

**Bernards Bros., Inc.**

CIGNA DENTAL CARE INSURANCE

**EFFECTIVE DATE: January 1, 2022**

CN011  
3336137

This document printed in January, 2022 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*

**CIGNA HEALTH AND LIFE INSURANCE COMPANY**

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

**POLICYHOLDER: Bernards Bros., Inc.**

**GROUP POLICY(S) — COVERAGE**

3336137 - DHMO CIGNA DENTAL CARE INSURANCE

**EFFECTIVE DATE:** January 1, 2022

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.



*Jill Stadelman, Corporate Secretary*

### **Explanation of Terms**

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

## Important Notices

### Discrimination is Against the Law

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

Cigna:

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

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to [ACAGrievance@cigna.com](mailto:ACAGrievance@cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
P.O. Box 188016  
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to [ACAGrievance@cigna.com](mailto:ACAGrievance@cigna.com). You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.

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### Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시고, 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki

dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** –

注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711) まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنید).

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## Nevada Division of Insurance

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

**The Department of Business Industry, Division of Insurance**  
**Toll free number: (888) 872-3234**

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

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

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

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## Eligibility - Effective Date

### Employee Insurance

This plan is offered to you as an Employee.

### Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

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

### Eligibility for Dependent Insurance

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

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

### Waiting Period

The first day of the month following date of hire.



## Classes of Eligible Employees

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

## Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible. If you are a Late Entrant, you may elect the insurance only during an Open Enrollment Period. Your insurance will become effective on the first day of the month after the end of that Open Enrollment Period in which you elect it.

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

## Late Entrant – Employee

You are a Late Entrant if:

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

## Open Enrollment Period

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

## Dependent Insurance

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

## Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until Cigna agrees to insure that Dependent.

Your Dependents will be insured only if you are insured.

## Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

## Choice of Dental Office for Cigna Dental Care

When you elect Employee Insurance, you may select a Dental Office from the list provided by CDH. If your first choice of a Dental Office is not available, you will be notified by CDH of your designated Dental Office, based on your alternate selection. No Dental Benefits are covered unless the Dental Service is received from your designated Dental Office, referred by a Network General Dentist at that facility to a specialist approved by CDH, or otherwise authorized by CDH, except for Emergency Dental Treatment. A transfer from one Dental Office to another Dental Office may be requested by you through CDH. Any such transfer will take effect on the first day of the month after it is authorized by CDH. A transfer will not be authorized if you or your Dependent has an outstanding balance at the Dental Office.

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## Important Information about Your Dental Plan

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

- **Cigna Dental Care; or**
- **Cigna Dental Preferred Provider**

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

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

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

## Change in Option Elected

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

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

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

## Effective Date of Change

If you change options during open enrollment, you (and your Dependents) will become insured on the effective date of the plan. If you change options other than at open enrollment (as



allowed by your plan), you will become insured on the first day of the month after the transfer is processed.

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## Dental Benefits – Cigna Dental Care

### Your Cigna Dental Coverage

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

### Member Services

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

### Other Charges – Patient Charges

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

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

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

### Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of

an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

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

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

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

### Your Payment Responsibility (General Care)

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

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

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

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

### Emergency Dental Care – Reimbursement

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

bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

- **Emergency Care Away From Home**

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

- **Emergency Care After Hours**

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

### **Limitations on Covered Services**

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

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

evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

### **General Limitations - Dental Benefits**

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

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

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

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

- services not listed on the Patient Charge Schedule.
- services provided by a non-network Dentist without Cigna Dental's prior approval (except in emergencies).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.

- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
  - cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless the service is specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; other types of bleaching methods are not covered.
  - general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
  - prescription medications.
  - procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion.
  - replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
  - surgical placement of a dental implant; repair, maintenance or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
  - services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
  - procedures or appliances for minor tooth guidance or to control harmful habits.
  - hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for network Dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
  - the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
  - the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
  - consultations and/or evaluations associated with services that are not covered.
  - endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
  - bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
  - bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
  - intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
  - services performed by a prosthodontist.
  - localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
  - infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
  - the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
  - the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
  - services to correct congenital malformations, including the replacement of congenitally missing teeth.
  - the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period when this limitation is noted on your Patient Charge Schedule.
  - crowns, bridges and/or implant supported prosthesis used solely for splinting.
  - resin bonded retainers and associated pontics.
- Pre-existing conditions are not excluded if the procedures involved are otherwise covered in your Patient Charge Schedule.
- Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

### **Appointments**

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

### **Broken Appointments**

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

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

### **Office Transfers**

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

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

### **Specialty Care**

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

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

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

### **Specialty Referrals**

#### **In General**

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

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

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

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

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

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

#### **Definitions –**

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

## Patient Charges

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

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

## Additional Charges

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

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

## Orthodontics in Progress

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

## Complex Rehabilitation/Multiple Crown Units

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

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you

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

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

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## Alternate Benefit Provision

The following limiting provision applies to your dental plan.

If more than one service may be used to treat a dental condition, coverage will be limited to the less costly Covered Service provided it is: a professionally accepted; necessary; and appropriate method of treatment.

If treatment is provided by a Network Dentist, and the patient requests or accepts a more costly Covered Service, the specific Patient Charge for such service is equal to:

- the Patient Charge for the less costly service; plus
- the difference in cost between the Usual Fee for the more costly service and Usual Fee for the less costly service

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## Coordination of Benefits

Under this dental plan Coordination of Benefits rules apply to specialty care only.

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 medical or 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.

### **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.

### **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.
- 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. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

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

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

Cigna 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**

Cigna, 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.

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## **Expenses For Which A Third Party May Be Responsible**

This plan does not cover:

- Expenses incurred by you or your Dependent; (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.



## Right Of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

## Lien Of The Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

## Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund

Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

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## Payment of Benefits

### To Whom Payable

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal

guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

### Recovery of Overpayment

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

HC-POB4

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### Miscellaneous

Certain Dental Offices 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 Office to determine if such discounts are offered.

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

HC-POB27

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## Termination of Insurance

### Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

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

### Temporary Layoff or Leave of Absence

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

### Injury or Sickness

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

### Note:

When a person's Dental Insurance ceases, Cigna does not offer any Converted Policy either on an individual or group basis. However, upon termination of insurance due to termination of employment in an eligible class or ceasing to qualify as a Dependent, you or any of your Dependents may apply to Cigna Dental Health, Inc. for coverage under an individual dental plan.

Upon request, Cigna Dental Health Inc. or your Employer will provide you with further details of the Converted Policy.

### 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.
- 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.

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04-10

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## Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

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.

HC-BEX38

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## Federal Requirements

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

HC-FED1

10-10

## Notice of Provider Directory/Networks

### Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of dental practitioners, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78

10-10

## Qualified Medical Child Support Order (QMCSO)

### Eligibility for Coverage Under a QMCSO

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

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

### Qualified Medical Child Support Order Defined

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

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

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

## Payment of Benefits

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

HC-FED4

10-10

## Effect of Section 125 Tax Regulations on This Plan

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

### A. Coverage elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if your Employer agrees, and you meet the criteria shown in the following Sections B through F and enroll for or change coverage within the time period established by your Employer.

### B. Change of status

A change in status is defined as:

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

### C. Court order

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

### D. Medicare or Medicaid eligibility/entitlement

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

### E. Change in cost of coverage

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

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

### F. Changes in coverage of spouse or Dependent under another employer's plan

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

HC-FED95

04-17

## Eligibility for Coverage for Adopted Children

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

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

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09-14

## Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is

cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13

10-10

## **Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)**

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

### **Continuation of Health Insurance During Leave**

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

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

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

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

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

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

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

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

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

## **Continuation of Coverage**

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

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

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

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

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

### **Reinstatement of Benefits (applicable to all coverages)**

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

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

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

HC-FED18

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## **Claim Determination Procedures under ERISA Procedures Regarding Medical Necessity Determinations**

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

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

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

#### **Postservice Determinations**

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

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

#### **Notice of Adverse Determination**

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

## **COBRA Continuation Rights Under Federal Law**

### **For You and Your Dependents**

#### **What is COBRA Continuation Coverage?**

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

#### **When is COBRA Continuation Available?**

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

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

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

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

#### **Who is Entitled to COBRA Continuation?**

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

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

“Secondary Qualifying Events” and “Medicare Extension For Your Dependents” are not applicable to these individuals.

### **Secondary Qualifying Events**

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

### **Disability Extension**

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

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

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

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

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

### **Medicare Extension for Your Dependents**

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before

the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

### **Termination of COBRA Continuation**

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

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

### **Employer’s Notification Requirements**

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the

occurrence of a qualifying event, 44 days after the qualifying event occurs; or

- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

### **How to Elect COBRA Continuation Coverage**

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

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

### **How Much Does COBRA Continuation Coverage Cost?**

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

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

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

#### *First payment for COBRA continuation*

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

#### *Subsequent payments*

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

#### *Grace periods for subsequent payments*

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

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

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

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



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

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

### **Newly Acquired Dependents**

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

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

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

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

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

## **ERISA Required Information**

The name of the Plan is:

Bernards Bros., Inc.

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

Bernards Bros., Inc.  
555 First Street  
San Fernando, CA 91340  
818-336-3553

Employer Identification  
Number (EIN):

952920045

Plan Number:

501

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

Employer named above

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

Employer named above

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

The Cigna Claim Office responsible for this Plan

The cost of the Plan is paid by the Employer.

The Plan’s fiscal year ends on 07/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

### **Plan Trustees**

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

### **Plan Type**

The plan is a healthcare benefit plan.

### **Collective Bargaining Agreements**

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

### **Discretionary Authority**

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit

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

#### **Plan Modification, Amendment and Termination**

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

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

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

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

#### **Statement of Rights**

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

#### **Receive Information About Your Plan and Benefits**

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance

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

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

#### **Continue Group Health Plan Coverage**

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

#### **Prudent Actions by Plan Fiduciaries**

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

#### **Enforce Your Rights**

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

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse

the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

### **Assistance with Your Questions**

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

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## **Dental Conversion Privilege**

### **Dental Conversion Privilege for Cigna Dental Care, Cigna Dental Preferred Provider and Cigna Traditional Dental**

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 Cigna; provided that: he applies in writing and pays the first premium to Cigna within 31 days after his insurance ceases; and he is not considered to be overinsured.

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

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## **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.

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## **The Following Will Apply To Residents of Nevada**

### **When You Have A Complaint or an Appeal**

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

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

#### **Start with Member Services**

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

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

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

#### **Appeals Procedure**

Cigna 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.

### **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.

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.

### **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 Cigna's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For 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.

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.

### **Independent Review Procedure**

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

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

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

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

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

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

### **Appeal to the State of Nevada**

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

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

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

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

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

## Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

HC-APL61

04-10

V1

## Definitions

### Active Service

You will be considered in Active Service:

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

HC-DFS1

04-10

V1

### Adverse Determination

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

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

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

HC-DFS350 04-10  
V1

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

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

HC-DFS352 04-10  
V1

**Contract Fees**

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

HC-DFS353 04-10  
V1

**Covered Services**

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

HC-DFS354 04-10  
V1

**Dental Office**

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

HC-DFS355 04-10  
V1

**Dental Plan**

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

HC-DFS356 04-10  
V2

**Dentist**

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

HC-DFS125 04-10  
V3

**Dependent**

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child from the earlier of: the date the adoption becomes effective; or the first day of the child's placement in the home. A Pre-existing Condition Limitation will not apply to an adopted or placed child. It also includes a stepchild, a foster child, or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

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

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

HC-DFS257 04-10  
V1

**Domestic Partner**

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

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

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

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS223

04-10  
V2

**Employee**

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7

04-10  
V3

**Employer**

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8

04-10  
V1

**Group**

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

HC-DFS357

04-10  
V1

**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.

HC-DFS16

04-10  
V1

**Medicare**

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

HC-DFS17

04-10  
V1

**Network General Dentist**

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

HC-DFS358 04-10  
V1

**Network Specialty Dentist**

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

HC-DFS359 04-10  
V1

**Patient Charge Schedule**

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

HC-DFS360 04-10  
V1

**Service Area**

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

HC-DFS361 04-10  
V1

**Specialist**

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

HC-DFS362 04-10  
V1

**Subscriber**

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

HC-DFS363 04-10  
V1

**Usual Fee**

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

HC-DFS138 04-10  
V1



## **Cigna Dental Care – Cigna Dental Health Plan**

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

CDO32

## Cigna Dental Companies

Cigna Dental Health Plan of Arizona, Inc.

Cigna Dental Health of Colorado, Inc.

Cigna Dental Health of Delaware, Inc.

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

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

Cigna Dental Health of Kentucky, Inc.

Cigna Dental Health of Maryland, Inc.

Cigna Dental Health of Missouri, Inc.

Cigna Dental Health of New Jersey, Inc.

Cigna Dental Health of North Carolina, Inc.

Cigna Dental Health of Ohio, Inc.

Cigna Dental Health of Virginia, Inc.

**P.O. Box 453099**

**Sunrise, Florida 33345-3099**

**This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers 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 dentists dental care may be obtained.**

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

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

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

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

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

## I. Definitions

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

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

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

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer 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 Dentist agreement with Cigna Dental.

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

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

**Dental Plan** - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

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

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

For a dependent child 26 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

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

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

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

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

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

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

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

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

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

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

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

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

## II. Introduction To Your Cigna Dental Plan

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

### III. Eligibility/When Coverage Begins

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

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

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

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

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

### IV. Your Cigna Dental Coverage

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

#### A. Customer Service

If you have any questions or concerns about the Dental Plan, Customer Service 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 Customer Service from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

#### B. Premiums

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

#### C. Other Charges – Patient Charges

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

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

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

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

#### D. Choice of Dentist

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits. You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** - When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

#### **General Limitations Dental Benefits**

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

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

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

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

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical

- placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
  - procedures or appliances for minor tooth guidance or to control harmful habits.
  - hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
  - services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)
  - the completion of crowns, bridges, dentures, or root canal treatment, already in progress on the effective date of your Cigna Dental coverage?
  - the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
  - consultations and/or evaluations associated with services that are not covered.
  - endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
  - bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
  - bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
  - intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
  - services performed by a prosthodontist.
  - localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
  - any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
  - infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
  - the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
  - the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
  - services to correct congenital malformations, including the replacement of congenitally missing teeth.
  - the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
  - crowns, bridges and/or implant supported prosthesis used solely for splinting.
  - resin bonded retainers and associated pontics.
- Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.
- Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

## V. Appointments

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

## VI. Broken Appointments

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

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

## VII. Office Transfers

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at [myCigna.com](http://myCigna.com), or call the Dental Office Locator at 1-800-Cigna24.

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

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

## VIII. Specialty Care

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

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

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

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

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

## IX. Specialty Referrals

### A. In General

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for

which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

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

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

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

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

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



teeth, frequently a first phase preceding comprehensive treatment.

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

## 2. Patient Charges

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

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

## 3. Additional Charges

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

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

## 4. Orthodontics In Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at 1-800-Cigna24 to

find out if you are entitled to any benefit under the Dental Plan.

## X. Complex Rehabilitation/Multiple Crown Units

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

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

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

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

For the purposes of this section, any reference to "you" or "your" also refers to a representative or dentist 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 Customer Service

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-Cigna24 toll-free and explain your concern to one of our Customer Service Representatives. You can also

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

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

## **B. Appeals Procedure**

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

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

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

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

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

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

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

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

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

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

### **3. Independent Review Procedure**

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

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

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

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

## **XII. Dual Coverage**

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

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

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

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

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

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

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

#### **B. Effect on Dependents**

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

### **XIV. Extension of Benefits**

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

disenrollment unless disenrollment was due to nonpayment of Premiums.

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

### **XV. Continuation of Benefits (COBRA)**

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

### **XVI. 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 (3) 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 Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group, or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at 1-800-Cigna24 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 customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at [myCigna.com](http://myCigna.com).

### **XVIII. Miscellaneous**

As a Cigna Dental plan customer, 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 [myCigna.com](http://myCigna.com) for details.

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

**SEE YOUR STATE RIDER FOR ADDITIONAL DETAILS.**

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## **State Rider Cigna Dental Health Plan of Arizona, Inc.**

**Arizona Residents:**

### **I. Definitions**

#### **Dependent**

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

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

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

Employees may enroll within 31 days of becoming eligible.

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

## **IV. Your Cigna Dental Coverage**

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

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

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

The following bullet does not apply to Arizona residents.

- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. Arizona residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded.

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

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

### **B. Problems Concerning Denied Pre-authorizations or Denied Claims for Services Already Provided**

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

#### **1. Expedited Review Process (Pre-authorizations Only)**

##### **a. Expedited Review**

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

**b. Expedited Appeal**

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

**c. Expedited External Independent Review**

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

**2. Informal Reconsideration (Pre-authorizations Only)**

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

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

a. Denied Pre-authorizations: You have 60 days from the date you receive notice that your denial was upheld at the Informal Reconsideration level to request a Formal Appeal. Cigna Dental will

notify you and your dentist of its decision in writing within 15 days.

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

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

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

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

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

**5. Appeals to the State**

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

**XII. Dual Coverage**

If you are also an insured or a certificate holder under an indemnity health insurance policy that provides benefits for Covered Services provided by the Dental Plan, the indemnity health insurance policy will pay benefits without regard to the existence of the Cigna Dental Plan. Notwithstanding, the indemnity plan is not obligated to pay any amount for a



procedure provided under the Dental Plan at no charge or to pay in excess of the amount of the Patient Charge for any Covered Service. In the event the Patient Charge has been paid to the Network Dentist, then the Indemnity Plan must remit any payments due directly to you.

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## **Cigna Dental Care – Cigna Dental Health Plan**

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

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

400 North Brand Boulevard, Suite 400  
Glendale, California 91203

### **COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM**

This Combined Evidence of Coverage and Disclosure Form is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the “Group Contract”). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. A specimen copy of the Group Contract will be furnished upon request. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers 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 dentists dental care may be obtained.

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

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

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

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

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



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## I. Definitions

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

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

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

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

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

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

**Contract Fees** – the fees contained in the Network Dentist agreement with Cigna Dental.

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

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

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

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

**Dependent** –

your lawful spouse; or your Domestic Partner; your unmarried child (including newborns, children of the noncustodial parent, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a Dependent

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

- A. less than 26 years old; or
- B. over 26 years old if he or she is both:
  1. a full-time student enrolled at an accredited educational institution, and
  2. primarily supported by you; or
- C. over 26 years old if he or she is both:
  1. incapable of self-sustaining employment due to by reason of a physically or mentally disabling injury, illness or condition; and
  2. chiefly dependent upon you (the Subscriber) for support and maintenance and support.

For a Dependent child 26 years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category C. above, you will need to furnish Cigna Dental proof of the child's condition and his or her reliance upon you, within sixty (60) days from the date that you are notified by Cigna Dental to provide this information.

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

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

**Emergency Medical Condition** – a dental condition of recent onset and severity which would lead a reasonable person 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.

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

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

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

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

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

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

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

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

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

**Subscriber/You** – the enrolled employee or customer of the Group.

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

## II. Introduction To Your Cigna Dental Plan

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

## III. Eligibility/When Coverage Begins

### A. In General

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

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

dates other than the first day of the month are provided for in your Group Contract).

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

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

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

### B. New Enrollee Transition of Care

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

- (1) an acute condition. An acute condition is a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of the Covered Services shall be provided for the duration of the acute condition.
- (2) newborn children between birth and age 36 months. Cigna Dental shall provide for the completion of Covered Services for newborn children between birth

and age 36 months for 12 months from the effective date of coverage for a newly covered enrollee.

- (3) performance of a surgery or other procedure that is approved by Cigna Dental and has been recommended and documented by the non-Network Dentist to occur within 180 days of the effective date of your Cigna Dental coverage.

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

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

### **IV. Your Cigna Dental Coverage**

Cigna Dental maintains its principal place of business at 400 North Brand Boulevard, Suite 400, Glendale, CA 91203, with a telephone number of 1-800-Cigna24.

This section provides information that will help you to better understand your Dental Plan. Included is information about how to access your dental benefits and your payment responsibilities.

#### **A. Customer Service**

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

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

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

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

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. Network Specialty Dentists are compensated based on a contracted fee arrangement for services rendered. No bonuses or financial incentives are used as inducements to limit services. Network Dentists are also compensated by the Copayments that you pay, as set out in your Patient Charge Schedule. You may request general information about these matters from Customer Service or from your Network Dentist.

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

Your Network General Dentist is instructed to tell you about Copayments for Covered Services, the amount you must pay for optional or non-Covered Services and the Dental Office’s payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances. **IMPORTANT:** If you opt to receive dental services that are not Covered Services under this plan, a participating dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Service at 1-800-Cigna24 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Your Patient Charge Schedule is subject to change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Copayments at least 30 days prior to such change. You will be responsible for the Copayments listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

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

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

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment.

The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a Network Pediatric Dentist as the Network General Dentist for your Dependent child under age 13 by calling Customer Service at 1-800-Cigna24 to get a list of Network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 13 to a Network Pediatric Dentist, the Network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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

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

## 2. Appointments

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

## 3. Office Transfers

If you decide to change Dental Offices, we encourage you to complete any dental procedure in progress first. To arrange a transfer, call Customer Service at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at [myCigna.com](http://myCigna.com), or call the Dental Office Locator at 1-800-Cigna24.

Your transfer request may take up to 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. You can check

the status of your request by visiting [myCigna.com](http://myCigna.com), or by calling us at 1-800-Cigna24.

There is no charge to you for the transfer; however, all Copayments which you owe to your current Dental Office must be paid before the transfer can be processed. Copayments for procedures not completed at the time of transfer may be required to be prorated between your current Dental Office and the new Dental Office, but will not exceed the amount listed on your Patient Charge Schedule.

## E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the Copayments listed on your Patient Charge Schedule, subject to applicable exclusions and limitations. For services listed on your Patient Charge Schedule provided at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist available in the Service Area to treat you, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Copayment for Covered Services. Cigna Dental will pay the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. If you seek treatment for Covered Services from a non-Network Dentist without approval from Cigna Dental, you will be responsible for paying the non-Network Dentist his or her Usual Fee.

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

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

## F. Specialty Care

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

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

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

Network Specialty Dentist. Payment authorization is not required for coverage of services by a Network Specialty Dentist.

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

## G. Specialty Referrals

### 1. In General

Payment authorization is not required for coverage of services by a Network Specialty Dentist.

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

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

If a pre-determination of treatment has been approved by Cigna Dental, such treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90-day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

If Cigna Dental makes an Adverse Determination of the requested referral (i.e. Cigna Dental does not approve payment to the Network Specialty Dentist for Covered Services), or if the dental services sought are not Covered Services, you will be responsible to pay the Network Specialty Dentist's Usual Fee for the services rendered. If you have a question or concern regarding an approval or a denial, contact Customer Service.

Specialty referrals will be approved by Cigna Dental if the services sought are: Covered Services; rendered to an eligible customer; within the scope of the Specialty Dentist's skills and expertise; and meet Clinical Necessity requirements. Cigna Dental may request medical information regarding your condition and the information surrounding the dentist's determination of the Clinical Necessity for the request. Cigna Dental shall respond in a timely fashion appropriate for the nature of your condition, not to exceed 5 business days from Cigna Dental's receipt of the information reasonably necessary and requested by Cigna Dental to make the

determination. When you face imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal time frame for the decision making process would be detrimental to your life or health or could jeopardize your ability to regain maximum function, the decision to approve, modify, or deny requests shall be made in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request. Decisions to approve, modify, or deny requests for approval prior to the provision of dental services shall be communicated to the requesting dentist within 24 hours of the decision. Decisions resulting in denial, delay, or modification of all or part of the requested dental service shall be communicated to the customer in writing within 2 business days of the decision. Adverse Determinations may be appealed as described in the Section entitled "What To Do If There Is A Problem/Grievances."

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the specialist'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 approve a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Copayment for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. For non-Covered Services or services not approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee. Or, if you seek treatment for Covered Services from a non-Network Dentist without approval from Cigna Dental, you will be responsible for paying the dentist's Usual Fee.

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

### 2. Second Opinions

If you have questions or concerns about your treatment plan, second opinions are available to you upon request by calling Customer Service. Second

opinions will generally be scheduled within 5 days. In the case of an imminent and serious health threat, as determined by Cigna Dental clinicians, second opinions will be rendered within 72 hours. Cigna Dental's policy statement on second opinions may be requested from Customer Service.

## V. Covered Dental Services

### A. Categories of Covered Services

Dental procedures in the following categories of Covered Services are covered under your Dental Plan when listed on your Patient Charge Schedule and performed by your Network Dentist. Please refer to your Patient Charge Schedule for the procedures covered under each category and the associated Copayment. The Plan or Insurer will cover services delivered through telehealth to the same extent it covers services rendered through in-person contact including the same cost-share or any applicable benefit maximums or lack thereof.

#### 1. Diagnostic/Preventive

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

##### a. Limitation

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

#### 2. Restorative (Fillings)

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

#### 3. Crown and Bridge

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

artificial tooth used in a bridge to replace the missing tooth is called a pontic.

Crowns, inlays or onlays are benefits when there is insufficient tooth structure to support a filling or to replace an existing restoration that is non-functional or nonrestorable.

The replacement of an existing inlay, onlay, crown, bridge or a removable full or partial denture is a benefit when:

- The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, or
- The existing partial denture must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

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

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

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



charge for complex rehabilitation will not be applied to the first 5 units of crown or bridge.

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

**b. Limitations**

- (1) All charges for crown and bridge are per unit (each replacement or supporting tooth equals one unit).
- (2) Limit 1 every 5 years unless Cigna Dental determines that replacement is necessary because the existing crown or bridge is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes in tooth structure or supporting tissues since the placement of the crown or bridge.
- (3) If more than one service may be used to treat a dental condition, coverage will be limited to the less costly Covered Service provided it is: a professionally accepted, necessary and appropriate method of treatment.  
If treatment is provided by a Network Dentist and the patient requests or accepts a more costly Covered Service, the specific Patient Charge for such service is equal to:
  - i. the Patient Charge for the less costly service, plus
  - ii. the difference in cost between the Usual Fee for the more costly service and Usual Fee for the less costly service.
- (4) Fixed bridges are benefits when there are only one or two teeth missing in the arch which can be replaced by a maximum of four units. If there are multiple missing teeth in the same arch, not already replaced by a prior bridge, and if more than four units (combination of abutments and pontics) are needed, the benefit will be limited to a removable partial denture. This limitation will not apply if a fixed bridge is determined by the dentist to be the treatment most consistent with professionally accepted standards of care.

**c. Exclusion**

- (1) There is no coverage for crowns, bridges used solely for splinting. This exclusion will not apply if a crown or bridge is determined

by Cigna Dental to be the treatment most consistent with professionally accepted standards of care.

- (2) There is no coverage for implant supported prosthesis used solely for splinting unless specifically listed on your Patient Charge Schedule.
- (3) There is no coverage for resin bonded retainers and associated pontics.

**4. Endodontics**

Endodontics is root canal treatment which may be required when the nerve of a tooth is damaged due to trauma, infection, or inflammation. Treatment consists of removing the damaged nerve from the root of the tooth and filling the root canal with a rubber-like material. Following endodontic treatment, a crown is usually needed to strengthen the weakened tooth.

**Exclusions**

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

**5. Periodontics**

Periodontics is treatment of the gums and bone which support the teeth. Periodontal disease is chronic. It progresses gradually, sometimes without pain or other symptoms, destroying the support of the gums and bone. The disease is a combination of deterioration plus infection.

**a. Preliminary Consultation**

This consultation by your Network General Dentist is the first step in the care process. During the visit, you and your Network General Dentist will discuss the health of your gums and bone.

**b. Evaluation, Diagnosis and Treatment Plan**

If periodontal disease is found, your Network General Dentist or Network Specialty Dentist will develop a treatment plan. The treatment plan consists of mapping the extent of the disease around the teeth, charting the depth of tissue and bone damage and listing the procedures necessary to correct the disease.

Depending on the extent of your condition, your Network General Dentist or Network Specialty

Dentist may recommend any of the following procedures:

- (1) **Nonsurgical Program** - This is a conservative approach to periodontal therapy. Use of this program depends upon how quickly you heal and how consistently you follow instructions for home care. This program may include:
  - scaling and root planing
  - oral hygiene instruction
  - full mouth debridement
- (2) **Scaling and Root Planing** - This periodontal therapy procedure combines scaling of the crown and root surface with root planing to smooth rough areas of the root. This procedure may be performed by the dental hygienist or your Network General Dentist.
- (3) **Osseous Surgery** - Bone (osseous) surgery is a procedure used in advanced cases of periodontal disease to restructure the supporting gums and bone. Without this surgery, tooth or bone loss may occur. Two checkups by the Periodontist are covered within the year after osseous surgery.
- (4) **Occlusal Adjustment** - Occlusal adjustment requires the study of the contours of the teeth, how they bite (occlude) and their position in the arch. It consists of a recontouring of biting surfaces so that direct biting forces are along the long axis of the tooth. If the biting forces are not properly distributed, the bone which supports the teeth may deteriorate.
- (5) **Bone Grafts and other regenerative procedures** - This procedure involves placing a piece of tissue or synthetic material in contact with tissue to repair a defect or supplement a deficiency.

**c. Limitations**

1. Periodontal scaling and root planing for four or more contiguous teeth or bounded teeth spaces per quadrant is limited to four quadrants per consecutive 12 months.
2. Periodontal scaling and root planing for one to three teeth per quadrant is limited to four quadrants per consecutive 12 months
3. Periodontal maintenance is limited to two within the first 12 months after active therapy.

**d. Exclusion**

1. General anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, IV sedation is covered when medically necessary and provided in conjunction with Covered Services performed by a Periodontist. General anesthesia is not covered when provided by a Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
2. There is no coverage for Periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
3. There is no coverage for the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
4. There is no coverage for bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
5. There is no coverage for bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
6. There is no coverage for localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

**6. Prosthodontics**

Prosthodontics is treatment dealing with the replacement of missing teeth and other oral structures with removable appliances like dentures or partial dentures.

**a. Limitation**

- (1) Interim partial dentures, in conjunction with fixed or removable appliances, are a benefit as replacements for extracted anterior teeth for adults during healing periods when the teeth cannot be added to an existing partial denture.
- (2) Denture relining is limited to one every 36 months.

- (3) Interim dentures are limited to one every five years.

**b. Exclusion**

- (1) services associated with the placement (i.e., surgically placing the implant into the bone) or prosthodontic restoration of a dental implant.
- (2) replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect.

**7. Oral Surgery**

Oral surgery involves the surgical removal of teeth or associated surgical procedures by your Network General Dentist or Network Specialty Dentist.

**a. Limitation**

The surgical removal of a wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Temporary pain from normal eruption is not considered disease. Your Patient Charge Schedule lists any limitations on oral surgery.

**b. Exclusion**

General anesthesia, sedation and nitrous oxide are not covered unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

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

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

- (1) **Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the Orthodontist.
- (2) **Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- (3) **Comprehensive Orthodontic Treatment** - treatment after the eruption of most

permanent teeth, generally the final phase of treatment before retention.

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

**b. Copayments**

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

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

**c. Additional Charges**

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

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

**d. Orthodontics in Progress**

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call Customer Service at 1-800-Cigna24 to find out the benefit to which you are entitled based upon your individual case and the remaining months of treatment.

**e. Exclusion**

Replacement of fixed and/or removable orthodontic appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

**B. Emergency Dental Care - Reimbursement**

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. Emergency dental care services may include examination, x-rays, sedative fillings, dispensing of antibiotics or pain relief medication or other palliative services prescribed by the treating dentist. You should contact your Network General Dentist if you have an emergency in your Service Area.

**1. Emergency Care Away From Home**

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

**2. Emergency Care After Hours**

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

**VI. Exclusions**

In addition to the exclusions and limitations listed in Section V, listed below are the services or expenses which are also NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section V.B.).
- services to the extent you, or your Dependent, are compensated for them under any group medical plan.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- prescription medications.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination. If special circumstances arise where a Network Dentist is not available, the Plan will make special arrangements for the provision of covered benefits as necessary for the dental health of the customer.)
- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction and the primary purpose of the restoration is to change the vertical dimension of occlusion or for cosmetic purposes.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- charges by Dental Offices for failing to cancel an appointment or canceling an appointment with less than 24 hours notice (i.e. a broken appointment). You will be responsible for paying any broken appointment fee unless your broken appointment was unavoidable due to emergency or exigent circumstances.
- consultations and/or evaluations associated with services that are not covered.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.

- services to correct congenital malformations, including the replacement of congenitally missing teeth.

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

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

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

## VII. Limitations

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

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

In addition to the above, the following limitation will also apply:

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

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

## VIII. What To Do If There Is A Problem/Grievances

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

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request. No Plan employee shall retaliate or discriminate against a customer (including seeking disenrollment of the customer) solely on the basis that the customer filed a grievance. Instances of such retaliation or discrimination shall be grounds for disciplinary action, (including termination) against the employee.

### A. Your Rights To File Grievances With Cigna Dental

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

Grievances include both complaints and appeals. Complaints may include concerns about people, quality of service, quality of care, benefit interpretations or eligibility. Appeals are requests to reverse a prior denial, or modified decision about your care. You may contact us by telephone or in writing with a grievance.

You have 365 days following the action that is the subject of your dissatisfaction to submit a grievance. If your grievance relates to the cancellation of your coverage, you have 365 days as of the date of the notice you allege to be improper to submit a grievance.

### B. How to File A Grievance

To contact us by phone, call us toll-free at 1-800-Cigna24 or the toll-free telephone number on your Cigna identification card. The hearing impaired may call the state TTY toll-free service listed in their local telephone directory.

Send written grievances to:

Cigna Dental Health of California, Inc.  
P.O. Box 188047  
Chattanooga, TN 37422-8047

We will provide you with a grievance form upon request, but you are not required to use the form in order to make a written grievance.

You may also submit a grievance online through the following Cigna website:  
<http://myCigna.com/health/consumer/medical/state/ca.html#dental>.

If the customer is a minor, is incompetent or unable to exercise rational judgment or give consent, the parent, guardian, conservator, relative, or other legal representative acting on behalf of the customer, as appropriate may submit a grievance to Cigna Dental or the California Department of Managed Health Care (DMHC or “Department”), as the agent of the customer. Also, a participating dentist may join with or assist you or your agent in submitting a grievance to Cigna Dental or the DMHC.

### 1. Complaints

If you are concerned about the quality of service or care you have received, a benefit interpretation, or have an eligibility issue, you should contact us to file a verbal or written complaint. If you contact us by telephone to file a complaint, we will attempt to document and/or resolve your complaint over the telephone. If we receive your complaint in writing, we will send you a letter confirming that we received the complaint within 5 calendar days of receiving your notice. This notification will tell you whom to contact should you have questions or would like to submit additional information about your complaint. We will investigate your complaint and will notify you of the outcome within 30 calendar days.

### 2. Appeals

If your grievance does not involve a complaint about the quality of service or care, a benefit interpretation or an eligibility issue, but instead involves dissatisfaction with the outcome of a decision that was made about your care and you want to request Cigna Dental to reverse the previous decision, you should contact us within one year of receiving the denial notice to file a verbal or written appeal. Be sure to share any new information that may help justify a reversal of the original decision. Within 5 calendar days from when we receive your appeal, we will confirm with you, in writing, that we received it. We will tell you whom to contact at Cigna Dental should you have questions or would like to submit additional information about your appeal. We will make sure your appeal is handled by someone who has authority to take action and who was not involved in the original decision. We will investigate your appeal and notify you of our decision, within 30 calendar days. You may request that the appeal process be expedited, if there is an imminent and serious threat to your health, including severe pain, potential loss of life, limb or major bodily function. A Dental Director for Cigna Dental, in consultation with your treating dentist, will decide if an expedited appeal is necessary. When an appeal is expedited,

Cigna Dental will respond orally and in writing with a decision within 72 hours.

### C. You Have Additional Rights Under State Law

Cigna Dental is regulated by the California Department of Managed Health Care (DMHC or the “Department”). If you are dissatisfied with the resolution of your complaint or appeal, the law states that you have the right to submit the grievance to the Department for review as follows:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-Cigna24 and use your health plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department’s internet website [www.dmhc.ca.gov](http://www.dmhc.ca.gov) has complaint forms, IMR application forms and instructions online.

There is no application or processing fee of any kind associated with the Independent Medical Review process.

You may file a grievance with the DMHC if Cigna Dental has not completed the complaint or appeal process described above within 30 days of receiving your grievance. You may immediately file an appeal with Cigna Dental and/or the DMHC in a case involving an imminent and serious threat to the health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the DMHC determines that an earlier review is warranted.

### D. Voluntary Mediation

If you have received an appeal decision from Cigna Dental with which you are not satisfied, you may also request voluntary mediation with us before exercising the right to submit a grievance to the DMHC. In order for mediation to take place, you and Cigna Dental each have to voluntarily agree to the mediation. Cigna Dental will consider each request for mediation on a case-by-case

basis. Each side will equally share the expenses of the mediation. To initiate mediation, please submit a written request to the Cigna Dental address listed above. If you request voluntary mediation, you may elect to submit your grievance directly to the DMHC after participating in the voluntary mediation process for at least 30 days.

For more specific information regarding these grievance procedures, please contact our Customer Service Department.

### IX. Coordination of Benefits

Coordination of benefit rules explain the payment process when you are covered by more than one Dental Plan. You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

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

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

- A. A customer may be covered as an employee by his/her employer and as a Dependent by his/her spouse’s employer. The plan that covers the customer as an employee (the policyholder) is the primary plan.
- B. Under most circumstances, if a child is covered as a Dependent under both parents’ coverage (and parents are not separated or divorced), the plan of the parent with the earliest birthday in the year is the primary plan.
- C. If a child of divorced or separated parents is covered as a Dependent under at least one of the parents’ (or stepparents’) coverage, benefits are determined in the following order:
  1. According to a court decree that designates the person financially responsible for the dental care coverage; or without such decree,
  2. The plan of the parent who has custody of the child;
  3. If the parent with custody of the child is remarried, then the stepparent’s plan; and finally,
  4. The plan of the parent without custody of the child.

- D. The benefits of a plan that covers an active employee (and any Dependents) are determined before those of a program which covers an inactive employee (laid-off or retired). However, if one of the plans does not have a provision regarding retired or laid-off employees, this section may not apply. Please contact the Plan at the number below for further instruction.
- E. If a customer is covered under a continuation plan (e.g. COBRA) AND has coverage under another plan, the following determines the order of benefits:
1. The plan that covers the customer as an employee (or Dependent of employee) will be primary;
  2. The continuation plan will be secondary.
- However, if the plan that covers the person as an employee does not follow these guidelines and the plans disagree about the order of determining benefits, then this rule may be ignored. Please contact Cigna Dental at the number below for further instructions.
- F. If none of the above rules determines the order of benefits, the plan that has been in effect longer is the primary plan. To determine which plan has been in effect longer, we will take into consideration the coverage you had previously with the same employer, even if it was a different plan, as long as there was no drop in eligibility during the transition between plans.
- G. Workers' Compensation - Should any benefit or service rendered result from a Workers' Compensation Injury Claim, the customer shall assign his/her right to reimbursement from other sources to Cigna Dental or to the Participating Dentist who rendered the service.
- H. When Cigna Dental is primary, we will provide or pay dental benefits without considering any other plan's benefits. When Cigna Dental is secondary, we shall pay the lesser of either the amount that we would have paid in the absence of any other dental coverage, or your total out of pocket cost payable under the primary Dental Plan for benefits covered by Cigna Dental.
- I. Please call Cigna Dental at 1-800-Cigna24 if you have questions about which plan will act as your primary plan or if you have other questions about coordination of benefits.

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

## **X. Disenrollment From The Dental Plan – Termination of Benefits**

Except for extensions of coverage as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan/termination of benefits and coverages will be as follows:

### **A. For The Group**

The Dental Plan is renewable with respect to the Group except as follows:

1. for nonpayment of the required Prepayment Fees;
2. for fraud or other intentional misrepresentation of material fact by the Group;
3. low participation (i.e. less than ten enrollees);
4. if the Dental Plan ceases to provide or arrange for the provision of dental services for new Dental Plans in the state; provided, however, that notice of the decision to cease new or existing Dental Plans shall be provided as required by law at least 180 days prior to discontinuation of coverage; or
5. if the Dental Plan withdraws a Group Dental Plan from the market; provided, however, that notice of withdrawal shall be provided as required by law at least 90 days prior to the discontinuation and that any other Dental Plan offered is made available to the Group.

### **B. For You and Your Enrolled Dependents**

The Dental Plan may not be canceled or not renewed except as follows:

1. failure to pay the charge for coverage if you have been notified and billed for the charge and at least 30 days have elapsed since the notice of the start of the Grace Period.
2. fraud or deception in the use of services or Dental Offices or knowingly permitting such fraud or deception by another.

### **C. Termination Effective Date**

The effective date of the termination for you and/or your Dependents shall be as follows:

1. Cigna Dental shall provide written notice of non-receipt of payment on or before the twelfth (12th) day of the month following the month for which Premiums/Prepayment Fees remain due and owing. The Group shall have at least 30 days after the date of the notice of start of the Grace Period for the payment of any Premium/Prepayment Fee. The Contract shall remain in full force and effect during this Grace Period. If the Premium/Prepayment Fees are not remitted by the end of the Grace Period, the



Contract will terminate upon the expiration of the Grace Period.

2. In the case of failure to meet eligibility requirements enrollment will be canceled as of the date of termination specified in the written notice, provided that at least 15 days have expired since the date of notification.
3. On the last day of the month after voluntary disenrollment by you and/or your Dependents.
4. Termination of Benefits due to fraud or deception shall be effective as described in the notice of Cancellation, Rescission, or Nonrenewal that will be issued at least 30 days before the cancellation, rescission, or nonrenewal.

#### **D. Effect on Dependents**

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

#### **E. Right to Review**

If you believe that your termination from the Dental Plan is due to your dental health status or requirements for dental care services, you may request review of the termination by the Director of the Department of Managed Health Care. Grievances received by the Dental Plan pertaining to cancellations, rescissions, or nonrenewals will be treated in the same manner as expedited grievances.

#### **F. Notice of End of Coverage**

If the Group Contract is terminated for any reason described in this section, the notice of End of Coverage of the Group Contract or your coverage under the Group Contract shall be mailed by the Dental Plan to your Group or to you, as applicable. Such notice shall be dated and shall include information about your rights and other information as required by state law.

### **XI. Continuity Of Care**

If you are receiving care from a Network Dentist who has been terminated from the Cigna Dental network, Cigna Dental will arrange for you to continue to receive care from that dentist if the dental services you are receiving are for one of the following conditions:

- (1) an acute condition. An acute condition is a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of the Covered Services shall be provided for the duration of the acute condition.

- (2) newborn children between birth and age 36 months. Cigna Dental shall provide for the completion of Covered Services for newborn children between birth and age 36 months for 12 months from the termination date of the Network Dentist's contract.
- (3) performance of a surgery or other procedure that is approved by Cigna Dental and has been recommended and documented by the terminated dentist to occur within 180 days of the effective date of termination of the dentist's contract.

Cigna Dental is not obligated to arrange for continuation of care with a terminated dentist who has been terminated for medical disciplinary reasons or who has committed fraud or other criminal activities.

In order for the terminated Participating Dentist to continue to care for you, the terminated dentist must comply with the Cigna Dental's contractual and credentialing requirements and must meet the Cigna Dental's standards for utilization review and quality assurance. The terminated dentist must also agree with Cigna Dental to a mutually acceptable rate of payment. If these conditions are not met, Cigna Dental is not required to arrange for continuity of care.

If you meet the necessary requirements for continuity of care as described above, and would like to continue your care with the terminated Dentist, you should call Customer Service.

If you do not meet the requirements for continuity of care or if the terminated dentist refuses to render care or has been determined unacceptable for quality or contractual reasons, Cigna Dental will work with you to accomplish a timely transition to another qualified Network Dentist.

### **XII. Continuation of Benefits (COBRA)**

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

### **XIII. Individual Continuation Of Benefits**

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within 3 months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- permanent breakdown of the dentist-patient relationship;

- fraud or misuse of dental services and/or Dental Offices;
- nonpayment of Prepayment Fees by the Subscriber;
- selection of alternate dental coverage by your Group; or
- lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at 1-800-Cigna24 to obtain current rates and make arrangements for continuing coverage.

#### **XIV. 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 customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24, or via the Internet at [myCigna.com](http://myCigna.com).

A STATEMENT DESCRIBING Cigna DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

#### **XV. Miscellaneous**

##### **A. Programs Promoting General Health**

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

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

##### **B. Organ and Tissue Donation**

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. The California Health and Safety Code states that an anatomical gift may be made by one of the following ways:

- a document of gift signed by the donor.

- a document of gift signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the donor and of each other and state that it has been so signed.
- a document of gift orally made by a donor by means of a tape recording in his or her own voice.

One easy way individuals can make themselves eligible for organ donation is through the Department of Motor Vehicles (DMV). Every time a license is renewed or a new one is issued to replace one that was lost, the DMV will automatically send an organ donor card. Individuals may complete the card to indicate that they are willing to have their organs donated upon their death. They will then be given a small dot to stick on their driver's license, indicating they have an organ donor card on file. For more information, contact your local DMV office and request an organ donor card.

##### **C. 911 Emergency Response System**

You are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when you have an Emergency Medical Condition that requires an emergency response.

CAVP/A09 (09 Series Value Plans/A-Series).4

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## **CALIFORNIA LANGUAGE ASSISTANCE PROGRAM NOTICE**

### **IMPORTANT INFORMATION ABOUT FREE LANGUAGE ASSISTANCE**

**No Cost Language Services** for customers who live in California and customers who live outside of California who are covered under a policy issued in California. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-244-6224 for Cigna medical/dental or 1-866-421-8629 for Cigna Behavioral Health mental health/substance abuse. For more help, call either the HMO Help Center at 1-888-466-2219 or for Non-HMO plans (e.g. PPO) call the CA Dept. of Insurance at 1-800-927-4357. **English**

**Servicios de idioma sin costo** para asegurados que viven en California y para asegurados que viven fuera de California y que están cubiertos por una póliza emitida en California. Puede obtener un intérprete. Puede hacer que le lean los documentos en español y que le envíen algunos de ellos en ese idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al



1-800-244-6224 para servicios médicos/dentales de Cigna o al 1-866-421-8629 para servicios de salud mental/farmacodependencia de Cigna Behavioral Health. Para obtener ayuda adicional, llame al Centro de ayuda HMO al 1-888-466-2219 o para los planes que no sean HMO (p. ej. PPO) llame al Departamento de Seguros de CA al 1-800-927-4357.

**Spanish**

居住在加州境內的被保人和居住在加州境外但受到加州境內核發保單承保的被保人可取得免費語言服務。您可取得口譯員服務。我們可以用中文將文件讀給您聽，並將部分備有中文版的文件寄送給您。欲取得協助，請撥打您會員卡上所列示的電話號碼，或致電 1-800-244-6224 與 Cigna 醫療 / 牙科聯絡，或撥打 1-866-421-8629 聯繫 Cigna Behavioral Health 精神健康 / 物質濫用。欲取得其他協助，請致電 1-888-466-2219 與 HMO 協助中心聯絡，或非 HMO 計畫 (例如：PPO) 請致電

1-800-927-4357 與加州保險部聯絡。 **Chinese**

خدمات لغوية بدون تكلفة للعملاء المقيمين في ولاية كاليفورنيا والعملاء المقيمين خارج ولاية كاليفورنيا الذين تشملهم سياسة تأمين صادرة في ولاية كاليفورنيا. يُمكنك الاستعانة بمترجم. يمكنك طلب قراءة الوثائق لك وإرسال بعض منها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-244-6244 لخدمات Cigna الطبية / صحة الأسنان أو على الرقم 1-866-421-8629 لخدمات Cigna للصحة السلوكية والنفسية / إساءة استخدام المواد المخدرة. للحصول على المزيد من المساعدة، اتصل إما بمركز HMO للمساعدة على الرقم 1-888-466-2219 أو للبرامج الأخرى غير HMO (مثل PPO)، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. **Arabic**

캘리포니아 거주 고객 및 캘리포니아에서 발행된 보험으로 보장을 받는 캘리포니아 이외 지역 거주 고객님들을 위한 무료 언어 지원 서비스. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스를 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 기재된 안내번호 혹은 Cigna 의료/치과 안내번호(1-800-244-6224번), 혹은 Cigna Behavioral Health 정신 건강/약물 남용 안내번호(1-866-421-2219번)으로 연락해주시십시오. 더 많은 도움이 필요하신 분은 HMO 헬프 센터(HMO Help Center), 안내번호 1-888-466-2219번으로 문의하시거나 HMO 플랜(예: PPO)에 해당하시는 분은 캘리포니아주

보험국(CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 연락해주시십시오. **Korean**

**Walang Gastos na Mga Serbisyo sa Wika** para sa mga customer na nakatira sa California at mga customer na nakatira sa labas ng California na sakop ng isang polisiyang inisyu sa California. Makakakuha ka ng interpreter. Maaari mong ipabasa para sa iyo ang mga dokumento at maaaring ipadala sa iyo ang ilan sa iyong wika. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-244-6224 para sa medikal/dental ng Cigna o sa 1-866-421-8629 para sa kalusugang pangkaisipan/pag-abuso sa droga ng Cigna Behavioral Health. Para sa karagdagang tulong, tumawag sa HMO Help Center sa 1-888-466-2219 o para sa mga planong Hindi HMO (hal. PPO) tawagan ang CA Dept. of Insurance sa 1-800-927-4357. **Tagalog**

**Dịch vụ trợ giúp ngôn ngữ miễn phí** cho khách hàng sinh sống trong tiểu bang California và khách hàng sống ngoài California được đài thọ qua một hợp đồng bảo hiểm y tế ký kết tại California. Quý vị có thể được cấp thông dịch viên. Quý vị có thể được có người đọc văn bản cho quý vị hoặc được nhận tài liệu, văn bản bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên (ID) của quý vị hoặc gọi cho chương trình bảo hiểm y tế/nha khoa Cigna tại số 1-800-244-6224, hoặc gọi số 1-866-421-8629 cho chương trình chăm sóc sức khỏe tâm thần/lạm dụng chất gây nghiện thuộc Chương trình Sức khỏe Hành vi của Cigna. Để được giúp đỡ thêm, vui lòng gọi Trung tâm Trợ giúp HMO tại 1-888-466-2219 hoặc gọi Bộ Bảo hiểm California tại số 1-800-927-4357 cho các vấn đề thuộc các chương trình bảo hiểm không thuộc loại HMO (như các chương trình PPO). **Vietnamese**

**សេវាបកប្រែភាសាដោយឥតគិតថ្លៃ**  
សំរាប់អតិថិជនដែលរស់នៅក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា និងអតិថិជនដែលរស់នៅក្រៅរដ្ឋកាលីហ្វ័រនីញ៉ា ដែលបានរ៉ាប់រង នៅក្រោមច្បាប់សន្យា បានចេញឲ្យក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា។ អ្នកអាចទទួលបានជំនួយពីអ្នកបកប្រែបាន។ អ្នកអាចឲ្យគេអានឯកសារជូនអ្នក និងឆ្លើយឯកសារខ្លះ ទៅឲ្យអ្នក ជាភាសាខ្មែរ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកក់នៅលើប័ណ្ណ ID របស់អ្នក ឬលេខ 1-800-244-6224 សំរាប់ខាង សុខភាព/ផ្ទេរ Cigna ឬ 1-866-421-8629 សំរាប់ខាងកម្រិតបច្ចេកទេស/ការរំលោភសារធាតុញៀន Cigna។ សំរាប់ជំនួយថែមទៀត ទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយ HMO តាមលេខ 1-888-466-2219 ឬសំរាប់ករណីមិនមែនជា HMO (ដូចជា PPO) ទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រង រដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ **Khmer**

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਹਨ ਜੋ ਕੈਲੀਫੋਰਨੀਆ ਵਿੱਚ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਜੋ ਕੈਲੀਫੋਰਨੀਆ ਤੋਂ ਬਾਹਰ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਕੈਲੀਫੋਰਨੀਆ ਵਿੱਚ ਜਾਰੀ ਕੀਤੀ ਗਈ ਪਾਲਿਸੀ ਦੇ ਅਧੀਨ ਕਵਰਡ ਹਨ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਸਾਨੂੰ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਉੱਤੇ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਤੇ ਜਾਂ Cigna ਮੈਡੀਕਲ/ਡੈਂਟਲ ਲਈ 1-800-244-6224 ਤੇ ਜਾਂ Cigna ਵਿਵਹਾਰਕ ਸਿਹਤ ਮਾਨਸਿਕ ਸਿਹਤ/ਪਦਾਰਥਾਂ ਦੇ ਦੁਰਉਪਯੋਗ ਲਈ 1-866-421-8629 ਤੇ ਫੋਨ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ, ਜਾਂ ਤਾਂ HMO ਮਦਦ ਕੇਂਦਰ ਨੂੰ 1-888-466-2219 ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਗੈਰ HMO ਯੋਜਨਾਵਾਂ (ਉਦਾਹਰਣ ਲਈ PPO) ਲਈ CA ਦੇ ਬੀਮਾ ਵਿਭਾਗ (CA Dept. of Insurance) ਨੂੰ 1-800-927-4357 ਤੇ ਫੋਨ ਕਰੋ।

**Punjabi**

**خدمات مجانی مربوط به زبان** برای مشتریانی که در کالیفرنیا زندگی می کنند و مشتریانی که در خارج کالیفرنیا زندگی کرده و بر اساس بیمه نامه ای که در کالیفرنیا صادر شده تحت پوشش هستند. می توانید از خدمات یک مترجم شفاهی برخوردار شوید. می توانید بگویند که مدارک به زبان شما برایتان قرائت شوند و برخی از آنها به زبان شما برایتان ارسال شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید و یا به شماره 1-800-244-6224 برای طرح پزشکی/دندانپزشکی Cigna و یا به شماره 1-866-421-8629 برای برنامه بهداشت روانی/سوء استفاده از مواد مخدر طرح بهداشت رفتاری Cigna تلفن کنید. برای دریافت کمک بیشتر، به مرکز کمک HMO به شماره 1-866-466-2219 و یا برای طرح های غیر HMO (برای مثال PPO) به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. **Persian**

**無料の言語サービス。**カリフォルニア州にお住まいのお客様、および、カリフォルニア州外にお住まいで、カリフォルニア州において発行された保険のお客様が対象。通訳がご利用でき、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカードに記載の電話番号、またはCigna医療・歯科サービス担当：1-800-244-6224、またはCigna Behavioral Health（メンタルヘルス・薬物乱用）サービス担当：1-866-421-8629までご連絡ください。その他のお問い合わせは、HMO Help Center：1-888-466-2219、またはNon-HMOプラン（例：PPO「優先医療給付機構」）については、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。 **Japanese**

**Бесплатные услуги перевода** для клиентов, проживающих на территории штата Калифорния, а также для тех клиентов, которые проживают за его пределами и имеют страховой полис, выданный в штате Калифорния. Вы имеете право воспользоваться услугами устного переводчика. Вам могут прочесть ваши документы, а также выслать перевод некоторых из них на вашем языке. Для получения помощи, позвоните нам по телефону, указанному в вашей Идентификационной карте, по вопросам медицинского и стоматологического обслуживания, предоставляемого компанией Cigna, позвоните по телефону 1-800-244-6224, по вопросам связанным с психическим здоровьем/злоупотреблением алкоголем или наркотиками обращайтесь по телефону 1-866-421-8629 в программу

Cigna Behavioral Health. Для получения дополнительной помощи обращайтесь либо в Центр поддержки HMO по телефону 1-888-466-2219 либо обращайтесь в Министерство страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357 для получения информации в отношении не HMO планов (например PPO). **Russian**

**Անվճար Լեզվական Ծառայություններ** անդամների համար, ովքեր բնակվում են Կալիֆորնիայում և անդամների համար, ովքեր բնակվում են Կալիֆորնիայից դուրս բայց ապահովագրված են Կալիֆորնիայում տրված ապահովագրությամբ: Դուք կարող եք թարգմանիչ ձեռք բերել: Դուք կարող եք փաստաթղթերը ձեր լեզվով ընթերցել տալ ձեզ համար և նրանց մի մասը ստանալ ձեր լեզվով: Օգնության համար, զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ՝ 1-800-244-6244, Cigna-ի բժշկական/ատամնաբուժական ծրագրի համար կամ՝ 1-866-421-8629 Cigna Վարվեցողական Առողջապահության հոգվեան առողջության/թմրամոլության համար: Լրացուցիչ օգնության համար զանգահարեք կամ HMO-ի Օգնության կենտրոն 1-888-466-2219 համարով կամ՝ Ոչ-HMO ծրագրերի համար (օրինակ՝ PPO) զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք 1-800-927-4357 համարով: **Armenian**

**Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi** rau cov qhua uas nyob hauv xeev California thiab cov qhua uas nyob tawm Xeev California uas tau muaj kev pov fwm los ntawm California. Koj yeej muaj tau tus neeg txhais lus. Koj hais tau kom muab cov ntawv nyeem rau koj mloog thiab kom muab qee cov ntaub ntawv txhais ua koj hom lus xa rau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-244-6224 rau Cigna chaw pab them nqi kho mob/kho hniav los sis 1-866-421-8629 rau Cigna Chaw pab them nqi kho Kev Coj Cuj Pwm kev puas hlwb/kev quav tshuaj yeeb dej caw. Yog xav tau kev pab ntawm HMO Qhov Chaw Muab Kev Pab ntawm tus xov tooj 1-888-466-2219 los sis rau cov chaw pab them nqi kho mob uas Tsis Koom HMO (piv txwv li yog PPO) hu rau CA Lub Tuam Tsev Tswj Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. **Hmong**

**कैलिफोर्निया और कैलिफोर्निया के बाहर रहने वाले कैलिफोर्निया में जारी पॉलिसी के तहत कवर किये गए**

ग्राहकों के लिए निःशुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप इन दस्तावेजों को किसी से पढ़वा सकते हैं और कुछ दस्तावेजों को अपनी भाषा में प्राप्त कर सकते हैं। Cigna स्वास्थ्य/दंत के लिए अपने ID कार्ड पर सूचीबद्ध नंबर 1-800-244-6224 पर या Cigna व्यवहार स्वास्थ्य मानसिक स्वास्थ्य/नशे की अधिकता की सहायता के लिए, 1-866-421-8629 पर कॉल करें। अधिक सहायता के लिए, HMO सहायता केंद्र पर 1-888-466-2219 पर कॉल करें या गैर-HMO योजनाओं (उदा. PPO) के लिए 1-800-927-4357 पर CA बीमा विभाग (CA Dept. of Insurance) को कॉल करें। Hindi

### บริการภาษาโดยไม่เสียค่าใช้จ่าย

สำหรับลูกค้าที่อาศัยอยู่ในรัฐแคลิฟอร์เนีย และที่อาศัยอยู่นอกรัฐแคลิฟอร์เนียที่ได้รับการคุ้มครอง

ภายใต้กรมธรรม์ที่ออกในรัฐแคลิฟอร์เนีย คุณสามารถขอลามแปลภาษาได้ คุณสามารถขอให้อ่านเอกสารให้คุณฟัง และขอให้ส่งเอกสาร บางส่วนถึงคุณเป็นภาษาของคุณ หากต้องการความช่วยเหลือ โปรดโทรศัพท์ถึงเราตามหมายเลขที่ระบุไว้บนบัตรประจำตัวของคุณ หรือ หมายเลข 1-800-244-6224 สำหรับบริการของ Cigna ด้านการรักษาพยาบาล/ทันตกรรมของ Cigna หรือ 1-866-421-8629 สำหรับบริการของ Cigna Behavioral Health ด้านสุขภาพจิต/การใช้สารที่มีผลต่อจิตประสาทในทางที่ผิด หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ช่วยเหลือสำหรับแผนการรักษาพยาบาลแบบ HMO ที่หมายเลข 1-888-466-2219 หรือสำหรับแผนการรักษาพยาบาลที่ไม่ใช่ HMO (เช่น PPO) โปรดโทรศัพท์ถึง Dept. of Insurance ของรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

### DISCRIMINATION IS AGAINST THE LAW

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

Cigna:

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

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, gender identity, or sexual orientation, you can file a grievance by sending an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com). You can also file a civil rights complaint or a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, gender identity, or sexual orientation with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.

NOT253

## **Cigna Dental Care – Cigna Dental Health Plan**

**The following rider applies if you are a resident of: AZ, CO, DE, KS/NE, KY/IL, NJ.**

CDO34



## Benefit Rider

### Cigna Dental Companies

Cigna Dental Health Plan of Arizona, Inc.

Cigna Dental Health of Colorado, Inc.

Cigna Dental Health of Delaware, Inc.

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

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

Cigna Dental Health of Kentucky, Inc. (Kentucky and Illinois)

Cigna Dental Health of New Jersey, Inc.

Cigna Dental Health of Ohio, Inc.

Cigna Dental Health of Virginia, Inc.

**P.O. Box 453099**

**Sunrise, Florida 33345-3099**

This State Rider is attached to and made part of your Plan Booklet/Evidence of Coverage and replaces the following provisions:

#### D. Choice of Dentist

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

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 13 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 13 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 13 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 13, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

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

To obtain a list of Dental Offices near you, visit our website at [my.cigna.com](http://my.cigna.com), or call the Dental Office Locator at 1.800.Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

#### F. Emergency Dental Care - Reimbursement

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

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

#### G. Limitations On Covered Services

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

- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 13<sup>th</sup> birthday. Effective on your child's 13<sup>th</sup> birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.

#### 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 Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at [my.cigna.com](http://my.cigna.com), or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency,

you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. You can check the status of your request by visiting [myCigna.com](http://myCigna.com), or by calling us at 1.800.Cigna24.

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.

## IX. SPECIALTY REFERRALS

### A. IN GENERAL

Preauthorization is not required for coverage of services by a Network Specialty Dentist.

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

For non-Covered Services or if Cigna Dental does not approve 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 approval or a denial, contact Customer Service.

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 approve 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 approved for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

PB09 Rider GN

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v1

## **Cigna Dental Care – Cigna Dental Health Plan**

The rider(s) listed in the next section are general provisions that apply to residents of:

**AZ, CA, CO, CT, DE, IL, KS/NE, KY, MD, MO, NJ, NC, OH, TX, VA**

CDO35

## Domestic Partner Rider

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

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

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

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

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

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

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

Kentucky Residents: Coverage terminates (for the domestic partner and any dependents, if included) when the domestic partnership ends. Domestic Partners are entitled to Conversion rights upon termination of coverage.

DPRIDER02

V11

## **Alternate Benefit Provision Rider**

The following limiting provision applies to your dental plan.

**Alternate Benefit Provision** – If more than one service may be used to treat a dental condition, coverage will be limited to the less costly Covered Service provided it is: a professionally accepted; a necessary; and an appropriate method of treatment.

If treatment is provided by a Network Dentist, and the patient requests or accepts a more costly Covered Service, the specific Patient Charge for such service is equal to:

- A. the Patient Charge for the less costly service, plus
- B. the difference in cost between the Usual Fee for the more costly service and Usual Fee for the less costly service.

ABRIDER

## Federal Requirements

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

FDRL1

V2

## Notice of Provider Directory/Networks

### Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting [www.cigna.com](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.

FDRL79

## Qualified Medical Child Support Order (QMCSO)

### A. Eligibility for Coverage Under a QMCSO

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

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

### B. Qualified Medical Child Support Order Defined

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

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

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

### C. Payment of Benefits

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

FDRL2

V1

## Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits.

Otherwise, you will receive your taxable earnings as cash (salary).

#### **A. Coverage Elections**

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the date you meet the criteria shown in the following Sections B through F.

#### **B. Change of Status**

A change in status is defined as:

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

#### **C. Court Order**

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

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

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

#### **E. Change in Cost of Coverage**

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

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

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

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

FDRL70

#### **Eligibility for Coverage for Adopted Children**

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

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

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

FDRL6

#### **Group Plan Coverage Instead of Medicaid**

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

FDRL75

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

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, 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, as amended; and
- you are an eligible Employee under the terms of that Act.

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

### 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, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period 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, as amended.

FDRL74

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

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

### A. Continuation of Coverage

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

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

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

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

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

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

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

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

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

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

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

FDRL58

## Claim Determination Procedures Under ERISA Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the



Certificate, and in your provider's network participation documents as applicable.

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

#### **Postservice Medical Necessity Determinations**

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

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

FDRL64

#### **Postservice Claim Determinations**

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

#### **Notice of Adverse Determination**

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is

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

FDRL36

## **COBRA Continuation Rights Under Federal Law**

### **For You and Your Dependents**

#### **What is COBRA Continuation Coverage?**

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

#### **When is COBRA Continuation Available?**

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

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

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

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

### **Who is Entitled to COBRA Continuation?**

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

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

FDRL85

### **Secondary Qualifying Events**

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

### **Disability Extension**

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

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

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

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

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

### **Medicare Extension for Your Dependents**

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

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### **Termination of COBRA Continuation**

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer’s policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition

provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or

- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

FDRL22

V1

### Employer's Notification Requirements

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

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

### How to Elect COBRA Continuation Coverage

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

the due date, you may change your mind as long as you furnish a completed election form before the due date.

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

FDRL23

### How Much Does COBRA Continuation Coverage Cost?

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

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

### When and How to Pay COBRA Premiums

#### *First payment for COBRA continuation*

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

#### *Subsequent payments*

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

### *Grace periods for subsequent payments*

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

FDRL24

V2

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

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

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

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

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

### **Newly Acquired Dependents**

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your

COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

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V1

### **Trade Act of 2002**

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

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

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

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## ERISA Required Information

The name of the Plan is:

Bernards Bros., Inc.

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

Bernards Bros., Inc.  
555 First Street  
San Fernando, CA 91340  
818-336-3553

Employer Identification Number (EIN)	Plan Number
952920045	501

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

Employer named above

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

Employer named above

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

The Cigna Claim Office responsible for this Plan

The cost of the Plan is paid by the Employer.

The Plan's fiscal year ends on 07/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

### Plan Trustees

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

### Plan Type

The plan is a healthcare benefit plan.

### Collective Bargaining Agreements

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

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### Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include,

but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

### Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. 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 designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

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

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

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

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

### Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income

Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

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### **Receive Information About Your Plan and Benefits**

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

### **Continue Group Health Plan Coverage**

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

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your

union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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### **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.

### **Assistance with Your Questions**

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

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