enforce Your Rights**

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

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

### **ERISA Requires Disclosures About Your Plan**

If your plan is an ERISA plan, your Plan Administrator is required to include the following information in the Summary Plan Description:

- the name of the plan;



- the name, address zip code and business telephone number of the sponsor of the Plan;
- Employer Identification Number (EIN);
- the name, address, zip code and business telephone number of the Plan Administrator;
- the name, address and zip code of the person designated as agent for the service of legal process;
- the cost of the Plan; and
- the Plan's fiscal year ending date.

**The Plan Sponsor Has the Right to Modify, Amend or Terminate Your Plan**

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of Employees to be covered by the Plan, to amend or eliminate any other plan term or condition and to terminate the whole Plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of Employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator. No consent of any participant is required to terminate, modify, amend or change the Plan.

**Effect of Plan Termination**

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 dental expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to your 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 dental 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 effect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the last day of the calendar month in which you leave Active Service;
- the date you are no longer in an eligible class; if the Plan is contributory, the date you cease to contribute; or
- 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.

**Claim Determination Procedures Under ERISA:  
Procedures Regarding Medical Necessity Determinations**

In general, dental services and benefits must be medically necessary to be covered under the Plan. The procedures for determining the medical necessity vary, according to the type of service and benefit requested, and the type of dental plan. Medical necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below. When services or benefits are determined not to be medically necessary, you or your representative will receive a written description of the adverse determination. Appeals procedures are described in your booklet, in your provider's network participation documents and in the determination notices.

**Preservice Medical Necessity Determinations**

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." When you or your representative request a required medical necessity determination prior to care, we will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond our control, we will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 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 us within 45 days after receiving the notice. The determination period will be suspended on the date we send such a notice of missing information, and the determination will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Dentist with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, we will make the preservice determination on an expedited basis. Our Dental reviewer, in consultation with the treating Dentist, will decide if an expedited appeal is necessary. We will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, we will notify you or your representative within 24 hours after receiving the request to specify what information is needed.

You or your representative must provide the specified information to us within 48 hours after receiving the notice. We will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited



determinations may be provided orally, unless you or your representative requests written notification.

**Postservice Medical Necessity and Postservice Claims Determinations**

When your or your representative requests a medical necessity determination after services have been rendered or requests payment for services which have been rendered, we 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 our control, we 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 us within 45 days after receiving the notice. The determination period will be suspended on the date we send such a notice of missing information, and the determination 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 the statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal;
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit;
- in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

**Assistance With Your Questions**

If you have any questions about your Plan, you should contact your 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

Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

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**II. Notice of Federal Requirements Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

**What is USERRA?**

USERRA sets requirements for continuation and reinstatement of your and/or your Dependent's dental coverage and reemployment in regard to military leaves of absence.

Leaves are as follows:

For leaves of less than 31 days, coverage will continue as described in the "Termination" section of your plan booklet or certificate.

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:

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

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

Following continuation of dental coverage per USERRA requirements, you may convert to a plan of coverage as outlined in your plan booklet or certificate.

**USERRA Allows You to Reinstatement Your Benefits**

If your coverage ends during the leave 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 Dependent(s) may be reinstated if:

- you gave your Employer advance written or verbal notice of your military leave; and
- the duration of all military leaves while you are employed with your current Employer does not exceed five years.

You and your Dependent(s) will be subject to only the balance of a preexisting condition limitation or waiting period that was



not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, full plan limitations will apply. Any 63-day break in coverage regarding credit for time accrued toward a preexisting condition limitation waiting period will be waived.

**USERRA Sets Timeframes for Requesting Reemployment**

When a leave ends, you must report your intent to return to work as follows:

- for leaves of less than 31 days or for a fitness exam by reporting to your Employer by the next regularly scheduled work day following 8 hours of travel time;
- for leaves of 31 days or more but less than 181 days by submitting an application to your Employer within 14 days; and
- for leaves of more than 181 days, by submitting an application to your Employer within 90 days.

Consult your Employer for more details regarding your rights and your Employer's obligations for reemployment. This section will be superseded in whole or in part by any richer state-required provision shown in you plan booklet or certificate.

**III. Requirements of Family and Medical Leave Act of 1993 (FMLA)**

**Any provisions of the policy that provide for continuation of insurance during a leave of absence and reinstatement of coverage following a leave of absence is superseded by the FMLA provisions below.**

**What is FMLA?**

In general, FMLA provides an entitlement of up to 12 weeks of job-protected (state laws may allow more time), unpaid leave during any 12 months for:

- the birth and care of the Employee's child or placement for adoption or foster care of a child with the Employee;
- to care for an immediate family member (spouse, child, parent) who has a serious health condition; or
- for the Employee's own serious health condition.

**Continuation of Dental Insurance During Leave**

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

- that leave qualifies as a leave of absence under FMLA; and
- you are an eligible Employee under the terms of that Act.

The cost of your dental insurance during such leave of absence must be paid, whether by your Employer or 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 FMLA, any canceled insurance (health, dental, life or disability) will be reinstated as of the

date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirement of any Preexisting Condition Limitation to the extent that they have been satisfied prior to start of such leave of absence. Your Employer will give you detailed information about FMLA if you choose to take a leave of absence.

**IV. Continuation Required by the Consolidated Omnibus Budget Reconciliation Act (COBRA)**

**The Continuation required by federal law does not apply for any benefits for loss of life, dismemberment or loss of income and is only available for certain groups. Please contact your Plan Administrator concerning COBRA eligibility under your Plan.**

**What is COBRA?**

COBRA is a federal law that enables you or your Dependent to continue dental insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue dental insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group plan(s) and is subject to federal law, regulations and interpretations.

**Employees and Dependents Continuation Provision**

If you or your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of:

- the date the reduction of your work hours are reduced or your termination of employment;
- the date the notice of the right to continue insurance is sent; or
- the date the insurance would otherwise cease.

You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by us for you and/or your Dependents, as applicable beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;



- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group dental plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

#### **Dependent Continuation Provision**

If dental insurance for your Dependents would otherwise cease because of:

1. your death;
2. divorce or legal separation; or
3. with respect to a Dependent child, failure to continue to qualify as a Dependent, such insurance may be continued upon payment of the required premium to the Employer. In the case of 2. or 3. above, you or your Dependent must notify your Employer within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

We will not continue the dental insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of 1., 2., or 3. above, whichever occurs first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group dental plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

#### **Subsequent Events Affecting Dependent Coverage**

If, within the initial 18-month continuation period, your Dependent would lose coverage because of an event described in 1, 2, or 3 above, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment or your work hours are reduced.

#### **Disabled Individuals Continuation Provisions**

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follows termination of employment or a reduction in work hours, the disabled person may continue dental insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in b., below.

To be eligible you or your Dependent must:

- a. be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and
- b. notify the Plan Administrative of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described above which apply to the initial 18 months will also apply to all or any covered persons for any additional months of coverage.

#### **Effect of Employer Chapter 11 Proceeding on Retiree Coverage**

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

#### **Payment of Premium**

COBRA plans may require the payment of an amount that does not exceed 102% of the applicable premium, except the



Plan may require payment of up to 150% of the applicable premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable premium is determined as follows:

- if the Employee alone elects to continue coverage, the Employer will be charged the active Employee rate;
- if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate;
- if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active Employee rate;
- if the entire family elects to continue coverage, they will be charged the family rate;
- if the Schedule of Premium Rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue his coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

If payment of premium is made within the grace period in an amount not significantly less than the amount the plan requires to be paid, the amount must be deemed to satisfy the plan's requirement. However, you must be notified and allowed at least 30 days after the notice is provided for payment to be made.

#### **Providing Notification of Status to Providers During the Grace Period**

If, after you elect to continue coverage, dental care provider contacts your Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

#### **Notification Requirements**

Your Employer should send your initial notification of coverage continuation rights as required by federal law when:

- when the Plan first becomes subject to federal continuation requirements;
- when you are hired; and
- when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage

under the Plan, you or your Dependent spouse must notify your Employer within 60 days of such event. Your Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

#### **Conversion Available Following Continuation**

If you or your Dependent's continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the dental conversion benefit then available to Employees and their Dependents.

#### **Interaction With Other Continuation Benefits**

A person who is eligible to continue insurance under both federal law and state law may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in your plan booklet or certificate.

#### **Newly Acquired Dependents**

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this continuation provided:

- the required premium is paid; and
- we are notified of your newly acquired Dependent in accordance with the terms of the policy.

If your death, divorce or legal separation subsequently occurs for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If your child who is born, adopted or placed for adoption as a newly acquired Dependent subsequently fails to continue to qualify as a Dependent, coverage would only be continued as stated in the Dependent Continuation Provision above.

### **V. Notice of Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93)**

#### **What is OBRA?**

OBRA requires that any group dental plan which provides coverage for Dependent children of plan participants, must provide benefits to Dependent children placed with participants for adoption under the same terms and conditions as apply in the case of Dependent children who are "natural" children of participants under the plan. OBRA also provides eligibility for Dependents under Qualified Medical Child Support Orders.

These coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income. Any other provisions in your plan booklet or certificate that provide for:



- the definition of an adopted child and the effective date of eligibility for coverage of that child; and
- eligibility requirements for a child for whom a court order for medical support is issued are superseded by these provisions required by OBRA '93, as amended.

#### **What is a Qualified Medical Child Support Order?**

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 health benefit coverage to such child and relates to benefits under the group health plan and satisfies all 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 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 Qualified Medical Child Support Order may not require the policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with state laws regarding child dental care coverage.

#### **When Your Natural Child is Eligible for Coverage**

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and 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, within 31 days of the Qualified Medical Child Support Order being issued.

#### **When Your Adopted/Placed for Adoption Child is Eligible for Coverage**

Any child under the age of 18 who is adopted by you, including a child who is placed for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support your child, totally or partially, prior to that child's adoption. If the child placed for adoption is not adopted, all coverage ceases when the

placement ends and will not be continued.

#### **Payment of Benefits**

Any payment of benefits in reimbursement for Covered Expenses paid by the child, 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.

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