

County of San Bernardino

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: January 1, 2013

CN001
3335755

This document printed in January, 2012 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Certification	5
Important Notices	7
Accident and Health Provisions	7
Eligibility - Effective Date	7
Employee Insurance	7
Important Information about Your Dental Plan	8
Your CIGNA Dental Coverage	8
Coordination of Benefits	12
Expenses For Which A Third Party May Be Liable	15
Payment of Benefits	15
Termination of Insurance	15
Employees	15
Dependents	16
Dental Benefits Extension	16
Federal Requirements	16
Notice of Provider Directory/Networks.....	16
Qualified Medical Child Support Order (QMCSO)	16
Coverage of Students on Medically Necessary Leave of Absence.....	17
Eligibility for Coverage for Adopted Children.....	17
Group Plan Coverage Instead of Medicaid.....	17
COBRA Continuation Rights Under Federal Law	18
Notice of an Appeal or a Grievance	20
When You Have A Complaint or an Appeal	20
Definitions	22
CIGNA Dental Care – CIGNA Dental Health Plan	26
The certificate and the state specific riders listed in the next section apply if you are a resident of one of the following states: AZ, CO, DE, FL, KS/NE, MD, NC, OH, PA, VA.....	26
State Rider CIGNA Dental Health Plan of Arizona, Inc.	36
State Rider CIGNA Dental Health of Colorado, Inc.	38
State Rider CIGNA Dental Health of Florida, Inc.	39
State Rider CIGNA Dental Health of Maryland, Inc.	40
State Rider CIGNA Dental Health of Ohio, Inc.	44
State Rider CIGNA Dental Health of Pennsylvania, Inc.	47
CIGNA Dental Care – CIGNA Dental Health Plan	49
The certificate(s) listed in the next section apply if you are a resident of one of the following states: CA, CT, KY, MO, NJ, TX	49

CIGNA Dental Health of California, Inc.	50
CIGNA HealthCare of Connecticut, Inc.	70
CIGNA Dental Health of Kentucky	82
CIGNA Dental Health of Missouri, Inc.	92
CIGNA Dental Health of New Jersey, Inc.	103
CIGNA Dental Health of Texas, Inc.	114
CIGNA Dental Care – CIGNA Dental Health Plan	133
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.....	133
Domestic Partner Rider	134
This definition of Domestic Partner applies to residents of: AZ, CA, CO, CT, DE, FL, KS/NE, KY, MD, NC, OH, PA, TX, VA.	134
Domestic Partner Rider	135
This definition of Domestic Partner applies to residents of: MO.	135
Domestic Partner Rider	136
This definition of Domestic Partner applies to residents of: NJ.	136

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: County of San Bernardino

GROUP POLICY(S) — COVERAGE
3335755 - DHMO CIGNA DENTAL CARE INSURANCE

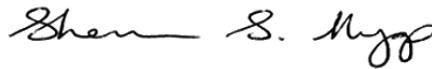
EFFECTIVE DATE: January 1, 2013

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.



Shermona Mapp, 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

Nevada Division of Insurance

You can contact the Nevada Division of Insurance at the following:

The Department of Business Industry, Division of Insurance

Toll free number: (888) 872-3234

Hours of operation of the division: Mondays through Fridays from 8:00 a.m. until 5:00 p.m., Pacific Standard Time (PST).

If you have local telephone access to the Carson City and Las Vegas offices of the Division of Insurance, you should call the local numbers.

Local telephone numbers are: Carson City, **702-687-4270** and Las Vegas, **702-486-4009**

GM6000 NOT242

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 PRO1V3

CLA43V20

Eligibility - Effective Date

Eligibility for Employee Insurance

You will become eligible for insurance on the date you retire.

To enroll, you must complete and submit the County's Dental Plan Enrollment/Change Form to the Plan Administrator. The Dental Plan Enrollment/Change Form must include the enrolling Retiree's and eligible Spouse or Domestic Partner and Dependent's name, Social Security number, address, telephone number and other information deemed necessary by the Plan. Upon enrollment, the Enrollee promises and agrees to pay the required Retiree Contribution for coverage.

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.

Classes of Eligible Employees

Each retired Employee as reported to the insurance company by your former Employer.

GM6000 EL 2

V-31

ELI5

Employee Insurance

This Plan is offered to you as a Retiree. To be insured, you will have to pay part of the cost.



Effective Date of Your Insurance

The date coverage is effective is governed by the established enrollment and Premiums payment procedures established by the County of San Bernardino

GM6000 ELI7V135

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

The date coverage is effective is governed by the established enrollment and Premiums payment procedures established by the County of San Bernardino. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

GM6000 EF 2

V-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

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

Your CIGNA Dental Coverage

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

Member Services

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

Other Charges – Patient Charges

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

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

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

Choice of Dentist

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

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Member Services at 1-800-Cigna24 for a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 7 to a network Pediatric Dentist, the network Pediatric Dentist’s office will have primary responsibility for your child’s care. Your Network General Dentist will provide care for children 7



years and older. If your child continues to visit the Pediatric Dentist after his/her 7th birthday, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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

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

Your Payment Responsibility (General Care)

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

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

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

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

Emergency Dental Care – Reimbursement

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

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, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to CIGNA Dental at the address listed for your state on the front of this booklet.

2. Emergency Care After Hours

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

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. Pediatric Dentistry** – Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
- 3. Oral Surgery** – The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- 4. Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- 5. Clinical Oral Evaluations** - Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

General Limitations – Dental Benefits

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

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



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

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's prior approval (except in emergencies).
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) unless the service is specifically listed on your Patient Charge Schedule (PCS). If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; other types of bleaching methods are not covered.
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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
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 conditions or disorders 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 higher; or c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or d. restore the occlusion.
10. replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. surgical placement of a dental implant; repair, maintenance or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
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. the completion of crowns, bridges, dentures, root canal treatment, or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your CIGNA Dental coverage.
16. consultations and/or evaluations associated with services that are not covered.
17. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
18. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
19. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
20. services performed by a prosthodontist.
21. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
22. infection control and/or sterilization. CIGNA Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
23. the recementation of any inlay, onlay, crown, post and core, fixed bridge or implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. CIGNA Dental considers



recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

24. services to correct congenital malformations, including the replacement of congenitally missing teeth.
25. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
26. crowns, bridges and/or implant supported prosthesis used solely for splinting.
27. resin bonded retainers and associated pontics.

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

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

Appointments

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

Broken Appointments

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

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

Office Transfers

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

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

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

Specialty Care

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

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

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

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

Specialty Referrals

In General

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

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

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

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

When your Network General Dentist determines that you need specialty care and a Network Specialist is not available, as determined by CIGNA Dental, CIGNA Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such



cases, you will be responsible for the applicable Patient Charge for Covered Services. CIGNA Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

Orthodontics (This section is only applicable if Orthodontia is listed on your Patient Charge Schedule.)

Definitions –

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

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.

Additional Charges

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

- incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- orthognathic surgery and associated incremental costs;
- appliances to guide minor tooth movement;
- appliances to correct harmful habits; and

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

Orthodontics in Progress

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

Complex Rehabilitation/Multiple Crown Units

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

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

GM6000 DEN210

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 which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- (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.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and 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

v7

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:

- (1) 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.

- (2) 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.
- (3) 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.
- (4) 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, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

GM6000 COB12

Reasonable Cash Value

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

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 you as a Dependent shall be the Secondary Plan;
- (2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;



- (3) If you are 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 parent not having custody of the child, and
 - (e) finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

- (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) CG'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, CG 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 will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, 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 pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15



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:

1. 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.
2. 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:
 - a. the amount actually paid for such Covered Expenses by CG; or
 - b. the amount you actually receive from the third party for such Covered Expenses;
 at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

GM6000 CCP7

CCL7

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 POB5

V-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

Miscellaneous

If you are a CIGNA Dental plan member you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

GM6000 POB8 V4

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the last day of the month for which a retiree contribution was made for coverage;
- the last day of the month for which a Premium is paid for your coverage;
- the date dental Benefits for Retirees is no longer offered;
- the date the policy is canceled.

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

GM6000 TRM15

V3



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 of the month for which a retiree contribution was made for coverage;
- 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 commences while the person is insured and the expenses are incurred within 60 days after his insurance ceases.

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

GM6000 BEX184

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

v2

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

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

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

FDRL79

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.

FDRL.2

v1

Coverage of Students on Medically Necessary Leave of Absence

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

- The date that is one year after the first day of the medically necessary leave of absence; or

- The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A “medically necessary leave of absence” is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: starts while the child is suffering from a serious illness or condition; is medically necessary; and causes the child to lose student status under the terms of the plan.

FDRL.80

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.

FDRL.6

Group Plan Coverage Instead of Medicaid

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

FDRL.75



COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, 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. 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. Your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

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: 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).

FDRL85

If you retire and you became enrolled in Medicare (Part A, Part B or both) within the 18 months retirement, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare.

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

V1

Employer’s Notification Requirements

Your former 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 or your dependents must notify the Plan Administrator of the 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 proper notification by the due date shown on the notice, your Dependents will lose the right to elect COBRA continuation coverage. If COBRA continuation coverage is rejected before the due date, your Dependents may change their mind as long as they 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.

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. For example:

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

V2

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.

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, 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.

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

V1

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.

FDRL82

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

The Following Will Apply To Residents of Nevada

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 your concern, we will get back to you as soon as possible, but in any case within 30 days.

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

Appeals Procedure

CG has a two step appeals procedure for coverage decisions. 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.

GM6000 APL296

V1

Level One Appeal

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.

For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. 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 to complete the review.

GM6000 APL297

V1

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start 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 at least 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 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 APL298

V2

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level two appeal review denial. CG will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CG's Dentist reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

Appeal to the State of Nevada

You have the right to contact the Consumer Service Section for assistance at any time. The Consumer Service Section may be contacted at the following address and telephone number:

For Carson City:
788 Fairview Dr. #300
Carson City, NV 89701
1-888-872-3234

For Las Vegas:
2501 E. Sahara Ave. #302
Las Vegas, NV 89104
1-888-872-3234

GM6000 APL299

V2

Notice of Benefit Determination on Appeal

Every notice of a determination on 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; (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 any voluntary appeal procedures offered by the plan and 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.



You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. 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 APL300

Definitions

Adverse Determination

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

- be consistent with the symptoms, diagnosis or treatment of the condition present;
- conform to commonly accepted standards of treatment;
- not be used primarily for the convenience of the member or provider of care; and

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

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

DFS1946

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

Contract Fees

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

DFS1947

Covered Services

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

DFS1948

Dental Office

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

DFS1949

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; or
- your Domestic Partner; and
- any unmarried child of yours who is
 - less than 26 years old;
 - 26 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 an adopted child from the earlier of: (a) the date the adoption becomes effective; or (b) the first day of the child's placement in the home. A Pre-existing Condition Limitation will not apply to an adopted or placed child. It also includes a stepchild who lives with you. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.

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

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

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

DFS2105

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite 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 "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

DFS1222

DFS2051

Employee

The term Employee means a retired employee.

DFS211

Employer

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

Maximum Reimbursable Charge - Dental

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

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

Network General Dentist

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

DFS1950

Network Specialty Dentist

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

DFS1951

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

Service Area

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

DFS1952

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

Subscriber

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

DFS1953



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

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

CDO18



CIGNA Dental Companies

CIGNA Dental Health Plan of Arizona, Inc.

CIGNA Dental Health of Colorado, Inc.

CIGNA Dental Health of Delaware, Inc.

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

CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska)

CIGNA Dental Health of Kentucky, Inc.

CIGNA Dental Health of Maryland, Inc.

CIGNA Dental Health of Missouri, Inc.

CIGNA Dental Health of New Jersey, Inc.

CIGNA Dental Health of North Carolina, Inc.

CIGNA Dental Health of Ohio, Inc.

CIGNA Dental Health of Pennsylvania, Inc.

CIGNA Dental Health of Virginia, Inc.

P.O. Box 453099

Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between CIGNA Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective 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 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-Cigna24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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



I. Definitions

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

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

- A. be consistent with the symptoms, diagnosis or treatment of the condition present;
- B. conform to commonly accepted standards throughout the dental field;
- C. not be used primarily for the convenience of the 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, or your Domestic Partner; your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 26 years old; or
- (b) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

For a dependent child 26 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless

of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

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

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

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

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

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

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

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

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

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

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

Subscriber/You - the enrolled employee or 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 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 call Member Services from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY

toll-free relay service number listed in their local telephone directory.

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

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

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

D. Choice of Dentist

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

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Member Services at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service



Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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

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

E. Your Payment Responsibility (General Care)

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

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

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

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

F. Emergency Dental Care - Reimbursement

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

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

1. Emergency Care Away From Home

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

2. Emergency Care After Hours

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

G. Limitations on Covered Services

Listed below are limitations on services 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. Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- 3. Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- 4. Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12



consecutive months, when covered on the Patient Charge Schedule.

5. **Clinical Oral Evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

General Limitations Dental Benefits

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

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

H. Services Not Covered Under Your Dental Plan

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

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA 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) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
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. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
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 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 higher, c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
10. replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
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 under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent



compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)

16. the completion of crowns, bridges, dentures, root canal treatment, or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your CIGNA Dental coverage. (California and Texas residents: Pre-existing conditions, including the completion of crowns, bridges, dentures, root canal treatment or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule.)
17. consultations and/or evaluations associated with services that are not covered.
18. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
19. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
20. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
21. services performed by a prosthodontist.
22. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
23. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
24. infection control and/or sterilization. CIGNA dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
25. the recementation of any inlay, onlay, crown, post and core, fixed bridge or implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

26. services to correct congenital malformations, including the replacement of congenitally missing teeth.
27. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
28. crowns, bridges and/or implant supported prosthesis used solely for splinting.
29. resin bonded retainers and associated pontics.

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

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

V. Appointments

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

VI. Broken Appointments

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

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

VII. Office Transfers

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

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

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



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.

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

IX. Specialty Referrals

A. In General

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

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

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

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

2. Patient Charges

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



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

3. Additional Charges

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

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

4. Orthodontics In Progress

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

X. Complex Rehabilitation/Multiple Crown Units

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

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to

as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

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. **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 can call 1-800-Cigna24 toll-free and explain your concern to one of our Member Services Representatives. You can also express that concern in writing to CIGNA Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

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

1. Level-One Appeals

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



appropriateness will be reviewed by a dental professional.

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

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, 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. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review. The Level-Two Appeals process does not apply to resolutions made solely on the basis that the Dental Plan does not provide benefits for the service performed or requested.

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

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

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

3. Independent Review Procedure

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

4. Appeals to the State

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

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

XII. Dual Coverage

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

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

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

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames for Disenrollment/Termination

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group



Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

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

B. Effect on Dependents

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

XIV. Extension of Benefits

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

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

XV. Continuation of Benefits (COBRA)

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

XVI. 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-CIGNA24, or via the Internet at www.cigna.com.

XVII. 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 for details.

As a CIGNA Dental plan member, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and members participating in certain disease management programs. Please review your plan enrollment materials for details.

SEE YOUR STATE RIDER FOR ADDITIONAL DETAILS.

PB08

CDC-08-GEN
01.01.11

**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 Pre-authorizations or Denied Claims for Services Already Provided

If your problem concerns a specialty referral pre-authorization that is not approved for payment or a claim for services already provided that is denied by CIGNA Dental, you or your designated representative may request a review as set out below by contacting Member Services, P.O. Box 188047, Chattanooga, TN 37422, Telephone 1-800-Cigna24.

1. Expedited Review Process (Pre-authorizations Only)

a. Expedited Review

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

b. Expedited Appeal

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

Dental upholds the denial, you may request an Expedited External Independent Review.

c. Expedited External Independent Review

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

2. Informal Reconsideration (Pre-authorizations Only)

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

3. Formal Appeal (Pre-authorizations and Claims for Services Already Provided)

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

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

You must send your request for a Formal Appeal in writing to the Appeals Coordinator at the above address. You or your Network Dentist must provide



CIGNA Dental with any material justification or documentation to support your request. CIGNA Dental will acknowledge your appeal in writing within 5 business days of your request. If CIGNA Dental upholds the denial, the written notice will include the criteria used, the clinical reasons for the decision, references to any supporting documentation, and your right to proceed to External Independent Review.

4. External Independent Review (Pre-authorizations and Claims for Services Already Provided)

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

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

5. Appeals to the State

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

XII. Dual Coverage

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

State Rider

CIGNA Dental Health of 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's 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 CIGNA Dental's 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.

91100.CO

CORIDER01V1
02.10.03

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 pre-enrolled at the time of birth or adoption.

III. Eligibility/When Coverage Begins

There will be at least one open enrollment period of not less than 30 days every 18 months unless CIGNA Dental Health



and your Group mutually agree to a shorter period of time than 18 months.

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

IV. Your CIGNA Dental Coverage

B. Premiums/Prepayment Fees

Your Group Contract has a 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-CIGNA24 (244.6224) or by writing to P.O. Box 188047, Chattanooga, TN 37422.

1. Level One Appeals

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

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

4. Appeals to the State

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

XIII. Disenrollment from the Dental Plan/Termination

A. Causes for Disenrollment/Termination

- 3. Permanent breakdown of the dentist-patient relationship, as determined by CIGNA Dental Health, is defined as disruptive, unruly, abusive, unlawful, or uncooperative behavior which seriously impairs CIGNA Dental Health's ability to provide services to 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.

91100.FL

FLRIDER01V2

02.10.03

State Rider

CIGNA Dental Health of Maryland, Inc.

1571 Sawgrass Corporate Parkway,
Suite 140
Sunrise, FL 33323

Maryland Residents:

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

IV. Your CIGNA Dental Coverage

D. Choice of Dentist

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



be made after you submit appropriate reports and x-rays to CIGNA Dental.

H. Services Not Covered Under Your Dental Plan

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-Cigna24 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-Cigna24.

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 pre-authorization, CIGNA Dental will render a final decision in writing, to you and any provider acting on your behalf, within 15 calendar days after we receive your Appeal. For Appeals concerning all other Coverage Decisions, CIGNA Dental will render a final decision in writing, to you and any provider acting on your behalf, within 30 calendar days after we receive your Appeal. If we need more time or information to 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. CIGNA Dental will notify you, and any provider acting on your behalf, of the Appeals Committee’s final decision, in writing, within 5 business days after the meeting. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the Appeal resolution be expedited if the timeframes under the above 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's 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's Level One Appeals Procedure.

If you are not satisfied with CIGNA Dental's final resolution regarding your Coverage Decision, you may, within 60 working days of receipt of CIGNA Dental's Level One or Level Two Appeal 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 188047, Chattanooga, TN 37422; Phone 1-800-Cigna24.

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

For grievances involving Covered Services already provided, you or your Network Dentist may request a review in writing within 180 days of receipt of an Adverse Determination. CIGNA Dental shall render a final decision in writing within 45 working days after the date a grievance is filed; unless you or your designated representative agrees in writing to an extension for a period not to exceed 30 working days.

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

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

- a. the specified factual basis for the decision;
- b. the specific criteria and standards, including interpretive guidelines on which the grievance decision was based;



- c. the name, business address and telephone number of the CIGNA Dental Appeals Coordinator; and
- d. the instructions and time frame for filing a complaint with the Maryland Insurance Commissioner, including the Commissioner’s address, telephone number and facsimile number.

3. Appeals to the State

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

If you have exhausted CIGNA Dental’s internal grievance process and are not satisfied with CIGNA Dental’s decision, you may also file a written complaint with the Maryland Insurance Commissioner, within 30 working days of receipt of CIGNA Dental’s grievance decision, at Maryland Insurance Administration, Chief of Complaints, 525 St. Paul Place, Baltimore, MD 21202; Phone 1-800-492-6116; Fax (410) 468-2270.

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

You or your Network Dentist may file a complaint with the Maryland Insurance Commissioner without first exhausting CIGNA Dental’s internal grievance process, if you can demonstrate to the Commissioner a compelling reason why you should not proceed under CIGNA Dental’s internal grievance process. A “compelling reason” demonstrates that the potential delay in receipt of a health care service until after the 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.

91993.MD

MDRIDER02V2
03.27.06

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

Ohio Residents:

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

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

III. Eligibility/When Coverage Begins

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

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

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



Section IV is renamed:

IV. Your CIGNA Dental Plan

E. Your Payment Responsibility (General Care)

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

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

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

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

XI. What To Do If There Is A Problem

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

A. Start With Member Services

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

B. Appeals Procedure

1. Level One Appeals

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

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

The Ohio Department of Insurance is located at 50 W. Town Street, Suite 300, Columbus, Ohio 43215, Attention Consumer Services Division. The

Department’s toll-free number is 1-800-686-1526 or (614) 644-2673.

XII. Dual Coverage

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

The following supersedes Section XII of your Plan Booklet.

A. Coordination of Benefits

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

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

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

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

B. Plans That Do Not Coordinate

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

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

C. How CIGNA Dental Pays As Primary Plan

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



D. How CIGNA Dental Pays as Secondary Plan

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

E. Which Plan is Primary?

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

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

says the father’s plan is always primary), we will follow the rules of that plan.

5. Other Situations

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

F. Coordination Disputes

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

G. Subrogation

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

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

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

XIII. Disenrollment From The Dental Plan/Termination of Benefits

A. Causes For Disenrollment/Termination

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

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

XVII. 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.

91100b.OH

OHRIDER01V4

05.07.09

**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.
- Any unmarried child of yours who is:
 - less than 26 years old. If, while a full-time registered student, the child was called or ordered to active duty (other than active duty for training) for 30 or more consecutive days in the Pennsylvania National Guard or any reserve component of the armed forces of the United States, the child is eligible to enroll as a Dependent while a full-time student for a period equal to the duration of the military service. Eligibility in this situation will end when the child is no longer a full-time student. The child must submit the form provided by the Department of Military and Veterans Affairs to CIGNA when initially called to duty, when returning from duty, and when reenrolling as a full-time student.

III. Eligibility/When Coverage Begins

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

If you have family coverage, a newly born 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, Bureau of Managed Care, Room 912 Health & Welfare Building, 625 Forster Street, Harrisburg, Pennsylvania, 17120-0701, (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. § 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.



CIGNA HealthCare

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.

91100.PA

PARIDER03V4

09.15.08



CIGNA Dental Care – CIGNA Dental Health Plan

The certificate(s) listed in the next section apply if you are a resident of one of the following states: CA, CT, KY, MO, NJ, TX

CD019



CIGNA Dental Health of California, Inc.

400 North Brand Boulevard, Suite 400
Glendale, California 91203

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

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-Cigna24 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. Limitations**
- VIII. 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**
- IX. Coordination of Benefits**
- X. 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**
- XI. Continuity of Care**
- XII. Continuation of Benefits (COBRA)**
- XIII. Individual Continuation of Benefits**
- XIV. Confidentiality/Privacy**



XV. 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, under certain circumstances, 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; or your Domestic Partner; 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 26 years old; or
- B. any age if he or she is both:
 1. incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
 2. chiefly dependent upon you (the subscriber) for support and maintenance.

For a child who falls into category B. above, you will need to furnish CIGNA Dental proof of the child's condition and his or her reliance upon you, within sixty (60) days from the date that you are notified by CIGNA Dental to provide this information. CIGNA Dental will initially request this information at least ninety (90) days prior to the child's nineteenth (19th) birthday, and will subsequently request such proof on an annual basis after the child turns twenty-one (21).

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 Pediatric Dentist - a licensed Network Specialty Dentist who has completed training in a specific program to provide dental health care for children.

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



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 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 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) newborn children between birth and age 36 months. CIGNA Dental shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the effective date of coverage for a newly covered enrollee.
- (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-Cigna24.

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 or other matters, call Member Services from any location at 1-800-Cigna24. 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 inducements 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. IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-800-Cigna24 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

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.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Member Services at 1-800-



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

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

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

2. Appointments

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

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-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at 1-800-Cigna24.

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

There is no charge to you for the transfer; however, all 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. Except for Pediatrics, Orthodontics and Endodontic services, payment authorization is required for coverage of services by a Network Specialty Dentist.

See Section IV.D *Facilities-Choice of Dentist*, regarding treatment by a Pediatric 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 Pediatrics, Orthodontics and 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.

If your Patient Charge Schedule reflects coverage for Orthodontic services, a referral from a Network General Dentist is not required to receive care from a Network Orthodontist. However, your Network General Dentist may be helpful in assisting you to choose or locate a Network Orthodontist.

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.7, *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 (i) Covered Services; (ii) rendered to an eligible member; (iii) within the scope of the Specialty Dentists skills and expertise; and (iv) 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 five

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.

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

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit copayment for each unit of crown, bridge and /or implant supported prosthesis (including crowns and bridges) 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) there is no coverage for crowns, bridges and/or implant supported prosthesis 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) there is no coverage for resin bonded retainers and associated pontics.
- (3) there is no coverage for the recementation of any inlay, onlay, crown, post and core, fixed bridge and/or implant supported prosthesis within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

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.

Exclusions

1. Coverage is not provided for Endodontic treatment of teeth exhibiting a poor or hopeless periodontal prognosis.
2. Coverage is not provided for intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

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 planing
 - oral hygiene instruction
 - full mouth debridement
- (2) **Scaling and Root Planing** - this periodontal therapy procedure combines scaling of the crown and root surface with root planing 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. Limitations

1. Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.
2. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

d. Exclusion

1. 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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
2. There is no coverage for Periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
3. There is no coverage for the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
4. There is no coverage for bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
5. There is no coverage for localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

6. 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 may not be 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. Your Patient Charge Schedule lists any limitations on oral surgery.

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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

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

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 (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 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-Cigna24 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 (including fixed and 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 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:

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA Dental's prior approval (except emergencies, as described in Section V.B.).
3. services to the extent you, or your Dependent, are compensated for them under any group medical plan.
4. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
5. surgical placement of a dental implant; repair, maintenance or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
7. prescription drugs.
8. 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.)

9. 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;
 - (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.
10. procedures or appliances for minor tooth guidance or to control harmful habits.
11. 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.
12. consultations and/or evaluations associated with services that are not covered.
13. infection control and/or sterilization. CIGNA Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
14. services to correct congenital malformations, including the replacement of congenitally missing teeth.

As noted in Section V, the following exclusions also apply:

15. there is no coverage for crowns, bridges and/or implant supported prosthesis 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.

16. there is no coverage for resin bonded retainers and associated pontics.
 17. general anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
 18. replacement of fixed and/or removable orthodontic appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
 19. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
 20. the recementation of any inlay, onlay, crown, post and core, fixed bridge or implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
 21. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
 22. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
 23. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
 24. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- Should any law require coverage for any particular service(s) noted above, the exclusion for that service(s) shall not apply.

VII. Limitations

In addition to the limitations listed in Section V, listed below are the services or expenses which have limited coverage under your Dental Plans. No payment will be made for expense incurred or services received:

1. for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
2. for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;



3. to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
4. for the charges which the person is not legally required to pay;
5. for charges which would not have been made if the person had no insurance;
6. due to injuries which are intentionally self-inflicted;
7. periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

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

VIII. 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. No Plan employee shall retaliate or discriminate against a member (including seeking disenrollment of the member) solely on the basis that the member filed a grievance. Instances of such retaliation or discrimination shall be grounds for disciplinary action, (including termination) against the employee.

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 may 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 may 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-Cigna24 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.
P.O. Box 188047
Chattanooga, TN 37422-8047

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/health/consumer/medical/state/ca.html#dental>.

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-Cigna24 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 with which you are not satisfied, 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.

IX. 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.

The following is a more detailed explanation of the rules used to determine which plan must pay first (your “primary” plan) and which plan must pay second (your “secondary” plan):

- A. A member may be covered as an employee by his/her employer and as a dependent by his/her spouse’s employer. The plan that covers the Member as an employee (the policyholder) is the primary plan.
- B. Under most circumstances, if a child is covered as a dependent under both parents’ coverage (and parents are not separated or divorced), the plan of the parent with the earliest birthday in the year is the primary plan.



- C. If a child of divorced or separated parents is covered as a dependent under at least one of the parents' (or stepparents') coverage, benefits are determined in the following order:
1. According to a court decree that designates the person financially responsible for the dental care coverage; or without such decree,
 2. The plan of the parent who has custody of the child;
 3. If the parent with custody of the child is remarried; then the stepparent's plan; and finally,
 4. The plan of the parent without custody of the child.
- D. The benefits of a plan that covers an active employee (and any dependents) are determined before those of a program which covers an inactive employee (laid-off or retired). However, if one of the plans does not have a provision regarding retired or laid-off employees, this section may not apply. Please contact the Plan at the number below for further instruction.
- E. If a Member is covered under a continuation plan (e.g. COBRA) AND has coverage under another plan, the following determines the order of benefits:
1. The plan that covers the member as an employee (or dependent of employee) will be primary;
 2. The continuation plan will be secondary.
- However, if the plan that covers the person as an employee does not follow these guidelines and the plans disagree about the order of determining benefits, then this rule may be ignored. Please contact CIGNA Dental at the number below for further instructions.
- F. If none of the above rules determines the order of benefits, the plan that has been in effect longer is the primary plan. To determine which plan has been in effect longer, we will take into consideration the coverage you had previously with the same employer, even if it was a different plan, as long as there was no drop in eligibility during the transition between plans.
- G. Workers' Compensation – Should any benefit or service rendered result from a Workers' Compensation Injury Claim, the Member shall assign his/her right to reimbursement from other sources to CIGNA Dental or to the Participating Provider who rendered the service.
- H. When CIGNA Dental is primary, we will provide or pay dental benefits without considering any other plan's benefits. When CIGNA Dental is secondary, we shall pay the lesser of either the amount that we would have paid in the absence of any other dental coverage, or your total out of pocket cost payable under the primary dental plan for benefits covered by CIGNA Dental.

- I. Please call CIGNA Dental at 1-800-Cigna24 if you have questions about which plan will act as your primary plan or if you have other questions about coordination of benefits.

Additional 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.

X. 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. less 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.

XI. 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:

- (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) newborn children between birth and age 36 months. CIGNA Dental shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Network Dentist's contract.
- (3) 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.

XII. 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.

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-CIGNA24, or via the Internet at 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 for details.

As a CIGNA Dental plan member, you may also be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women. Please review your plan enrollment materials 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.



CALIFORNIA LANGUAGE ASSISTANCE PROGRAM NOTICE

IMPORTANT INFORMATION ABOUT FREE LANGUAGE ASSISTANCE

If you have a limited ability to speak or read English you have the right to the following services at no cost to you:

- Access to an interpreter when you call CIGNA's Member Services Department.
- Access to an interpreter when you talk to your doctor or health care provider.
- If you read Spanish or Traditional Chinese, you also have the right to request that we read certain documents that CIGNA has mailed to you, in your preferred language. You may also request written translation of these documents.

To inform CIGNA of your preferred written and spoken languages, your race and/or ethnicity, or to request assistance from someone who speaks your language, please call us at the telephone number on your Identification (ID) card or your customer service phone number.

We are pleased to assist you in the language you prefer and understand.

INFORMACIÓN IMPORTANTE SOBRE LA ASISTENCIA GRATUITA CON EL IDIOMA

Si su dominio para hablar o leer en inglés es limitado, usted tiene derecho a acceder a los siguientes servicios, sin ningún costo para usted:

- Acceso a un intérprete cuando se comunica con el Departamento de Servicios a los miembros de CIGNA.
- Acceso a un intérprete cuando habla con su médico o con el proveedor de atención médica.
- Si usted lee español o chino tradicional, también tiene derecho a solicitar que le leamos ciertos documentos que CIGNA le ha enviado a usted por correo, en el idioma que usted prefiera. También puede solicitar la traducción por escrito de estos documentos.

Para informarle a CIGNA el idioma escrito u oral que usted prefiere, su raza y/o origen étnico, o para solicitar ayuda de alguien que hable su idioma, por favor, llámenos al teléfono que figura en su Tarjeta de identificación (ID) o al teléfono del servicio de atención al cliente.

Nos complace ayudarle en el idioma que usted prefiere y entiende.

有關免費語言協助的重要訊息

如果您的英語說話或閱讀能力有限，您有權可免費取得下列服務：

- 您打電話給CIGNA的會員服務部門時，由口譯員為您翻譯。
- 您與您的醫生或醫療保健提供者溝通時，由口譯員為您翻譯。
- 如果您能閱讀西班牙文或繁體中文，您也有權可要求我們把CIGNA郵寄給您的部分文件，用您熟悉的語言朗讀給您聽。您也可以索取這些文件的書面翻譯。

如果您想告訴CIGNA您習慣閱讀和說的語言、您的種族和(或)族裔，或想申請由和您說同樣語言的人來協助您，請您撥您的會員卡上的電話，或撥我們的顧客服務電話與我們聯絡。

我們十分樂意用您熟悉且能清楚瞭解的語言來協助您。

THÔNG TIN QUAN TRỌNG VỀ DỊCH VỤ TRỢ GIÚP NGÔN NGỮ MIỄN PHÍ

Nếu quý vị không nói hoặc đọc tiếng Anh thông thạo, quý vị có quyền được nhận các dịch vụ miễn phí sau đây:

- Có thông dịch viên trợ giúp khi quý vị gọi Ban Dịch Vụ Hội Viên của CIGNA.
- Có thông dịch viên trợ giúp khi quý vị nói chuyện với bác sĩ hoặc nhà cung cấp dịch vụ chăm sóc sức khỏe của quý vị.
- Nếu quý vị biết đọc tiếng Tây ban nha hoặc tiếng Hoa truyền thống, quý vị cũng có quyền yêu cầu chúng tôi đọc một số tài liệu mà CIGNA đã gửi cho quý vị, bằng ngôn ngữ mà quý vị ưa dùng. Quý vị cũng có thể yêu cầu bản chuyển ngữ của các tài liệu này.

Để cho CIGNA biết về các ngôn ngữ viết và nói mà quý vị ưa dùng, sắc tộc và/hoặc chủng tộc của quý vị, hoặc nhờ người nói được ngôn ngữ của quý vị giúp đỡ, xin gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc số điện thoại của ban dịch vụ khách hàng.

Chúng tôi luôn sẵn lòng trợ giúp quý vị bằng ngôn ngữ mà quý vị ưa dùng.



無料言語支援サービスに関する重要情報

英語による読み書きにご不自由を感じるお客様のために、以下のサービスを無料でご提供しています。

- CIGNA 会員サービス部に電話をする際の通訳サービス。
- 担当医または医療保険プロバイダとの会話を支援する通訳サービス。
- スペイン語または繁体字中国語をお話しになる方を対象に、CIGNA がお手元にお送りする特定の文書をご希望の言語でお読みするサービス。該当文書の翻訳もご請求いただけます。

CIGNA にご希望言語（書面および会話）、または、該当する人種・民族の通知を行う場合、または、言語サービスをご希望の場合には、お手持ちの身分証明(ID)カード記載の電話番号、または、カスタマー・サービスの電話番号までご連絡ください。

お客様のご希望の言語で、サービスをご提供いたします。

무료 통번역 서비스에 대한 중요 정보 사항

영어로 읽고 말하는데 어려움을 겪는 분이 계시다면 다음의 무료 통번역 서비스를 받으실 수 있습니다:

- CIGNA 고객 서비스 센터에 전화하실 때 통역사 서비스를 받으실 수 있습니다.
- 본인의 의사나 헬스 케어 제공자와 대화하실 때 통역사 서비스를 받으실 수 있습니다.
- 스페인어나 중문 번체를 읽으실 수 있는 분은 CIGNA가 우편으로 보낸 특정 서류에 대해 선호하는 언어로 번역해 줄 것을 요청하실 수 있습니다. 또한 이러한 서류 등에 대해 번역본을 요청하실 수도 있습니다.

CIGNA 에게 본인이 선호하는 문어 및 구어, 인종 및/또는 민족에 대해 알려주고 싶으신 분이나, 혹은 본인이 사용하는 언어를 구사할 수 있는 도우미를 요청하고 싶으신 분은 가입자님의 ID 카드에 기재된 전화번호나 해당 고객 서비스 센터의 안내번호로 전화해 주십시오.

CIGNA 는 항상 여러분에게 편리하고 이해하기 쉬운 언어 서비스를 제공하기 위해 최선을 다하고 있습니다.

NOT199



CIGNA HealthCare

CIGNA HealthCare of Connecticut, Inc.

**CIGNA HealthCare of Connecticut, Inc.
900 Cottage Grove Road
Hartford, CT 06152-1118**

**CIGNA Dental Health, Inc.
1571 Sawgrass Corporate Parkway, Suite 140
Sunrise, FL 33323
Phone: 1-800-Cigna24**

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.

Consumer Notice: Your out-of-pocket expense for certain complex procedures may exceed 50% of a dentist’s usual charge for those procedures. Please read your plan documents carefully and discuss your treatment options and financial obligations with your dentist. If you have any questions about your plan, please call Member Services or visit <http://www.cigna.com> for additional information.

READ YOUR PLAN BOOKLET CAREFULLY

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

PB08CT

01.01.11
CDC-08-CT



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. 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. Confidentiality/Privacy**
- XVII. Miscellaneous**



I. Definitions

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

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

- A. be consistent with the symptoms, diagnosis or treatment of the condition present;
- B. conform to commonly accepted standards throughout the dental field;
- C. not be used primarily for the convenience of the 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 - 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; or your Domestic Partner; your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a Dependent child who resides in your home as a result of court order or administrative placement) who is:

- A. less than 26 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.

For a child who falls into category (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 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 to you.

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

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

Premiums - fees that your Group remits directly or indirectly 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 61 days of life. If you wish to continue coverage beyond the first 61 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, or other matters, call Member Services from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

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

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

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

D. Choice of Dentist

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



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

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

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

E. Your Payment Responsibility (General Care)

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

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

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

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

F. Emergency Dental Care - Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the

condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. Emergency Care Away From Home

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

2. Emergency Care After Hours

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

G. Limitations on Covered Services

Listed below are limitations on services 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. Pediatric Dentistry** – Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
- 3. Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- 4. Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.



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

5. **Clinical Oral Evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

General Limitations Dental Benefits

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

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

H. Services Not Covered Under Your Dental Plan

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

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA 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) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
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 or
 - d. restore the occlusion.
10. replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost; stolen; or damaged due to patient abuse, misuse or neglect.
11. surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
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 under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.
16. the completion of crowns, bridges, dentures, root canal treatment, or implant supported prosthesis



(including crowns, bridges and dentures) already in progress on the effective date of your CIGNA Dental coverage.

17. consultations and/or evaluations associated with services that are not covered.
18. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis, unless dentally necessary.
19. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction or when performed in conjunction with an apicoectomy or periradicular surgery.
20. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
21. service performed by a prosthodontist.
22. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
23. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
24. infection control and/or sterilization. CIGNA dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
25. the recementation of any inlay, onlay, crown, post and core, fixed bridge or implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. CIGNA dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
26. services to correct congenital malformation, including the replacement of congenitally missing teeth.
27. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
28. crowns and bridges used solely for splinting.
29. resin bonded retainers and associated pontics.

V. Appointments

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

VI. Broken Appointments

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

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

VII. Office Transfers

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

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

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

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.

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



IX. Specialty Referrals

A. In General

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

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

1. Definitions

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

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

2. Patient Charges

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

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

3. Additional Charges

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

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



- b. orthognathic surgery and associated incremental costs;
- c. appliances to guide minor tooth movement;
- d. appliances to correct harmful habits; and
- e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

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

X. Complex Rehabilitation/Multiple Crown Units

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

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

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 concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Member Services Representatives. You can also express that concern in writing to CIGNA Dental at P.O. Box 188047, Chattanooga, TN 37422-8047. We’ll do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we’ll get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

CIGNA Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to CIGNA Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of receipt 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-Cigna24.

1. Level One Appeals

Your level one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional in the field related to the care under consideration, under the authority of a Connecticut licensed dentist.

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 the lesser of 72 hours after the appeal is received, or 2 business days 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:

- it will be deemed as a request by you for an extension; and
- 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 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 the lesser of 72 hours or 2 business days 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 60 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. The appeal must include a \$25 filing fee and a 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 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

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 and 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.

In the event of termination of your Group Contract by either CIGNA Dental or the Group, the Group shall within 15 days provide a notice of termination to each Covered Person.

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. 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. Confidentiality/Privacy

CIGNA HealthCare 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-CIGNA24, or via the Internet at www.cigna.com.

XVII. Miscellaneous

As a CIGNA HealthCare 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 for details.

As a CIGNA HealthCare plan member, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and members participating in certain disease management programs. Please review your plan enrollment materials for details.



State Rider

CIGNA HealthCare of Connecticut, Inc.

Connecticut Residents:

Your CIGNA Dental Care coverage is provided by CIGNA HealthCare of Connecticut, Inc.

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

I. Definitions

The following Medical Necessity definition is added to the definition section of your plan booklet immediately following the definition of "Group".

Medically necessary or medical necessity - means health care services that a physician/dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (1) In accordance with generally accepted standards of medical/dental practice;
- (2) Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- (3) Not primarily for the convenience of the patient, physician/dentist or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this definition, "generally accepted standards of medical/dental practice" means standards that are based on credible scientific evidence published in peer-reviewed medical/dental literature generally recognized by the relevant medical/dental community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.



CIGNA Dental Health of Kentucky

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

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

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



I. Definitions

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

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

- A. be consistent with the symptoms, diagnosis or treatment of the condition present;
- B. conform to commonly accepted standards throughout the dental field;
- C. not be used primarily for the convenience of the 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, or your Domestic Partner; your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 26 years old; or
- (b) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

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

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

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

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

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

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

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

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

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

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

Subscriber/You - the enrolled employee or 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 for up to 24 months.

III. Eligibility/When Coverage Begins

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

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the



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

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

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

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

IV. Your CIGNA Dental Coverage

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

A. 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 or other matters, call Member Services from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

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

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

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

D. Choice of Dentist

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

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Member Services at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist



upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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

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

E. Your Payment Responsibility (General Care)

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

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

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

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

F. Emergency Dental Care - Reimbursement

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

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive

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

2. Emergency Care After Hours

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

G. Limitations on Covered Services

Listed below are limitations on services 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. Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
- 3. Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- 4. Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- 5. Clinical Oral Evaluations** - Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are



limited to a total of 4 evaluations during a 12 consecutive month period.

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; if eligible for benefits under any workers' compensation act or similar law;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. Services Not Covered Under Your Dental Plan

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

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA 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) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
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 conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
10. replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
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 under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. Kentucky residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded.
16. the completion of crowns, bridges, dentures, root canal treatment, or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your CIGNA Dental coverage.



17. consultations and/or evaluations associated with services that are not covered.
18. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
19. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
20. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
21. services performed by a prosthodontist.
22. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
23. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
24. infection control and/or sterilization. CIGNA dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
25. the recementation of any inlay, onlay, crown, post and core, fixed bridge, or implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
26. services to correct congenital malformations, including the replacement of congenitally missing teeth.
27. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
28. crowns and bridges used solely for splinting.
29. resin bonded retainers and associated pontics.

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

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

V. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your

Dental Office will ask for your identification number and will check your eligibility.

VI. Broken Appointments

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

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

VII. Office Transfers

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

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

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

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.



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

IX. Specialty Referrals

A. In General

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

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

1. **Definitions** – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - b. **Interceptive Orthodontic Treatment** – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
 - c. **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
 - d. **Retention (Post Treatment Stabilization)** – the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient Charges

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

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

3. Additional Charges

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

- a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- b. orthognathic surgery and associated incremental costs;
- c. appliances to guide minor tooth movement;



- d. appliances to correct harmful habits; and
- e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

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

X. Complex Rehabilitation/Multiple Crown Units

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

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

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. **Time frames or requirements may vary depending on the laws in your State.**

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-Cigna24 toll-free and explain your concern to one of our Member Services Representatives. You can also express that concern in writing to CIGNA Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

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

A member is entitled to an internal appeal and can be attained with respect to the denial, reduction, or termination of a plan or the denial of a claim for a health care service in accordance with KRS 304.17C-030(2)(g)(2). A member, authorized person, or provider acting on behalf of the member may request an internal appeal within at least 1 year of receipt of a notice of the initial decision made by CIGNA Dental. CIGNA Dental will provide a written internal appeal determination within thirty (30) days following receipt of a request for an internal appeal.

1. Level-One Appeals

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

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



calendar days and to specify any additional information needed to complete the review.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, 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. 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 the 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 receipt of your level-one 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.

3. Appeals to the State

You have a right to contact the Kentucky Department of Insurance by sending to P.O. Box 517, Frankfort, KY 40602-0517 or toll free 1.800.648.6056.

CIGNA Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by

CIGNA Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. Dual Coverage

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

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

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

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames for Disenrollment/Termination

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

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



B. Effect on Dependents

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

programs. Please review your plan enrollment materials for details.

PBKY08

01.11.11
CDC-08-KY

XIV. Extension of Benefits

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

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

XV. Continuation of Benefits (COBRA)

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

XVI. 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-CIGNA24, or via the Internet at www.cigna.com.

XVII. 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 for details.

If you are a CIGNA Dental Care member, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and members participating in certain disease management



CIGNA Dental Health of Missouri, Inc.

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

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between CIGNA Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective 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 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-Cigna24 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**
 - 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. 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. Confidentiality/Privacy**
- XVII. Miscellaneous**



I. Definitions

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

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

- A. be consistent with the symptoms, diagnosis or treatment of the condition present;
- B. conform to commonly accepted standards throughout the dental field;
- C. not be used primarily for the convenience of the 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, or your Domestic Partner; your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than 26 years old; or
- (b) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

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

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

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

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

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

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

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

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

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

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

Subscriber/You - the enrolled employee or 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 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 or other matters, call Member Services from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

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

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

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

D. Choice Of Dentist

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

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



Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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

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

E. Your Payment Responsibility (General Care)

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

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

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

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

F. Emergency Dental Care - Reimbursement

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

1. Emergency Care Away From Home

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from

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

2. Emergency Care After Hours

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

G. Limitations On Covered Services

Listed below are limitations on services 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. Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- 3. Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- 4. Periodontal (gum tissue and supporting bone) Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- 5. Clinical Oral Evaluations** - Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.



General Limitations Dental Benefits

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

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

H. Services Not Covered Under Your Dental Plan

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

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA 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) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
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

8. or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
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 conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
10. replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
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. the completion of crowns, bridges, dentures, root canal treatment, or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your CIGNA Dental coverage.
16. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
17. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
18. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
19. services performed by a prosthodontist.



20. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
21. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
22. infection control and/or sterilization. CIGNA dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
23. the recementation of any inlay, onlay, crown, post and core, fixed bridge or implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
24. services to correct congenital malformations, including the replacement of congenitally missing teeth.
25. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
26. crowns, bridges and/or implant supported prosthesis used solely for splinting.
27. resin bonded retainers and associated pontics.

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

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

V. Appointments

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

VI. Broken Appointments

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

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

VII. Office Transfers

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

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

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

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.

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

IX. Specialty Referrals

A. In General

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



your treatment plan has been authorized for payment by CIGNA Dental before treatment begins.

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

1. **Definitions** – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - b. **Interceptive Orthodontic Treatment** – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.

- c. **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- d. **Retention (Post Treatment Stabilization)** – the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient Charges

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

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

3. Additional Charges

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

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

4. Orthodontics In Progress

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



X. Complex Rehabilitation/Multiple Crown Units

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

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

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. **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 can call 1-800-Cigna24 toll-free and explain your concern to one of our Member Services Representatives. You can also express that concern in writing to CIGNA Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. Appeals Procedure

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

1. Level-One Appeals

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

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

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, 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. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review. The Level-Two



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

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

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

3. Independent Review Procedure

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

4. Appeals to the State

Missouri Department of Insurance,
Financial Institutions and
Professional Registration
301 West High Street, Room 530
Jefferson City, MO 65101

Mailing Address:
PO Box 690
Jefferson City, MO 65102-0690

Phone number:
800-726-7390

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

XII. Dual Coverage

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each

other or the same Dependents twice, please contact your Benefit Administrator.

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

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

XIII. Disenrollment From The Dental Plan – Termination Of Benefits

A. Time Frames For Disenrollment/Termination

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

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

B. Effect On Dependents

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



XIV. Extension Of Benefits

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

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

XV. Continuation Of Benefits (COBRA) (COBRA)

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

XVI. 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-CIGNA24, or via the Internet at www.cigna.com.

XVII. 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 for details.

As a CIGNA Dental plan member, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and members participating in certain disease management programs. Please review your plan enrollment materials for details.



CIGNA Dental Health of New Jersey, Inc.

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

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

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

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

READ YOUR PLAN BOOKLET CAREFULLY

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



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. 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**
 - A. In General**
 - B. How CIGNA Dental Pays As Primary Plan**
 - C. How CIGNA Dental Pays As Secondary Plan**
- 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. Confidentiality/Privacy**
- XVII. Miscellaneous**



I. Definitions

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

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

- A. be consistent with the symptoms, diagnosis or treatment of the condition present;
- B. conform to commonly accepted standards throughout the dental field;
- C. not be used primarily for the convenience of the 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, civil union or your domestic partner (if established in New Jersey prior to February 19, 2007 or if established outside the state of New Jersey prior to or after February 19, 2007); your unmarried or unpartnered child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a Dependent child who resides in your home as a result of court order or administrative placement; or a Dependent child acquired through a civil union) who is:

- A. less than 26 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 Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

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

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

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

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

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

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

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

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

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

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

Subscriber/You - the enrolled employee or 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 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 or other matters, call Member Services from any location at 1-800-Cigna24. The hearing impaired may

contact the state TTY toll-free relay service number listed in their local telephone directory.

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

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

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

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

D. Choice of Dentist

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

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Member Services at 1-800-Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child



under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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

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

E. Your Payment Responsibility (General Care)

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

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

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

F. Emergency Dental Care – Reimbursement

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

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 on the front of this booklet.

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

G. Limitations on Covered Services

Listed below are limitations on services 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. **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist.
3. **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
4. **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
5. **Clinical Oral Evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

General Limitations Dental Benefits

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

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



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

H. Services Not Covered Under Your Dental Plan

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

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA 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) unless specifically listed on your Patient Charge Schedule.
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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
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;
 - c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
10. replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
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. the completion of crowns, bridges, dentures, root canal treatment or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your CIGNA Dental coverage.
16. consultations and/or evaluations associated with services that are not covered.
17. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
18. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
19. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
20. services performed by a prosthodontist.
21. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.



22. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
23. infection control and/or sterilization. CIGNA dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
24. the recementation of any inlay, onlay, crown, post and core, fixed bridge or implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
25. services to correct congenital malformations, including the replacement of congenitally missing teeth.
26. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
27. crowns, bridges and/or implant supported prosthesis used solely for splinting.
28. resin bonded retainers and associated pontics.

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

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

V. Appointments

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

VI. Broken Appointments

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

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

VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in

progress before transferring to another Dental Office. To arrange a transfer, call Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at 1-800-Cigna24.

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

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

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.

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

IX. Specialty Referrals

A. In General

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

When CIGNA Dental authorizes payment to the Network Specialty Dentist, the fees for no-charge services listed on the Patient Charge Schedule in effect on the date each



procedure is started will apply, except as set out in Section IX. B. *Orthodontics*. Treatment by the Network Specialist must begin within 90 days from the date of CIGNA Dental's authorization. If you are unable to obtain treatment within the 90-day period, please call 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.

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

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

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

2. Patient Charges

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

treatment, a later change in the Patient Charge Schedule may apply.

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

3. Additional Charges

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

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

4. Orthodontics in Progress

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

X. Complex Rehabilitation/Multiple Crown Units

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

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or



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

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

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

B. Appeals Procedure

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

1. Level-One Appeals

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

appropriateness will be reviewed by a dental professional.

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

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

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

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

2. Level-Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review. The Level-Two Appeal process does not apply to resolutions made solely on the basis that the Dental Plan does not provide benefits for the service performed or requested.

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

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



expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

3. Appeals to the State

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

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

XII. Dual Coverage

A. In General

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

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

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

B. How CIGNA Dental Pays As Primary Plan

When you receive care from a Network Specialty Dentist, CIGNA Dental pays the Network Specialty Dentist a contracted fee amount less your copayment for the Covered Service. When we are primary, we will pay the full benefit allowed as if you had no other coverage.

C. How CIGNA Dental Pays As Secondary Plan

1. If your primary plan pays on the basis of UCR, CIGNA Dental will pay the difference between the provider’s billed charges and the benefits paid by the primary plan up to the amount CIGNA Dental would have paid if primary. CIGNA Dental’s payment will first be applied toward satisfaction of your

copayment of your primary plan. You will not be liable for any billed charges in excess of the sum of the benefits paid by your primary plan, CIGNA Dental as your secondary plan and the copayment you paid under either the primary or secondary plan. When CIGNA Dental pays as secondary, you will never be responsible for paying more than your copayment for the Covered Service.

2. When both your primary plan and CIGNA Dental pay network providers on the basis of a contractual fee schedule and the provider is a network provider of both plans, the allowable expense will be considered to be the contractual fee of your primary plan. Your primary plan will pay the benefit it would have paid regardless of any other coverage you may have. CIGNA Dental will pay the copayment for the Covered Service for which you are liable up to the amount CIGNA Dental would have paid if primary and provided that the total amount received by the provider from the primary plan, CIGNA Dental and you does not exceed the contractual fee of the primary plan. You will not be responsible for an amount more than your copayment.
3. When your primary plan pays network providers on a basis of capitation or a contractual fee schedule or pays a benefit on the basis of UCR, and CIGNA Dental pays network providers on the basis of capitation and a service or supply is provided by a network provider of CIGNA Dental, we will not be obligated to pay to the network provider any amount other than the capitation payment required under the contract between CIGNA Dental and the network provider and we shall not be liable for any deductible, coinsurance or copayment imposed by your primary plan. You will not be responsible for the payment of any amount for eligible services.
4. We will pay only for health care expenses that are covered by CIGNA Dental.
5. We will pay only if you have followed all of our procedural requirements, including: care is obtained from or arranged by your primary care dentist; coverage in effect when procedures begin; procedures begin within 90 days of referral.

XIII. Disenrollment From the Dental Plan – Termination of Benefits

A. Time Frames For Disenrollment/Termination

Except as otherwise provided in the sections titled “Extension/Continuation of Benefits” or in your Group Contract, disenrollment from the Dental Plan and



termination of benefits will occur on the last day of the month:

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

B. Effect on Dependents

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

XIV. Extension of Benefits

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

XV. Continuation of Benefits (COBRA)

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

XVI. 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-CIGNA24, or via the Internet at www.cigna.com.

XVII. 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 for details.

If you are a CIGNA Dental Care member you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and members participating in certain disease management programs. Please review your plan enrollment materials for details.

PB08NJ

01.11.11
CDC-08-NJ



CIGNA HealthCare

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-Cigna24 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.

If you have a visual disability, you may call Member Services and request this booklet in a larger print type or Braille.

PB08TX

01.11.11
CDC-08-TX



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-Cigna24

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.



CIGNA HealthCare

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-Cigna24

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.

PB08TX

01.11.11
CDC-08-TX



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. 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. Treatment In Progress**
 - A. Treatment In Progress For Procedures Other Than Orthodontics**
 - B. Treatment In Progress For Orthodontics**
- 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)**
- XVII. Confidentiality/Privacy**
- XVIII. Miscellaneous**



I. Definitions

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

Adverse Determination - a determination by a utilization review agent that the dental care services provided or proposed to be furnished to you or your Dependents are not medically necessary or are experimental or investigational. To be considered medically 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:

- less than 26 years old; or
- any age if he or she is both:
 - incapable of self sustaining employment due to mental or physical disability; and
 - 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 - employer, labor union or other organization that has entered into a Group Contract with CIGNA Dental for managed dental services on your behalf.

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

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

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

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

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

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

Service Area - the geographical area designated by CIGNA Dental within which it shall provide benefits and arrange for dental care services, as set out in the attached list of service areas.

Spouse - the individual of the opposite sex with whom you have entered into a marriage relationship which would be considered valid under the Texas Family Code.

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, work or reside 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 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 or other matters, call Member Services from any location at 1-800-Cigna24. 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.

In addition to any other premiums for which the Group is liable, the Group shall also be liable for a member's premiums from the time the member is no longer eligible for coverage under the contract until the end of the month in which the Group notifies CIGNA Dental that the member is no longer part of the group eligible for coverage.

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 payment for out-of-network benefits.

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

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

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

You may always obtain a current Dental Office Directory by calling Member Services.

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.

- 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 without restrictions as to where the services are rendered. 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 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. Claims for non-emergency services will be processed within the same timeframes as claims for emergency services.

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. 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. **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.
3. **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
4. **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
5. **Clinical Oral Evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

General Limitations Dental Benefits

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

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

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

H. Services Not Covered Under Your Dental Plan

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

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA 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) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
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. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
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 the 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; or d. restore the occlusion.
10. replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. surgical placement of a dental implant, repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
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 under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.
16. crowns, bridges and/or implant supported prosthesis used solely for splinting.
17. resin bonded retainers and associated pontics.
18. consultations and/or evaluations associated with services that are not covered.
19. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless prognosis.
20. bonegrafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
21. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
22. services performed by a prosthodontist.

23. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
24. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
25. infection control and/or sterilization. CIGNA Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
26. the recementation of any inlay, onlay, crown, post and core, fixed bridge or implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. CIGNA Dental considers recementation within the timeframe to be incidental to and part of the charges for the initial restoration.
27. services to correct congenital malformations, including the replacement of congenitally missing teeth.
28. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.

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

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

V. Appointments

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

VI. Broken Appointments

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



Cigna24. To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at 1-800-Cigna24.

Your transfer 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.

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.

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.

Contact your Benefit Administrator for more information.

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

IX. Specialty Referrals

A. In General

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

your treatment plan has been authorized for payment by CIGNA Dental before treatment begins.

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

1. **Definitions** - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. **Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - b. **Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.



- c. **Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
- d. **Retention (Post Treatment Stabilization)** - the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient Charges

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

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

- 3. **Additional Charges** - You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:
 - a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
 - b. orthognathic surgery and associated incremental costs;
 - c. appliances to guide minor tooth movement;
 - d. appliances to correct harmful habits; and
 - e. services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.
- 4. **Orthodontics in Progress** - If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Member Services at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

X. Complex Rehabilitation/Multiple Crown Units

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

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

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 get back to you as soon as possible, usually by the end of the next business day. You can call Member Services at 1-800-Cigna24 or you may write P.O. Box 188047, Chattanooga, TN 37422-8047.

If you are unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the dentist providing you dental care, please contact CIGNA



at 1-800-Cigna24 and we will assist you in getting the care you need.

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) you 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 timeframes for resolving your complaint. For oral complaints, you will be asked to complete a one-page complaint form to confirm the nature of your problem or to provide additional information.

Upon receipt of your written complaint or one-page 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 (“Appeal”)

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, including the location where you normally receive services, 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 purpose 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 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 appeal is denied, the letter will include:

- (1) the clinical basis and principal reasons for the denial;
- (2) the specialty of the dentist making the denial;
- (3) a description of the source of the screening criteria used as guidelines in making the adverse determination; and
- (4) 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 medical 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 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.

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 30 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.

XII. Treatment In Progress

A. Treatment In Progress For Procedures Other Than Orthodontics

If your dental treatment is in progress when you enroll in the CIGNA Dental Plan, you should check to make sure your provider is in the CIGNA Dental Plan Network by contacting Member Services at 1-800-Cigna24. You can elect a new provider at this time. If you do not, your treatment expenses will not be covered by the CIGNA Dental Plan.

B. Treatment in Progress For Orthodontics

If orthodontic treatment is in progress for you or your Dependent at the time you enroll in this Dental plan, the copays listed on your Patient Charge Schedule do not apply to treatment that is already in progress. This is because your enrollment in this Dental plan does not override any obligation you or your Dependent may have under any agreement with an Orthodontist prior to your enrollment. CIGNA may make a quarterly contribution toward the completion of your treatment, even if your Orthodontist does not participate in the CIGNA Dental Health network. CIGNA's contribution is based on the Patient Charge Schedule selected by your Employer and

the number of months remaining to complete your interceptive or comprehensive treatment, excluding retention. Please call Member Services at 1-800-Cigna24 to obtain an Orthodontics in Progress Information Form. You and your Orthodontist should complete this form and return it to CIGNA to receive confirmation of CIGNA's contribution.

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 in which your Group notifies CIGNA Dental of your termination from the Dental Plan.
4. the last day of the month after voluntary disenrollment.
5. upon 15 days written notice from CIGNA Dental due to fraud or intentional material misrepresentation or fraud in the use of services or dental offices.
6. immediately for misconduct detrimental to safe plan operations and delivery of services.
7. 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 cancelled at the end of the 30-day period.



8. upon 30 days notice, due to neither residing, living nor working in the Service Area. Coverage for a dependent child who is the subject of a medical support order cannot be cancelled solely because the child does not reside, live 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 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. 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-Cigna24 or via the Internet at www.cigna.com.

XVII. Miscellaneous

- A. As a CIGNA Dental plan member you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and members participating in certain disease management programs. Please review your plan enrollment materials for details.
- B. **Notice:** Any notice required by the Group Contract shall be in writing and 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 non-renew an enrollee's coverage or 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.
- E. **Conformity With State Law:** If this Certificate of Coverage contains any provision not in conformity with



CIGNA HealthCare

the Texas Insurance Code Chapter 1271 or other applicable laws, it shall not be rendered invalid but shall be considered and applied as if it were in full compliance with the Texas Insurance Code Chapter 1271 and other applicable laws.

PB08TX

01.11.11
CDC-08-TX



**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

CDO12 M



Domestic Partner Rider

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

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

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

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

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

This insert contains CIGNA Dental's standard Domestic Partner definition. Your Group may have purchased one or

both coverages (same/opposite sex partners). Consult your Group Contract for additional information.

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

Kentucky Residents: Coverage terminates (for the domestic partner and any dependents, if included) when the domestic partnership ends.

DPRIDER02

V3



Domestic Partner Rider

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

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

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

- D. has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- E. is currently legally married to another person; or
- F. 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.



Domestic Partner Rider

This definition of Domestic Partner applies to residents of NJ.

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

- (1) Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following:
 - (a) a joint deed, mortgage agreement or lease;
 - (b) a joint bank account;
 - (c) designation of one of the persons as a primary beneficiary in the other person's will;
 - (d) designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
 - (e) joint ownership of a motor vehicle;
- (2) Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;
- (3) Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;
- (4) Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
- (5) Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older and not of the same sex may establish a domestic partnership if they meet the requirements set forth in this section;
- (6) Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
- (7) Both persons are at least 18 years of age;
- (8) Both persons file jointly an Affidavit of Domestic Partnership; and
- (9) Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and, in all cases in which a person registered a prior domestic partnership, the domestic partnership shall have been terminated in accordance with the provisions of section 10 of P.L. 2003, c. 246 (C. 26:8A-10).

DPRIDER02

V5