

**Federal Reserve System /  
Board of Governors**

CIGNA DENTAL CARE INSURANCE

**EFFECTIVE DATE: January 1, 2006**

CN001/DHMO  
2464022

This document printed in December, 2005 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.



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*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:** Federal Reserve System / Board of Governors

GROUP POLICY(S) — COVERAGE  
2464022 - DHMO CIGNA DENTAL CARE INSURANCE

**EFFECTIVE DATE:** January 1, 2006

**NOTICE**

This certificate does not apply to any employee unless this space is covered by a sticker indicating the employee's name and the certificate date.

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.



*Corporate Secretary*

### **Explanation of Terms**

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





## Effect Of Section 125 Regulations On This Plan

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

**Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.**

### Coverage Elections

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

- the date you meet Special Enrollment criteria per federal requirements as described in the Section entitled “Eligibility – Effective Date/Exception to Late Entrant Definition”; or
- the date you meet criteria shown in the section entitled “Change of Status.”

GM 6000 SCT125V1

### Change in Status

A change in status is defined as:

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

Any changes in coverage must pertain directly to the change in status.

### Court Order

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

### Medicare Eligibility/Entitlement

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

### Change in Cost of Coverage

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

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

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

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

GM6000 SCT125V2

## Accident and Health Provisions

### Claims

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

### Notice of Claim

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

### Claim Forms

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

### Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of



loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

**Physical Examination**

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

**Legal Actions**

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

GM6000 PRO1V3CLA43V20

**Eligibility - Effective Date**

**Eligibility For Employee Insurance**

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time or part-time Employee; and

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

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

**Eligibility for Dependent Insurance**

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

**Waiting Period**

Initial Employee Group: The beginning of a Pay Period following your enrollment.

New Employee Group: The beginning of a Pay Period following your enrollment.

**Classes of Eligible Employees**

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

GM6000 EL 2V-31  
EL15 M

**For Dental Insurance – Employees**

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

**Effective Date of Your Insurance**

You will become insured on the beginning of a Pay Period after the receipt of an enrollment form, but no earlier than the date you become eligible.

You will become insured on your first date of eligibility following your election if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

**Open Enrollment Period**

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

**Choice of Participating Dental Facility**

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

GM6000 EF 17 EL163V9

**For Dental Insurance - Dependents**

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



### Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the beginning of a Pay Period once you complete an enrollment form, but no earlier than the day you become eligible for Dependent Insurance.

Your Dependents will be insured only if you are insured.

GM6000 EF 2V-40  
ELI68

## Dental Benefits – CIGNA Dental Care

### For You and Your Dependents

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

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

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

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

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

### Covered Dental Service

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

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

GM6000 DEN48 V25

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

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

### Frequency

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

### Specialty Referrals

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

Covered specialists include:

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

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

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

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

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

GM6000 DEN112V2

### Pediatric Dentistry

If your child up to age 7 needs to be treated by a Pediatric Dentist, contact your Participating General Dentist for a specialty referral. Upon appropriate referral, your child may



continue under the care of the Specialist up to age 7 without additional referrals. If you need to change your child's Pediatric Dentist, you should return to your Participating General Dentist for a new referral up to the child's 7th birthday.

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

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

### Orthodontics

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

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

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

The Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, the Specialist may charge you an additional amount for each additional month of treatment. If you require less than 24 months of treatment, your fees will be reduced on a prorated basis.

GM6000 DEN113V1

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

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

### Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call CDH at to find out if you are entitled to any benefit under the Dental Plan.

### Oral Surgery

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

### Complex Rehabilitation

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

GM6000 DEN114

Covered Dental Services will not include nor, where applicable, will payment be made for any:

- services performed solely for cosmetic reasons;
- replacement of fixed and/or removable prosthodontic or orthodontic appliances that have been lost; stolen; or damaged due to patient abuse, misuse, or neglect;
- procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) diagnose or treat conditions or dysfunction of the temporomandibular joint "TMJ," unless TMJ therapy is specifically listed on your Patient Charge Schedule; or (3) restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction;
- prescription drugs;
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Dental Services performed by an Oral Surgeon or Periodontist;
- procedures or appliances for minor tooth guidance or to control harmful habits;



- procedures or services associated with the placement or prosthodontic restoration of a dental implant;
- services to the extent that they are compensable under any group medical plan;
- crowns or bridges used solely for splinting;
- resin bonded retainers and associated pontics;
- hospitalization, including any associated incremental charges for dental services performed in a Hospital;

GM6000 DEN115 M

## General Limitations

### Dental Benefits

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

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected condition;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- which the person would not be legally required to pay;
- when charges would not have been made if the person had no insurance;
- for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses or services by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- due to Injuries which are intentionally self-inflicted.

GM6000 GEN340

## 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:

- 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.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- 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:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and



customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

#### **Claim Determination Period**

A calendar year, 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:

- 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;
- 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;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - 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;
  - then, the Plan of the parent with custody of the child;

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

GM6000 COB13

- 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.
- 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.
- 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:

- CG's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and



- 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

## **Payment of Benefits**

### **To Whom Payable**

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

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

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

GM6000 POB5V-10  
PMT121

### **Miscellaneous**

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

GM6000 POB2

## **Termination of Insurance - Employees**

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- with respect to your Dental benefits, the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least one opportunity to transfer to another Participating Dental Facility.
- the date the policy is canceled.
- the last day of the pay period in which your Active Service ends except as described below.

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

### **Temporary Layoff or Leave of Absence**

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

### **Injury or Sickness**

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



### Termination Of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- with respect to your Dental benefits, the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least one opportunity to transfer to another Participating Dental Facility.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

### Dental Benefits Extension

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.

### Federal Information

### Notice Regarding Provider Directories and Provider Networks

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

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

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

### Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

#### Continuation of Coverage

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

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

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

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

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

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

### Reinstatement of Benefits (Applicable To All Coverages)

If your coverage ends during the leave because you do not elect USERRA or an available conversion plan at the



expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if, (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

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

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

NOT142

### **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

### **Notice of Federal Requirements**

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the social security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

GM6000 NOT99

### **Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93)**

**These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.**

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, as amended, where applicable.

#### **A. Eligibility for Coverage Under a Qualified Medical Child Support Order**

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the

order and 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 Qualified Medical Child Support Order being issued.

#### **Qualified Medical Child Support Order**

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides 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.

OBRA1

The Qualified Medical Child Support Order 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 an order may require a plan to comply with State laws regarding child health care coverage.

#### **Payment of Benefits**

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

#### **B. 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.

OBRA4

### Requirements of Family and Medical Leave Act of 1993

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

#### A. Continuation of Health Insurance During Leave

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

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

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

#### B. Reinstatement of Canceled Insurance Following Leave

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

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

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

GM6000 TRM191V1

### Provisions

#### Dental Conversion Privilege

Any Employee or Dependent whose Dental Insurance ceases for a reason other than failure to pay any required contribution or cancellation of the policy may be eligible for coverage under another Group Dental Insurance Policy underwritten by CG; provided that: (a) he applies in writing and pays the first premium to CG within 31 days after his insurance ceases; and (b) he is not considered to be overinsured.

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

Conversion is not available if your insurance ceased due to:

- nonpayment of required premiums;
- selection of alternate dental insurance by your group;
- permanent breakdown of the dentist/patient relationship; or
- fraud or misuse of the Dental Plan.

GM6000 PRO64

### The Following Will Apply To Residents Of District Of Columbia

#### 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 APL524 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 APL526

### 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 APL528

### Appeal to District of Columbia

You have the right to contact the District of Columbia Department of Health for assistance at any time. The Director of Health, District of Columbia Department of Health may be contacted at the following address:

District of Columbia Department of Health  
825 North Capitol St., 4th Floor  
Washington, DC 20002

GM6000 APL529 V5

### 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 APL530

**Definitions**

**Active Service**

You will be considered in Active Service:

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

DFS1 M

**CIGNA Dental Health (herein referred to as CDH)**

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

DFS592

**Dentist**

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

DFS24

**Dependent**

Dependents are:

- your lawful spouse;
- your Domestic Partner as defined herein; and
- any unmarried child of yours or your dependent who is
  - less than 22 years old.
  - 22 years but less than 25 years old, enrolled in school as a full-time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 22nd birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 25.
  - 22 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child. It also includes a stepchild who lives with you. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.

Benefits for a Dependent child or student will continue until the last day of the calendar 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.

DFS294

**Domestic Partner**

The term domestic Partner means an individual who meets the definition of domestic partner under the Employer's Domestic Partner Benefits Policy.



DFS1222

**Employee**

The term Employee means an individual who is appointed into the Employer's service for a period of more than 365 days as a full-time, part-time or benefit - eligible temporary employee of the Employer.

DFS211 M

**Employer**

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

**Maximum Reimbursable Charge**

The Maximum Reimbursable Charge is the lesser of:

- the provider's normal charge for a similar service or supply; or
- 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

**Participating Dental Facility**

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

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

DFS593

**Participating General Dentist**

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

DFS594

**Patient Charge Schedule**

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

DFS1102

**Specialist**

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

DFS598

**Usual Fee**

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

DFS1834



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

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

CDO10 M



### **CIGNA Dental Companies**

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

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

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

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

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

#### **NOTICE**

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

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

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

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



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



## I. Definitions

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

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

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

Request for payment authorizations that are declined by CIGNA Dental based upon the above criteria will be the responsibility of the member at the Dentist's Usual Fees. A licensed Dentist will make any such denial.

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

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

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

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

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

**Dependent** – Your lawful spouse;

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

- A. less than 22 years old; or
- B. less than 25 years old if he or she is both:
  1. a full-time student enrolled at an accredited educational institution, and
  2. reliant upon you for maintenance and support; or
- C. any age if he or she is both:
  1. incapable of self-sustaining employment due to mental or physical disability; and

2. reliant upon you for maintenance and support.

For a Dependent child 22 years of age or older who is full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category (B.) or (C.) above, you will need to furnish CIGNA Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of 22 and once a year thereafter during his or her term of coverage.

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

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

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

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

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

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

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

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

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

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

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

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



## II. Introduction to Your CIGNA Dental Plan

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

## III. Eligibility/When Coverage Begins

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

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

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

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

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

## IV. Your CIGNA Dental Coverage

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

Group Contract will be furnished to you upon your request.

### A. Member Services

If you have any questions or concerns about the Dental Plan, Member Services Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Member Services from any location, at 1-800-367-1037. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

### B. Premiums/Prepayment Fees

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

### C. Other Charges - Patient Charges

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

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

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

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

### D. Choice of Dentist

You and your Dependents should have selected a Dental



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

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

To obtain a list of Dental Offices near you, visit our website at [www.cigna.com](http://www.cigna.com) or call the Dental Office Locator at 1-800-367-1037. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Member Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



emergencies, as described in Section IV.F.)

3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
7. general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist.
8. prescription drugs.
9. procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); or b. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) unless TMJ therapy is specifically listed on your Patient Charge Schedule; or if your Patient Charge Schedule ends in "-04" or a higher number; c. restore teeth which have been damaged by attrition, abrasion, erosion, and/or abfraction.
10. replacement of fixed and/or removable appliances that have been lost; stolen; or damaged due to patient abuse, misuse or neglect.
11. services associated with the placement or prosthodontic restoration of a dental implant.
12. services considered to be unnecessary or experimental in nature.
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. hospitalization, including any associated incremental charges for dental services performed in a Hospital. (Benefits are available for Network Dentist charges for covered services performed at a Hospital. Other associated charges are not covered should be submitted to the medical carrier for benefit determination.)
15. services to the extent you or your enrolled Dependent is compensated under any group medical plan, no-fault auto insurance policy, or an uninsured motorist

policy.

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

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

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

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

## V. Appointments

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

## VI. Broken Appointments

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

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

## VII. Office Transfers

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

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

## VIII. Specialty Care

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



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

Pediatric Dentists - Children's dentistry.

Endodontists – Root canal treatment.

Periodontists – Treatment of gums and bone.

Oral Surgeons – Complex extractions and other surgical procedures.

Orthodontists – Tooth movement.

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

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

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## IX. Specialty Referrals

### A. In General

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

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

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

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

Dentist's Usual Fees.

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

### B. Pediatric Dentistry

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

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

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

### C. Orthodontics

#### 1. Definitions

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

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



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

## 2. Patient Charges

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

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

## 3. Additional Charges

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

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

## 4. Orthodontics in Progress

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

Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

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

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

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

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

### A. Start with Member Services

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

### B. Appeals Procedure

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

## X. Complex Rehabilitation/Multiple Crown Units

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



800-367-1037.

### 1. Level One Appeals

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

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

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

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

### 2. Level Two Appeals

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

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

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

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

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

### 3. Independent Review Procedure

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

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

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

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

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

The Independent Review Procedure is a voluntary



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

#### 4. Appeals to the State

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

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

## XII. Dual Coverage

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

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

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

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

### A. Time Frames for Disenrollment/Termination

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

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

Office;

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

### B. Effect on Dependents

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

## XIV. Extension of Benefits

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

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

## XV. Continuation of Benefits (COBRA)

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

## XVI. Conversion Coverage

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

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



Subscriber;

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

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

### XVII. Confidentiality/Privacy

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

### XVIII. Miscellaneous

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

**SEE YOUR STATE RIDER FOR ADDITIONAL DETAILS**

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## State Rider

### CIGNA Dental Health of Colorado, Inc.

Colorado Residents:

#### IV. Your CIGNA Dental Coverage

##### D. Choice of Dentist

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

#### IX. Specialty Referrals

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

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

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

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

1. **Level One Appeals:** The reviewer will consult with a Dentist in the same or similar specialty as the care under consideration. A resolution to your written complaint will be provided to you and your Network Dentist, in writing, within 20 working days of receipt. The written decision will contain the name, title, and qualifying credentials of the reviewer and of any specialist consulted, a statement of the reviewer's understanding of the reason for your appeal, clinical rationale, a reference to the documentation used to make the determination, clinical criteria used, and instructions for requesting the clinical review criteria, and a description of the process for requesting a second level appeal.
2. **Level Two Appeals:** A majority of the Appeals Committee will consist of licensed Dentists who have appropriate expertise. The licensed Dentist may not have been previously involved in the care or decision under consideration, may not be members of the board of directors or employees of CIGNA Dental, and may have no direct financial interest in either the case or its outcome.

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

The Appeals Committee's decision will include: the names, titles and qualifying credentials of the reviewers; a statement of the reviewer's



understanding of the nature of the appeal and the pertinent facts; the rationale for the decision; reference to any documentation used in making the decision; instructions for requesting the clinical rationale, including the review criteria used to make the determination; additional appeal rights, if any; and the right to contact the Department of Insurance, including the address and telephone number of the Commissioner's office.

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

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

If the Appeals Committee upholds a denial based on clinical necessity, and you have exhausted CIGNA Dental Appeals Process, you may request that your appeal be referred to an Independent Review Organization (IRO). In order to request a referral to an IRO, the reason for the denial must be based on a dental necessity determination by CIGNA Dental. Administrative, eligibility or benefit coverage limits are not eligible for additional review under this process.

There is no charge for you to initiate this independent review process; however, you must provide written authorization permitting CIGNA Dental to release the information to the Independent Reviewer selected. The IRO is composed of persons who are not employed by CIGNA Dental or any of its affiliates. CIGNA Dental will abide by the decision of the IRO. To request a referral to an IRO, you must notify the Appeals Coordinator within 60 days of your receipt of the Appeals Committee's level two appeal review denial. CIGNA Dental will then forward the file to the Colorado Department of Insurance within 2 working days, or within 1 working day for expedited reviews. We will send you descriptive information on the entity that the Department selects to conduct the review.

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

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

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

## XVIII. Miscellaneous

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

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

### Florida Residents:

#### I. Definitions

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

#### III. Eligibility/When Coverage Begins

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

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

#### IV. Your CIGNA Dental Coverage

##### B. Premiums/Prepayment Fees

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



#### **D. Choice of Dentist**

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

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

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

#### **B. Appeals Procedure**

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

##### **1. Level One Appeals**

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

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

##### **4. Appeals to the State**

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

### **XVI. Converting From Your Group Coverage**

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

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

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

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

FLRIDER01

### **State Rider**

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

**P.O. Box 189060**

**Plantation, FL 33318-9060**

#### **Maryland Residents:**

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

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

#### **D. Choice of Dentist**

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



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

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

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

#### IX. Specialty Referrals

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

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

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

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

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

##### A. Start With Member Services

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

The Maryland Insurance Administration is also available to assist you with any complaint you may have against the Dental Plan. If your complaint concerns a Coverage Decision or an Adverse Determination, please refer to the appropriate section below. For all other issues, you may register your complaint with the Maryland Insurance

Administration, Life and Health Inquiry and Investigation Unit, 525 St. Paul Place, Baltimore, Maryland, 21202-2272, telephone 410-468-2244.

#### B. Complaints Involving Coverage Decisions

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

##### 2. Appeals Procedure

If you are not satisfied with the results of a Coverage Decision, you may start the Appeals Procedure.



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

**a. Level One Appeals**

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

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

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

**b. Level Two Appeals**

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

with a Dentist in the same or similar specialty as the care under review.

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

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

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

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

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

**3. Appeals to the State**

Before seeking the assistance of the Maryland Insurance Administration regarding the appeal of a Coverage Decision, you must first exhaust CIGNA Dental Level One Appeals Procedure. However, if your complaint involves an Urgent Medical Condition for which care has not yet been rendered,



you may file a complaint with the Maryland Insurance Administration without first exhausting CIGNA Dental Level One Appeals Procedure.

If you are not satisfied with CIGNA Dental final resolution regarding your Coverage Decision, you may, within 60 working days of receipt of CIGNA Dental level one or level two appeals decision, file a written complaint with the Maryland Insurance Administration. Your complaint should be addressed to the Life and Health Inquiry and Investigation Unit, 525 St. Paul Place, Baltimore, MD 21202, telephone (410) 468-2244, fax (410) 468-2260.

### C. Complaints Involving Adverse Determinations

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

#### 1. In General

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

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

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

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

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

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

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

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

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

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

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

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

#### 3. Appeals to the State

The Maryland Health Education and Advocacy Unit are available to assist you in filing a grievance under the CIGNA Dental internal grievance process or in mediating a resolution to an Adverse Determination. However, it is not available to represent or



accompany you during grievance proceedings. The Health Education and Advocacy Unit can be reached at: Consumer Protection Division, Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202; Phone (410) 528-1840 or 1-877-261-8807; Fax (410) 576-6571; Email: heau@oag.state.md.us

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

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

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

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

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

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

MDRIDER02

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

### **North Carolina Residents:**

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

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

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

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

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

A life status change may also include placement for adoption.

Evidence of good dental health is not required for late enrollees.

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

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

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

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

#### **B. Appeals Procedure**

##### **1. Level One Appeals**

The following replaces the third sentence of paragraph 2:

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

##### **2. Level Two Appeals**



The following replaces the last sentence of paragraph 2:

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

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

The Appeals Committee decision will be provided to you no later than 30 days after the date the appeal is made.

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

**3. Independent Review Procedure**

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

**XII. Dual Coverage**

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

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

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

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

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

**XVIII. Miscellaneous**

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

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

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

In addition, our CIGNA HealthCare affiliates may arrange

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

**B. Incontestability**

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

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

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

AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68



OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

NCRIDER01

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

Pennsylvania Residents:

### I. Definitions

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

### III. Eligibility/When Coverage Begins

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

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

### IV. Your CIGNA Dental Coverage

#### D. Emergency Dental Care - Reimbursement

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

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

Items 12 and 15 are amended as follows:

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

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

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

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

### XII. Dual Coverage

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

### XVIII. Miscellaneous

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

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

PARIDER02

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

Virginia Residents:

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

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

### III. Eligibility/When Coverage Begins

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

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



## IV. Your CIGNA Dental Coverage

### F. Emergency Dental Care - Reimbursement

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

#### 1. Emergency Care Away From Home

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

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

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

### B. Appeals Procedure

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

#### 1. Level One Appeals

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

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

You may request that the appeal resolution be expedited if the timeframes under the above process

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

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

#### 2. Level Two Appeals

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

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

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

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



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

### 3. Independent External Review Procedure

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

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

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

### 4. Appeals to the State

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

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

## XII. Dual Coverage

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

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

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

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

The following replaces Section XIII. of your Plan Booklet:

### A. Time Frames For Disenrollment/Termination

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

1. in which Premiums are not remitted to CIGNA Dental.
2. there will be a 31-day grace period for the payment of any premium falling due after the first premium, during which coverage shall remain in effect. If payment is not received within the 31 days, coverage may be canceled after the 31st day and you may be liable for the cost of services received during the grace period.
3. after 31 days notice from CIGNA Dental due to failure to meet eligibility requirements.
4. after 31 days notice from CIGNA Dental due to permanent breakdown of the dentist-patient relationship as determined by CIGNA Dental, after at least two opportunities to transfer to another Dental Office.
5. after 31 days notice from CIGNA Dental due to fraud



or misuse of dental services and/or Dental Offices.

6 after voluntary disenrollment.

**B. Effect On Dependents**

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

**XVIII. Miscellaneous**

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

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

**Member Rights and Responsibilities**

**Your Rights**

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



Dental Care network.

- You have the right to call Member Services if you need help choosing a Dentist or need more information to help you make that choice.
- You have the right to know who we are, what services we provide, which Dentists are part of our plan and your rights and responsibilities under the plan. If you have any questions or concerns, call Member Services.
- You have the right to receive a Patient Charge Schedule to determine benefits and covered services. If you do not receive one before your plan becomes effective, call Member Services to request one.
- You have the right to privacy and confidential treatment of information and dental records, as provided by law.

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

**Your Responsibilities**

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

**Important Information Regarding Your Dental Plan**

In the event you need to contact someone about this Dental Plan for any reason, please contact your Benefit

Administrator. If you have additional questions you may contact CIGNA Dental at the following address and telephone number:

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

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

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

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

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

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

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

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

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

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

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

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

TELEPHONE: Toll-Free: 1-800-955-1819



**CIGNA HealthCare**

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Out-of-State Calls: 1-804-367-2106

Fax Number: 1-800-367-2149

VARIDER02



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

**This section describes the CDC 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



CIGNA HealthCare

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## Domestic Partner Rider

The following definition of Domestic Partner applies:

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

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

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

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

This insert contains CIGNA Dental's standard Domestic

Partner definition. Your Group may have purchased one or both coverages (same/opposite sex partners). Consult your Group Contract for additional information.

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

Virginia Residents: Domestic Partner coverage is not available.

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## **Your Rights Under Federal Law**

As a participant in your CIGNA Dental plan, you are entitled to certain rights and protections under federal laws. This is a summary of those laws and the things you need to know.

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



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## **I. Employee Retirement Income Security Act of 1974 (ERISA)**

**The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.**

### **What is ERISA?**

ERISA is a federal law which governs different aspects of health and welfare plans including:

- Summary Plan Descriptions;
- Claim payments;
- Appeals procedures; and
- Reporting requirements.

Although most plans are subject to ERISA, some plans which are exempt include: (1) tax-exempt church employee groups; (2) state, local and federal government employee groups; (3) trust and association plans not funded by employers and plans maintained outside the U.S. for nonresident aliens. Exempt plans may also choose to be subject to ERISA. To be sure your plan is subject to ERISA, you should check with your Plan Administrator.

If your plan is subject to ERISA, you are afforded the following rights:

### **ERISA Entitles You to Receive Information About Your Plan and Benefits**

- to examine all documents governing the Plan at the Plan Administrator's office and at other specified locations, such as worksites and union halls, including insurance contracts and collective-bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. This is available at no charge.
- to obtain, upon written request to the Plan Administrator, copies of all documents governing the Plan. There may be a charge for copies.
- to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

### **ERISA Allows You and/or Your Dependent(s) to Continue Group Dental Plan Coverage**

- to continue dental care coverage for yourself, your spouse or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group dental plan. You should be provided a certificate of creditable coverage, free of charge, from your group dental plan or issuer when you lose coverage under the Plan, when you

become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **ERISA Requires Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any other way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

### **ERISA Allows You to Enforce Your Rights**

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

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

### **ERISA Requires Disclosures About Your Plan**

If your plan is an ERISA plan, your Plan Administrator is required to include the following information in the Summary Plan Description:

- the name of the plan;



- the name, address zip code and business telephone number of the sponsor of the Plan;
- Employer Identification Number (EIN);
- the name, address, zip code and business telephone number of the Plan Administrator;
- the name, address and zip code of the person designated as agent for the service of legal process;
- the cost of the Plan; and
- the Plan's fiscal year ending date.

**The Plan Sponsor Has the Right to Modify, Amend or Terminate Your Plan**

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

**Effect of Plan Termination**

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

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the last day of the calendar month in which you leave Active Service;
- the date you are no longer in an eligible class; if the Plan is contributory, the date you cease to contribute; or
- the date the policy(s) terminates.

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

**Claim Determination Procedures Under ERISA:  
Procedures Regarding Medical Necessity Determinations**

In general, dental services and benefits must be medically necessary to be covered under the Plan. The procedures for determining the medical necessity vary, according to the type of service and benefit requested, and the type of dental plan. Medical necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below. When services or benefits are determined not to be medically necessary, you or your representative will receive a written description of the adverse determination. Appeals procedures are described in your booklet, in your provider's network participation documents and in the determination notices.

**Preservice Medical Necessity Determinations**

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." When you or your representative request a required medical necessity determination prior to care, we will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond our control, we will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to us within 45 days after receiving the notice. The determination period will be suspended on the date we send such a notice of missing information, and the determination will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Dentist with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, we will make the preservice determination on an expedited basis. Our Dental reviewer, in consultation with the treating Dentist, will decide if an expedited appeal is necessary. We will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, we will notify you or your representative within 24 hours after receiving the request to specify what information is needed.

You or your representative must provide the specified information to us within 48 hours after receiving the notice. We will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited



determinations may be provided orally, unless you or your representative requests written notification.

### **Postservice Medical Necessity and Postservice Claims Determinations**

When your or your representative requests a medical necessity determination after services have been rendered or requests payment for services which have been rendered, we will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond our control, we will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to us within 45 days after receiving the notice. The determination period will be suspended on the date we send such a notice of missing information, and the determination will resume on the date you or your representative responds to the notice.

### **Notice of Adverse Determination**

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable, including the statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal;
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit;
- in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

### **Assistance With Your Questions**

If you have any questions about your Plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the

Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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## **II. Notice of Federal Requirements Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

### **What is USERRA?**

USERRA sets requirements for continuation and reinstatement of your and/or your Dependent's dental coverage and reemployment in regard to military leaves of absence.

Leaves are as follows:

For leaves of less than 31 days, coverage will continue as described in the "Termination" section of your plan booklet or certificate.

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

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

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

Following continuation of dental coverage per USERRA requirements, you may convert to a plan of coverage as outlined in your plan booklet or certificate.

### **USERRA Allows You to Reinstate Your Benefits**

If your coverage ends during the leave because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependent(s) may be reinstated if:

- you gave your Employer advance written or verbal notice of your military leave; and
- the duration of all military leaves while you are employed with your current Employer does not exceed five years.

You and your Dependent(s) will be subject to only the balance of a preexisting condition limitation or waiting period that was not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, full plan limitations will apply. Any 63-day break in coverage



regarding credit for time accrued toward a preexisting condition limitation waiting period will be waived.

### **USERRA Sets Timeframes for Requesting Reemployment**

When a leave ends, you must report your intent to return to work as follows:

- for leaves of less than 31 days or for a fitness exam by reporting to your Employer by the next regularly scheduled work day following 8 hours of travel time;
- for leaves of 31 days or more but less than 11 days by submitting an application to your Employer within 14 days; and
- for leaves of more than 181 days, by submitting an application to your Employer within 90 days.

Consult your Employer for more details regarding your rights and your Employer's obligations for reemployment. This section will be superseded in whole or in part by any richer state-required provision shown in your plan booklet or certificate.

### **III. Requirements of Family and Medical Leave Act of 1993 (FMLA)**

**Any provisions of the policy that provide for continuation of insurance during a leave of absence and reinstatement of coverage following a leave of absence is superseded by the FMLA provisions below.**

#### **What is FMLA?**

In general, FMLA provides an entitlement of up to 12 weeks of job-protected (state laws may allow more time), unpaid leave during any 12 months for:

- the birth and care of the Employee's child or placement for adoption or foster care of a child with the Employee;
- to care for an immediate family member (spouse, child, parent) who has a serious health condition; or
- for the Employee's own serious health condition.

#### **Continuation of Dental Insurance During Leave**

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

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

The cost of your dental insurance during such leave of absence must be paid, whether by your Employer or by you and your Employer.

#### **Reinstatement of Canceled Insurance Following Leave**

Upon your return to Active Service following a leave of absence that qualifies under FMLA, any canceled insurance (health, dental, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirement of any Preexisting

Condition Limitation to the extent that they have been satisfied prior to start of such leave of absence. Your Employer will give you detailed information about FMLA if you choose to take a leave of absence.

### **IV. Continuation Required by the Consolidated Omnibus Budget Reconciliation Act (COBRA)**

**The Continuation required by federal law does not apply for any benefits for loss of life, dismemberment or loss of income and is only available for certain groups. Please contact your Plan Administrator concerning COBRA eligibility under your Plan.**

#### **What is COBRA?**

COBRA is a federal law that enables you or your Dependent to continue dental insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue dental insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group plan(s) and is subject to federal law, regulations and interpretations.

#### **Employees and Dependents Continuation Provision**

If you or your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of:

- the date the reduction of your work hours are reduced or your termination of employment;
- the date the notice of the right to continue insurance is sent; or
- the date the insurance would otherwise cease.

You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by us for you and/or your Dependents, as applicable beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;



- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group dental plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

#### **Dependent Continuation Provision**

If dental insurance for your Dependents would otherwise cease because of:

1. your death;
2. divorce or legal separation; or
3. with respect to a Dependent child, failure to continue to qualify as a Dependent, such insurance may be continued upon payment of the required premium to the Employer. In the case of 2. or 3. above, you or your Dependent must notify your Employer within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

We will not continue the dental insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of 1., 2., or 3. above, whichever occurs first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group dental plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

#### **Subsequent Events Affecting Dependent Coverage**

If, within the initial 18-month continuation period, your Dependent would lose coverage because of an event described in 1, 2, or 3 above, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your

covered Dependent may continue coverage for up to 18 months from the date your employment or your work hours are reduced.

#### **Disabled Individuals Continuation Provisions**

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follows termination of employment or a reduction in work hours, the disabled person may continue dental insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in b., below.

To be eligible you or your Dependent must:

- a. be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and
- b. notify the Plan Administrative of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described above which apply to the initial 18 months will also apply to all or any covered persons for any additional months of coverage.

#### **Effect of Employer Chapter 11 Proceeding on Retiree Coverage**

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

#### **Payment of Premium**

COBRA plans may require the payment of an amount that does not exceed 102% of the applicable premium, except the Plan may require payment of up to 150% of the applicable premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.



Applicable premium is determined as follows:

- if the Employee alone elects to continue coverage, the Employer will be charged the active Employee rate;
- if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate;
- if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active Employee rate;
- if the entire family elects to continue coverage, they will be charged the family rate;
- if the Schedule of Premium Rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue his coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

If payment of premium is made within the grace period in an amount not significantly less than the amount the plan requires to be paid, the amount must be deemed to satisfy the plan's requirement. However, you must be notified and allowed at least 30 days after the notice is provided for payment to be made.

#### **Providing Notification of Status to Providers During the Grace Period**

If, after you elect to continue coverage, dental care provider contacts your Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

#### **Notification Requirements**

Your Employer should send your initial notification of coverage continuation rights as required by federal law when:

- when the Plan first becomes subject to federal continuation requirements;
- when you are hired; and
- when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your Employer within 60 days of such event. Your Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

#### **Conversion Available Following Continuation**

If you or your Dependent's continuation ends due to the

expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the dental conversion benefit then available to Employees and their Dependents.

#### **Interaction With Other Continuation Benefits**

A person who is eligible to continue insurance under both federal law and state law may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in your plan booklet or certificate.

#### **Newly Acquired Dependents**

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this continuation provided:

- the required premium is paid; and
- we are notified of your newly acquired Dependent in accordance with the terms of the policy.

If your death, divorce or legal separation subsequently occurs for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If your child who is born, adopted or placed for adoption as a newly acquired Dependent subsequently fails to continue to qualify as a Dependent, coverage would only be continued as stated in the Dependent Continuation Provision above.

### **V. Notice of Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93)**

#### **What is OBRA?**

OBRA requires that any group dental plan which provides coverage for Dependent children of plan participants, must provide benefits to Dependent children placed with participants for adoption under the same terms and conditions as apply in the case of Dependent children who are "natural" children of participants under the plan. OBRA also provides eligibility for Dependents under Qualified Medical Child Support Orders.

These coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income. Any other provisions in your plan booklet or certificate that provide for:

- the definition of an adopted child and the effective date of eligibility for coverage of that child; and
- eligibility requirements for a child for whom a court order for medical support is issued are superseded by these provisions required by OBRA '93, as amended.



### **What is a Qualified Medical Child Support Order?**

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

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

The Qualified Medical Child Support Order may not require the policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with state laws regarding child dental care coverage.

### **When Your Natural Child is Eligible for Coverage**

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and will not be considered a late entrant for Dependent insurance. You must notify your Employer and elect coverage for that child, and yourself if you are not already, within 31 days of the Qualified Medical Child Support Order being issued.

### **When Your Adopted/Placed for Adoption Child is Eligible for Coverage**

Any child under the age of 18 who is adopted by you, including a child who is placed for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support your child, totally or partially, prior to that child's adoption. If the child placed for adoption is not adopted, all coverage ceases when the placement ends and will not be continued.

### **Payment of Benefits**

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial

parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

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