Archdiocese of New York

CIGNA DENTAL PREFERRED
PROVIDER INSURANCE

RBLOW Plan

EFFECTIVE DATE: January 1, 2025

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This document printed in April, 2025 takes the place of any documents previously issued to You which described Your benefits.

Printed in U.S.A.

Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

This is Your

CIGNA DENTAL PREFERRED PROVIDER INSURANCE CERTIFICATE OF COVERAGE

Issued by

Cigna Health and Life Insurance Company

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between Cigna Health and Life Insurance Company (hereinafter referred to as "We", "Us" or "Our") and the Group listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers You the option to receive Covered Services on two benefit levels:

1. In-Network Benefits. In-Network benefits are the highest level of coverage available. In-Network benefits apply when Your care is provided by Participating Providers and Participating Pharmacies. You should always consider receiving health care services first through the In-Network benefits portion of this Certificate.
2. Out-of-Network Benefits. The Out-of-Network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive Out-of-Network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.

Alicia M. Morrow, ESQ, Corporate Secretary

If You need foreign language assistance to understand this Certificate, You may call Us at the number on Your ID card.

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SECTION I. Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated. If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Benefit Waiting Period: The Benefit Waiting Period is a plan feature available for any service(s), which can be applicable to all Members or all New Hires (if Initial Group is waived) that restricts utilization after enrollment until the length of the waiting period is satisfied. Your Dental Benefit Waiting Period for any Covered Service will be no longer than 12 months. Please refer to your Schedule of Benefits.

Certificate: This Certificate issued by Cigna Health and Life Insurance Company, including the Schedule of Benefits and any attached riders. The Certificate explains the benefits available to You under the Group Policy.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Contracted Fee: The term Contracted Fee means the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on You, according to Your dental benefit plan.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Emergency Dental Care: Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Refer to the Covered Services sections of this Certificate for details.

Exclusions: Dental care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

General Dentist: A dentist licensed under Title 8 of the New York State Education Law (or other comparable state law, if applicable) who is not a Specialist.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an agreement with Us as a policyholder.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider or to a Preferred Provider. The amount can vary by the type of Covered Service.

In-Network Cost-Sharing: Amounts You must pay to a Participating Provider or to a Preferred Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers or Preferred Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice, "Member" also means the Member's designee.

Network: The Providers We have contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of dental care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide dental care services to You. A list of Participating Providers and their locations is available on Our website www.cigna.com or upon Your request to Us. The list

will be revised from time to time by Us. You will pay higher Cost-Sharing to see a Participating Provider as compared to a Preferred Provider, but less than if You received Covered Services from a Non-Participating Provider.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: A calendar year ending on December 31 of each year.

Plan Year Maximum: This is the most We will pay for dental care within a Plan Year. Once You reach the maximum amount, You will be responsible for paying any costs for the remainder of the benefit period.

Policy: The Policy entered into between Cigna Health and Life Insurance Company and the Group and any riders attached to the Policy.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, or device that the Covered Service, procedure, treatment plan, or device is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

Preferred Provider: A Provider who has a contract with Us to provide dental care services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.

Premium: The amount that must be paid for Your dental insurance coverage.

Primary Care Dentist ("PCD"): A participating dentist who directly provides or coordinates a range of dental services for You.

Provider: An appropriately licensed, registered or certified dentist, dental hygienist, or dental assistant under Title 8 of the New York State Education Law (or other comparable state law, if applicable) that the New York State Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Provider's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under this Certificate.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form.

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements (if applicable), Referral requirements (if applicable), and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: all counties within New York State.

Specialist: A dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia and pediatric dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The cost of a dental service in a geographic area based on what Providers in the area usually charge for the same or similar dental service.

Us, We, Our: Cigna and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II. How Your Coverage Works

A. Your Coverage Under this Certificate.

Your employer (referred to as the "Group") has purchased a Group dental insurance Policy from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and/or their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.cigna.com.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken;
- Whether the Provider is a Preferred Provider; and
- Whether the Participating Provider is accepting new patients.

D. Preferred Providers.

Some Participating Providers are also Preferred Providers. Certain services may be obtained from Preferred Providers. If You receive Covered Services from Preferred Providers, Your Cost-Sharing may be lower than if You received the services from Participating Providers. See the Schedule of Benefits section of this Certificate for coverage of Preferred Provider services.

E. The Role of Primary Care Dentists.

This Certificate does not have a gatekeeper, usually known as a Primary Care Dentist ("PCD").

F. Access to Providers and Changing Providers.

Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a Cigna Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your Provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

G. Out-of-Network Services.

We Cover the services of Non-Participating Providers. See the Schedule of Benefits section of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to In-Network and Out-of-Network services.

H. Services Subject to Preauthorization.

Our Preauthorization is not required before You receive certain Covered Services.

I. Pre-Determination/Pre-Treatment Estimates.

We allow You to request and obtain an estimate of coverage. You or Your Provider may contact Us and request a pre-determination of benefits, also known as a pre-treatment estimate. If We determine that an alternative procedure or treatment is more appropriate than the requested service, You may appeal Our decision through an internal Appeal or external appeal. See the Utilization Review and External

Appeal sections of this Certificate for Your right to an internal Appeal and external appeal.

J. Medical Management.

The benefits available to You under this Certificate may be subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

K. Medical Necessity.

We Cover benefits described in this Certificate as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary (e.g., anesthesia, implants). The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your dental records;
- Our dental policies and clinical guidelines;
- Dental opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

L. Important Telephone Numbers and Addresses.

- CLAIMS

  Refer to the address on Your ID card

  (Submit claim forms to this address.)

  Refer to the address on Your ID card

  (Submit electronic claim forms to this e-mail address.)
- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS

  Call the number on Your ID card
- EMERGENCY DENTAL CARE

  Call the number on Your ID card
- MEMBER SERVICES

  Call the number on Your ID card
- REFERRAL

  Call the number on Your ID card
- OUR WEBSITE

  www.cigna.com

SECTION III. Cost-Sharing Expenses and Allowed Amount

A. Deductible

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered In-Network and Out-of-Network Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual

Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

You have a separate In-Network and Out-of-Network Deductible.

Cost-Sharing for Out-of-Network services applies toward Your In-Network Deductible.

Cost-Sharing for In-Network services applies toward Your Out-of-Network Deductible.

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.

B. Copayments.

There are no Copayments for Covered Services under this Certificate.

C. Coinsurance.

Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your In-Network or Out-of-Network benefit as shown in the Schedule of Benefits section of this Certificate.

You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.

D. Annual Maximum.

This Certificate has an In-Network and Out-of-Network annual maximum for In-Network and Out-of-Network benefits described in the Covered Service section of this Certificate. When Members receiving dental care have met the In-Network and Out-of-Network Covered Services in the Schedule of Benefits section of this Certificate, no more benefits will be payable for that Member for the remainder of that Plan Year.

If You have other than individual coverage, the individual in-network annual maximum for dental care benefits applies to each person covered under this Certificate. Once a person within a family meets the individual in-network annual maximum for dental care, no more benefits for services will be payable for that person.

Your Additional Payments for Out-of-Network Benefits.

When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductible and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge. When You receive Covered Services from a Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one (1) inclusive payment in that case, rather than a separate payment for each billed code.

Allowed Amount. "Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

Our payments to Participating Providers may include financial incentives to help improve the quality of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

The Allowed Amount for Non-Participating Providers will be determined as follows:

For Non-Participating Providers, the Allowed Amount will be a rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.

The Non-Participating Provider's actual charge may exceed Our Allowed Amount.

You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website www.cigna.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.

We reserve the right to negotiate a lower rate with Non-Participating Providers.

SECTION IV. Who is Covered

A. Who is Covered Under this Certificate.

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.
3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group.
2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage and Premium payment within 30 days thereafter, coverage for Your Spouse and Child starts on the first day of the following month after We receive Your application. If We do not receive notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.
4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

D. Special Enrollment Periods.

You, Your Spouse or Child can also enroll for coverage within 30 days of the loss of coverage in another group dental plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group dental plan due to:

1. Termination of employment;
2. Termination of the other group dental plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions towards the group dental plan were terminated for You or Your Dependents's coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group dental plan.

You, Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within 30 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

8. You or Your Spouse or Child loses eligibility for a state child dental plan; or
9. You or Your Spouse or Child becomes eligible for a state child dental plan.

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

SECTION V. Covered Services

The following lists Covered Services. We may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Us.

We Cover the following dental care services:

Covered Services

Teledentistry services are covered only when administered in conjunction with procedures and services which are covered under this plan. Covered Services delivered through teledentistry are covered to the same extent We cover services rendered through in-person contact including the same cost-share, frequency limitations or any applicable benefit maximums or lack thereof.

Class I Services – Diagnostic and Preventive

Clinical oral evaluation – limited to 2 per person per Plan Year. All oral cleaning services cross accumulate for frequency limit.

Palliative (emergency) treatment of dental pain, minor procedures - unlimited. Covered as a separate benefit only if no other services, other than exam and radiographic images, were performed during the visit.

Full mouth or panoramic radiographic images – limited to 1 per person, including panoramic images, in any 36 consecutive months.

Bitewing radiographic images – limited to 2 sets per person per Plan Year.

Extraoral posterior radiographic images – limited to 1 image in any Plan Year.

Prophylaxis (Cleaning) – limited to 2 per person per Plan Year. Oral cleaning services include prophylaxis, periodontal maintenance, or scaling in the presence of gingival inflammation; all oral cleaning services cross accumulate for frequency limit.

Periodontal maintenance procedures (following active therapy) – limited to 2 per person per Plan Year. Oral cleaning services include prophylaxis, periodontal maintenance, and scaling in the presence of gingival inflammation; all oral cleaning services cross accumulate for frequency limit.

Topical application of fluoride (excluding prophylaxis) – Limited to 1 per person per Plan Year.

Sealant, per tooth, on an unrestored primary and permanent bicuspid or molar tooth only - limited to 1 treatment per tooth in any 36 consecutive months.

Caries medicament application – limited to 2 per tooth in any 1 Plan Year.

Space Maintainers - limited to non-Orthodontic Treatment for prematurely removed or missing teeth.

Class II Services – Basic Restorations, Periodontics, Endodontics, Oral Surgery, Prosthodontic Maintenance

Amalgam restorations – unlimited. Multiple restorations on one surface will be treated as a single restoration. The replacement of any amalgam restoration involving the same surface(s) on the same tooth, by the same Dentist or a different Dentist in the same office, within a 12 consecutive month period is considered as part of the charges for the initial placement.

Resin-based composite restoration – unlimited. Multiple restorations on one surface will be treated as a single restoration. The replacement of any amalgam restoration involving the same surface(s) on the same tooth, by the same Dentist or a different Dentist in the same office, within a 12 consecutive month period is considered as part of the charges for the initial placement.

Pin Retention - Covered only in conjunction with amalgam or resin-based composite restoration. Payable one time per restoration regardless of the number of pins used.

Root canal therapy - any radiographic images, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Covered Service.

Root canal therapy, retreatment - unlimited - covered only if more than 6 consecutive months have passed since the original endodontic therapy and only if necessity is confirmed by professional review.

Gingivectomy or gingivoplasty - unlimited.

Gingival flap procedure - including root planing - unlimited.

Clinical crown lengthening - hard tissue - unlimited.

Osseous surgery - flap entry and closure is part of the allowance for osseous surgery and not a separate Covered Dental Service - unlimited.

Bone replacement graft - unlimited. If treatment involves an implant, the service is only covered if surgical implants are covered under Your plan.

Guided tissue regeneration - unlimited.

Pedicle soft tissue graft - unlimited.

Mesial/Distal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) - unlimited.

Free soft tissue graft (including recipient and donor surgical sites) - unlimited. If treatment involves an implant, the service is only covered if surgical implants are covered under Your plan.

Autogenous connective tissue graft procedure (including donor and recipient surgical site surgery) - unlimited. If treatment involves an implant, the service is only covered if surgical implants are covered under Your plan.

Non-autogenous connective tissue graft (including recipient site and donor material) - unlimited. If treatment involves an implant, the service is only covered if surgical implants are covered under Your plan.

Periodontal scaling and root planing - full mouth - unlimited.

Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation. Limited to 2 per Plan Year. Oral cleaning services include prophylaxis, periodontal maintenance, and scaling in the presence of gingival inflammation; all oral cleaning services cross accumulate for frequency limit.

Full Mouth Debridement - limited to one per lifetime.

Adjustments to complete and partial dentures within 6 months of its installation is part of the allowance for adjustments and is not a separate Covered Service.

Repairs to complete and partial dentures within 6 months of its installation is part of the allowance for repairs and is not a separate Covered Service.

Rebasing dentures - limited to rebasing done more than 6 months after the initial insertion, and then not more than one time in any 36 month period.

Relining dentures - limited to relining done more than 6 months after the initial insertion, and then not more than one time in any 36 month period.

Soft Liner - Complete or Partial Removable Dentures - limited to services done more than 6 months after the initial insertion, and then not more than one time in any 36 month period.

Tissue conditioning - maxillary or mandibular.

Re-cement or re-bond crown, inlays, onlays, veneer or partial coverage restoration, indirectly fabricated or prefabricated post and core. Limited to repairs performed more than 6 consecutive months after the initial insertion.

Crown repair and fixed partial dental repair. Limited to repairs performed more than 6 consecutive months after the initial insertion.

Re-cement fixed partial denture/bridge - limited to repairs done more than 6 months after the initial insertion.

Routine extractions.

Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.

Removal of impacted tooth, soft tissue, partially bony, completely bony.

Removal of residual tooth roots - 1 per tooth per lifetime.

Coronectomy - 1 per lifetime.

Biopsy of oral tissue.

Brush biopsy.

Alveoloplasty.

Vestibuloplasty.

Excision of benign cysts/lesions.

Removal of exostosis (maxilla or mandible).

Removal of torus services.

Incision and drainage.

Frenectomy/Frenuloplasty.

Excision of hyperplastic tissue - per arch or pericoronal gingiva.

Local anesthetic, analgesic and routine postoperative care for dental procedures are not separately reimbursed but are considered as part of the submitted fee for the global procedure.

General anesthesia - Paid as a separate benefit only when Medically Necessary and/or Dentally Necessary, in accordance with Our clinical guidelines, and only when administered in conjunction with procedures which are covered under this plan.

I. V. Sedation - Paid as a separate benefit only when Medically Necessary and/or Dentally Necessary, in accordance with Our clinical guidelines, and only when administered in conjunction with procedures which are covered under this plan.

Consultation – diagnostic service provided by dentist or physician other than the requesting dentist or physician.

Class III Services - Major Restorations, Dentures and Bridgework

Crowns – Initial placement of a crown is covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration due to major decay or fracture. Replacement of a crown within 5 Plan Years after the date it was originally installed is not covered.

Stainless steel crowns, resin crowns - covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration.

Inlays - covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration due to major decay or fracture.

Onlays - covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration due to major decay or fracture.

Core buildup, including any pins.

Post/post and core - covered only for endodontically treated teeth when there is insufficient tooth structure to retain the final restoration.

Complete dentures – limited to 1 complete denture per arch within 5 Plan Years unless the replacement is needed due to a Medically Necessary extraction of an additional functioning natural tooth while the person is covered under this plan.

Partial Dentures – limited to 1 partial denture per arch within 5 Plan Years unless the replacement is needed due to a Medically Necessary extraction of an additional functioning natural tooth while the person is covered under this plan.

Overdentures - complete and partial - limited to 1 denture per arch per 5 Plan Years unless there is a necessary extraction of an additional functioning natural tooth.

Fixed partial dentures/bridges, inlays and onlays (pontics and retainer crowns) – replacement is limited to 1 service per tooth per 5 Plan Years if the previous fixed partial denture/bridges is not serviceable and cannot be repaired.

Prosthesis Over Implant - A prosthetic device, supported by an implant or implant abutment is a Covered Dental Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 Plan Years old, is not serviceable and cannot be repaired.

Services Not Covered

- replacement of a partial denture, complete denture, fixed bridge, or any prosthesis over implant, within the frequency limitation stated under the Covered Services is not covered;
- replacement of a crown, bridge, onlay, post/post and core, or other laboratory prepared or CAD/CAM prepared restoration, partial denture, or complete denture within the frequency limitation stated under the Covered Services is not covered unless:
  - the replacement is made necessary by the placement of an original opposing complete denture or the Medically Necessary extraction of a functioning natural tooth; or
  - the crown, bridge, onlay, post/post and core, other laboratory prepared or CAD/CAM prepared restoration, partial denture, or complete denture while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- replacement of any amalgam or resin-based composite restoration involving the same surface(s) on the same tooth by the same Dentist or a different Dentist in the same office within the frequency limitation stated under the Covered Services is not covered;
- a combination of radiographic images (such as ten or more periapical radiographic images; or a panoramic radiographic image with bite-wing radiographic images) completed on the same date of service will not be covered when the allowance meets or exceeds the allowance for an intraoral complete series of radiographic images. Plan reimbursement will be based on an intraoral complete series;
- Cone Beam CT;
- localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth. Allowable only on teeth with both periodontal pocket depths of 5 mm or greater and a prior history of periodontal therapy. Not allowable when more than eight (8) of these procedures are reported on the same date of service;
- tissue preparation such as gingivectomy/gingivoplasty or crown lengthening as a separate allowance on the same date as a restoration on the same tooth;
- when covered by Your plan, any prosthesis over an implant is subject to the same exclusions, limitations, and frequency limitations as standard traditional restorative, fixed and removable prosthetics;
- Covered Services to the extent that billed charges exceed the rate of reimbursement as described in The Schedule of Benefits;
- any replacement of a crown, bridge, partial denture, or complete denture which is or can be made usable according to commonly accepted dental standardswhich is or can be made usable according to commonly accepted dental standards;
- crowns, inlays, cast restorations, or other laboratory prepared or CAD/CAM prepared restorations on teeth unless the tooth cannot be restored with an amalgam or resin-based composite restoration due to major decay or fractureon teeth unless the tooth cannot be restored with an amalgam or resin-based composite restoration due to major decay or fracture;

The benefits provided under this plan will be reduced so that the total payment will not be more than 100% of the charge

made for the dental service if benefits are provided for that service under this plan and any expense plan or prepaid treatment program sponsored or made available by the Group.

- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances, if orthodontics is covered) that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
- procedures, services, supplies, restorations, or appliances (except complete dentures), whose sole or primary purpose is to change or maintain vertical dimension;
- procedures, services, supplies, restorations or appliances whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint;
- the restoration of teeth which have been damaged by erosion, attrition, abfraction or abrasion;
- bite registration or bite analysis;
- precision or semi-precision attachments;
- any procedure, service, supply or appliance used primarily for the purpose of splinting;
- services to correct congenital malformations, including the replacement of congenitally missing teeth;
- procedures, restorations, appliances or services to stabilize periodontally involved teeth;
- services associated with the diagnosis, placement, treatment, repair, removal or replacement of a dental implant, or any other services related to implants, unless covered by Your specific plan;
- myofunctional therapy;
- replacement of a partial denture or complete denture which can be made serviceable;
- prescription drugs;
- treatment of jaw fractures and/or orthognathic surgery;
- Orthodontic Treatment;
- the treatment of cleft lip and cleft palate;
- charges for sterilization of equipment, infection control processes and procedures, disposal of medical waste or other requirements mandated or recommended by the Centers for Disease Control and Prevention (CDC), OSHA or other regulatory agencies; We consider these to be incidental to and part of the charges for services provided and not separately chargeable;
- charges for travel time; transportation costs;
- personal supplies, including but not limited to toothbrushes, rotary toothbrushes, floss holders, and water irrigation devices;
- oral hygiene instructions, tobacco counseling, substance use counseling, and nutritional counseling;
- charges for broken appointments; completion of claim forms; duplication of radiographic images and/or exams required by a third party;
- charges for treatment or surgery that does not meet plan guidelines;
- general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management;
- indirect pulp capping on the same date of service as a permanent restoration, We consider this to be incidental to and part of the charges for services provided and not separately chargeable;
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis;
- harmful habits treatment;
- intentional root canal treatment in the absence of injury or disease solely to facilitate a restorative procedure;
- services to the extent You are compensated under any group medical plan;
- house/extended care facility calls; hospital calls; office visits for observation (during regularly scheduled hours) when no other services are performed; office visits after regularly scheduled hours; and case presentations;
- procedures performed by a Dentist who is a member of the Covered Person's family except in the case of a dental emergency when no other Dentist is available. (Covered Person's family is limited to a Spouse, siblings, parents, children, grandparents, and the Spouse's siblings and parents);
- dental services that do not meet commonly accepted dental standards;
- replacement of teeth beyond the normal adult dentition of thirty-two (32) teeth;
- services not included in the list of Covered Services, unless We agree to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- procedures for which a charge would not have been made if the person had no insurance or for which the person is not legally required to pay. For example, if We determine that a provider is or has waived, reduced, or forgiven any portion

of its charges and/or any portion of the Deductible, and/or Coinsurance amount(s) You are required to pay for a Covered Service (as shown on The Schedule) without Our express consent, We shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that You remain responsible for any amounts that Your plan does not cover. We shall have the right to require You to provide proof sufficient to Us that You have made Your required cost share payment(s) prior to the payment of any benefits by Us. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge You or charged You at an In-Network benefits level or some other benefits level not otherwise applicable to the services received;

- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law;
- Covered Services to the extent that payment is unlawful where the Covered Person resides when the expenses are incurred;
- 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;
- athletic mouth guards.

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

SECTION VI. Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Cosmetic Services.

We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect.

Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

B. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

C. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

D. Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

E. Medical Services.

We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

F. Medically Necessary.

In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device is otherwise Covered under the terms of this Certificate.

G. Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

H. Military Service.

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

I. No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

J. Pre-Existing Conditions.

For a period of 12 months from the enrollment date, We do not Cover any conditions for which medical advice was given, treatment was recommended by or received from a physician within six (6) months before the effective date of Your coverage. We will not treat genetic information as a pre-existing condition in the absence of a diagnosis of the condition related to such information. The pre-existing condition exclusion does not apply to the pediatric dental essential health benefit.

K. Services Provided by a Family Member.

We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, step child, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

L. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

M. Services with No Charge.

We do not Cover services for which no charge is normally made.

N. War.

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

O. Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION VII. Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at www.cigna.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate or on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Certificate, on Your ID card or visiting Our website at www.cigna.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days for In-Network services; 180 days, for Out-of-Network services after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 180-day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION VIII. Grievance Procedures

A. Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.

You can contact Us by phone at the number on Your ID card or in writing to file a Grievance. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

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

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

You may ask that We send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website at www.cigna.com. You can opt out of electronic notifications at any time.

C. Grievance Determination.

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

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of Your Grievance.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

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

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

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 calendar days of receipt of Your Appeal.

E. Assistance.

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

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

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION IX. Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary or experimental or

investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card; or visit Our website at www.cigna.com. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at www.cigna.com.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website at www.cigna.com. You can opt out of electronic notifications at any time.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of earlier of the receipt of part of the requested information or the end of the 45-day period.
2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.
2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit

the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration.

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals.

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You, or Your designee, must submit:
   - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
   - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.
2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral

denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

- That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

   If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external Appeal.

   Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

J. Appeal Assistance.

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION X. External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and

- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
  - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
  - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

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

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

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

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure Covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

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

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

D. Your Right to Appeal a Determination that a Service is Out-of-Network.

If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

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

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the

appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

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

F. The External Appeal Process.

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

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

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

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

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

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

G. Your Responsibilities.

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

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

SECTION XI. Coordination of Benefits

This section applies when you also have group dental coverage with another plan. When You receive a Covered service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.
2. **"Plan"** is other group dental coverage with which We will coordinate benefits. The term "plan" includes:
   - Group dental benefits and blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.
3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.
2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's dental care expenses:
   - The plan of the parent who has custody will be primary;
   - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
   - If a court decree between the parents says which parent is responsible for the child's dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.

We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.

If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.

We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.
2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

SECTION XII. Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The date which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. The end of the month following the Group's provision of written notice of termination of coverage to Us; or on such later termination date requested by the Group's notice.
6. If the Subscriber has performed an act that constitutes fraud made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to one (1) year; Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.
7. The date that the Group Policy is terminated. If We decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days' prior written notice.
8. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
9. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group at least 30 days prior to when the coverage will cease.
10. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage.

We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage under COBRA or USERRA.

SECTION XIII. Extension of Benefits

Upon termination of insurance, whether due to termination of eligibility, or termination of the Certificate, an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that was started before Your coverage ended.

SECTION XIV. General Provisions

1. Agreements Between Us and Participating Providers.

Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.

You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits to any person, corporation or other organization and any such assignment will be void and unenforceable.

Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. Changes in this Certificate.

We may unilaterally change this Certificate upon renewal, if We give the Group 45 days' prior written notice.

4. Incontestability.

No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

5. PAYMENT OF BENEFITS

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you, you are responsible for reimbursing the Non-Participating Provider. Anti-abuse programs-allow us to pay direct to the customer/member in an In-Network/Out-of-Network plan.

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.

6. Recovery of Overpayments from Providers.

On occasion, a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

7. Subrogation and Reimbursement.

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Certificate. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury,

illness, or condition for which We provided benefits. Under Section 5-335 of the New York General Obligations Law, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

8. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

9. Translation Services.

Translation services are available free of charge under this Certificate for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

10. Who May Change this Certificate.

This Certificate may not be modified, amended, or changed, except in writing and signed by Our Corporate Secretary. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the Corporate Secretary.

11. Who Receives Payment under this Certificate.

Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You; the Subscriber or the Provider. However, We will directly pay a Provider instead of You for Emergency Services, including inpatient services following Emergency Department Care, pre-hospital emergency medical services, air ambulance services, and surprise bills.

12. Employer Premium.

Your Employer is charged a premium broken down into unpooled premium, pooled premium, and expenses. If your Employer's actual claims are less than what is expected, your Employer is reimbursed a set percentage of the difference between actual and expected claims. This percentage is determined during the sale of the policy. This reimbursement is received reimbursement either directly to your Employer's bank account or via check. Your Employer may or may not choose to pass this reimbursement, or some portion thereof, to You.

If You need more information or would like to contact Us, please go to Our website at www.cigna.com or call Us at the number on Your ID card.

SECTION XV. Other Covered Services

Alternate Benefit Provision

If more than one Covered Service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, Medically Necessary, and appropriate treatment.

SECTION XVI. Wellness Benefits

Oral Health Integration Program

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

If You are a Cigna Dental plan member and You have one or more of the conditions listed below, You may be eligible for reimbursement of Your coinsurance for certain periodontal or caries-protection procedures (up to the applicable plan maximum reimbursement levels and annual plan maximums).

For members with diabetes, cerebrovascular or cardiovascular disease:

- periodontal scaling and root planing (sometimes referred to as "deep cleaning");
- periodontal maintenance.

For members who are pregnant:

- periodic, limited and comprehensive oral evaluation;
- periodontal evaluation;
- periodontal maintenance;
- periodontal scaling and root planing (sometimes referred to as "deep cleaning");

- treatment of inflamed gums around wisdom teeth;
- an additional cleaning during pregnancy;
- palliative (emergency) treatment – minor procedure.

For members with chronic kidney disease, rheumatoid arthritis, Sjogren's syndrome, lupus, Parkinson's disease, amyotrophic lateral sclerosis, Huntington's disease, or going to or having undergone an organ transplant, or undergoing head and neck Cancer Radiation:

- topical application of fluoride;
- topical fluoride varnish;
- application of sealant;
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”);
- periodontal maintenance;
- interim caries arresting medicament application;
- caries preventive medicament application.

For members with opioid misuse and addiction:

- periodic, limited and comprehensive oral evaluation;
- topical application of fluoride;
- topical fluoride varnish;
- application of sealant;
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”);
- periodontal maintenance;
- interim caries arresting medicament application;
- caries preventive medicament application.

Before visiting Your dentist, You must enroll in the program by completing an Oral Health Integration Registration Form on myCigna.com, or by calling 1-800-Cigna24, and following the prompts for Dental to request an Oral Health Integration Registration Form. Complete and submit the form online, or complete the paper form, sign it and mail or fax to Cigna Dental as described on the form. Once You're enrolled, You can visit Your dentist and pay Your usual deductible, copay or coinsurance amount for the covered service. Once we receive the claim we will send Your reimbursement in 45 calendar days. If You need assistance completing the enrollment form, a representative will be happy to assist You.

Cigna Dental Preferred Provider Insurance

Section XVII. Schedule of Benefits

Benefits For You

The Dental Benefits Plan offered by Your Group includes two options. When You select a Participating Provider, this plan pays a greater share of the cost than if You were to select a Non-Participating Provider.

Emergency Services

The Benefit Percentage for Emergency Services incurred for charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider charges.

Deductibles

The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

BENEFIT MAXIMUMS AND DEDUCTIBLES	ADVANTAGE PARTICIPATING PROVIDER	TOTAL PARTICIPATING PROVIDER AND NON-PARTICIPATING PROVIDER
Classes I, II, III Combined Plan Year Maximum	$750	
Plan Year Deductible		
Individual	$100 per person Not Applicable to Class I	
Family Maximum	Not Applicable	
Expenses incurred for either Participating or Non-Participating Provider charges will be used to satisfy both the Participating and Non-Participating Provider Deductibles shown in the Schedule.		
Benefits Paid for Participating and Non-Participating Provider Services will be applied toward both the Participating and Non-Participating maximum shown in the Schedule.		

BENEFIT HIGHLIGHTS	ADVANTAGE PARTICIPATING PROVIDER	TOTAL PARTICIPATING PROVIDER AND NON-PARTICIPATING PROVIDER
Class I	**The Percentage of Covered Expenses the Member Pays**	**The Percentage of Covered Expenses the Member Pays**
Preventive Care	You pay 20%	You pay 30%

BENEFIT HIGHLIGHTS	ADVANTAGE PARTICIPATING PROVIDER	TOTAL PARTICIPATING PROVIDER AND NON-PARTICIPATING PROVIDER
Class II	**The Percentage of Covered Expenses the Member Pays**	**The Percentage of Covered Expenses the Member Pays**
Basic Restorative	You pay 30% after plan deductible	You pay 40% after plan deductible
Class III	**The Percentage of Covered Expenses the Member Pays**	**The Percentage of Covered Expenses the Member Pays**
Major Restorative	You pay 50% after plan deductible	You pay 50% after plan deductible

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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

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.

HC-FED93 10-17

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. 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 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 up to 102% of the total premium.

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

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you 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 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 10-10