

County of San Bernardino

CIGNA DENTAL PREFERRED
PROVIDER INSURANCE

EFFECTIVE DATE: July 28, 2012

ASO1
3335743

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

Printed in U.S.A.

Table of Contents

Important Information	3
How To File Your Claim	5
Important Information about Your Dental Plan	5
Eligibility Rules	5
CIGNA Dental Preferred Provider Insurance	7
The Schedule	7
Covered Dental Services	8
Dental PPO – In-Network and Out-of-Network Providers	8
Covered Dental Expense	8
Dental Benefits Extension	8
General Limitations	10
Expenses Not Covered	11
Coordination of Benefits	11
Expenses for Which a Third Party May Be Responsible	13
Payment of Benefits	14
Termination of Insurance	15
Employees	15
Dependents	15
Federal Requirements	15
Notice of Provider Directory/Networks	15
Qualified Medical Child Support Order (QMCSO)	15
Requirements of Medical Leave Act of 1993 (as amended) (FMLA)	16
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)	16
Dependents in military service are not eligible. When You Have a Complaint or an Appeal	16
COBRA Continuation Rights Under Federal Law	18
Definitions	20

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY COUNTY OF SAN BERNARDINO WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

AS01

Explanation of Terms

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

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Contact Information

If you have any questions about your coverage that are not answered within this booklet, please contact Cigna Dental Member Services or the County's Employee Benefits and Services Division at:

Cigna Dental
P.O. Box 188037
Chattanooga TN, 37422
Phone: (800) 238-5834

County of San Bernardino
Employee and Benefits Services Division
157 West Fifth Street, 1st Floor
San Bernardino, CA 92415-0440
email: ebsd@hr.sbcounty.gov
Phone: (909) 387-5787



How To File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing Connecticut General (CG) Claim Office.

Dental Expenses

The first Dental Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS:

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.
YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Accident and Health Provisions

Timely Filing of Out-of-Network Claims

CG will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

Important Information about Your Dental Plan

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

- CIGNA Dental Care (DHMO); or
- CIGNA Dental Preferred Provider(DPPO).

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

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

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

Eligibility Rules

Eligibility for Employee Insurance

Employees, their Spouses or Domestic Partners and their Dependents are eligible to enroll in the Plan as follows:

Employee Eligibility

- You must be an employee in a regular position scheduled for a minimum of forty hours and have received pay for at least one half plus one hour of scheduled hours in a Pay Period.
- You must complete and submit an enrollment form and pay the required Premiums to the Plan Administrator.
- Your coverage begins on the first day of the pay period following the pay period in which premiums are first collected.

Spouse, Domestic Partner, and Dependent Eligibility

Your dependents are eligible to enroll in coverage if you are eligible and enrolled in coverage.

Eligible dependents are defined by IRS Section 152 and the County's Section 1255 Plan Document. Dependents include, but are not limited to the following:

- Your legal Spouse or Domestic Partner
- Your child(ren), your spouse or domestic partner's natural child(ren), legally adopted child(ren), and child(ren) for whom you are the legal guardian and child(ren) you support as a result of a valid court order that are under the age 26 or over the age 26 if they are physically or mentally disabled and incapable of earning a living

Enrollment

You, your Spouse, or Domestic Partner and your dependents must complete and submit the County's Dental Plan Enrollment/Change Form to the County and pay the appropriate Premiums to become Enrollees.

You must elect coverage for yourself upon being hired, unless you are covered by other group sponsored insurance.



As a newly hired employee, you have 60 days from the date of hire to enroll yourself or eligible dependents in the DPPO Plan.

You may enroll dependents upon hire, during the annual Open Enrollment Period, or if you experience a qualifying IRS Section 125 Change in Status Event . You must be enrolled in the plan to enroll your dependents.

The Dental Plan Enrollment/Change Form must include your name, social security number, address, telephone number and other pertinent information to enroll. If you select the DHMO plan, they you must designate a provider or one will be assigned by Cigna to you and your enrolled dependents.

Through submittal of the Dental Plan Enrollment/Change Form, you agree to pay the Dental Plan Premiums and authorize the County to collect premiums through a bi-weekly payroll deduction. Additionally, you agree to the terms and conditions of the dental plan as defined in the DHMO/DPPO Master Contract between the County and Cigna Dental and any associated County Plan Documents.

Effective Date of Insurance

You and your dependents insurance coverage will become effective on the first day of the pay period following the date you submit the County’s Dental Plan Enrollment/Change Form to EBSD. Premiums must be received prior to commencement of coverage. *Please note, collection of premiums and coverage are governed by the County’s established procedures and are subject to change.*

Section 125 Change in Status Event/Mid-Year Change

Mid-Year Enrollment

You may enroll yourself or your dependents in the plan outside the Open Enrollment Period if you experience a qualifying IRS change-in-status event. Your request must be submitted to EBSD within 60 days of the qualifying change-in-status event.

Qualifying IRS change-in-status events include, but are not limited to:

- a) Marriage or Divorce
- b) Birth or adoption or legal guardianship or placement for adoption or legal guardianship of a child
- c) Commencement or Termination of spouse, domestic partner or other eligible dependent’s coverage
- d) Dependents loss of eligibility due to age

- e) Employee, spouse, or domestic partner being or return from an unpaid leave of absence

Please refer to the County’s Section 125 Plan Document for a detailed listing of qualifying change-in-status events.

Mid-Year Change Request Forms and Documentation

To request a mid-year change you must complete and submit the following forms and documentation to EBSD within 60 days of the qualifying change-in status event.

Dental Plan Enrollment/Change Form

Premium Deduction Election Form

Proof of dependent relationship. Examples include but are not limited to:

- a) Certified birth, marriage, or death certificate
- b) Certified court documents for a divorce, legal separation, or adoption
- c) Letter from employer verifying loss or gain of employment for spouse, domestic partner or other eligible dependent

Effective Date of Mid-Year Change

Enrollment due to a Change in Status Event is effective on the first day of the pay period following the date you submit the County’s Dental Plan Enrollment/Change Form to EBSD. Premiums must be received prior to commencement of coverage.

Exceptions are as follows:

- a) Newborns are covered on the date of their birth for the first 30 days during which you must enroll the newborn for participation the Plan.
- b) Children placed for adoption are covered for the first 30 days from and including the date they are placed in the home during which you must enroll the adoptee for participation in the Plan
- c) Marriage: If you notify EBSD of the change-in status event before the end of the month in which the event occurred coverage will be applied, including the billing of premiums on a retroactive basis to the date in which your spouse and/or domestic partner became eligible (e.g. If you get married on April 4 and submit forms to EBSD on April 25, coverage will be effective the first day of the pay period following your marriage or domestic partnership certificated date)



CIGNA Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes two options. When you select an In-Network Provider, this plan pays a greater share of the cost than if you were to select an Out-of-Network Provider.

Emergency Services

The Benefit Percentage for Emergency Services incurred for charges made by an Out-of-Network Provider is the same Benefit Percentage as for In-Network Provider Charges. Dental Emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

In-Network Provider Payment

In-Network Provider services are paid based on the Contracted Fee agreed upon by the provider and the Insurance Company.

Out-of-Network Provider Payment

Out-of-Network Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

Simultaneous Accumulation of Amounts

Benefits paid for In-Network and Out-of-Network Provider services will be applied toward both the In-Network and Out-of-Network Provider maximum shown in the Schedule.

BENEFIT HIGHLIGHTS	In Network	Out-of Network
Classes I, II, III Combined Calendar Year Maximum	\$1700	
Class IV Lifetime Maximum (Orthodontia)	\$1700	
Plan Benefit	Plan Pays	Plan Pays
Class I Preventive Care	100%	100%
Class II Basic Restorative	100%	90%
Class III Major Restorative	75%	70%
Class IV Orthodontia	50%	50%
Class VI Other Basic Benefits	90%	90%
Class IX Implants	75%	70%



Covered Dental Services

The following section lists covered dental services. CG 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 CG.

Dental PPO – In-Network and Out-of-Network Providers

Payment for a service delivered by an In-Network Provider is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by an Out-of-Network Provider is the Maximum Reimbursable Charge times the benefit percentage that applies to the class of service, as specified in the Schedule.

The covered person is responsible for the balance of the provider's actual charge.

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Dental Benefits Extension

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

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.

- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

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, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, CG recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by CG's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

CG will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, CG will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended (when charges exceed \$500 - \$1,000).

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Class I Services – Diagnostic And Preventive

Clinical oral examination – Only 2 per person per calendar year.

Prophylaxis (Cleaning) – Only 2 per person per calendar year.

Additional exam or cleanings available for members that are pregnant.

When an Enrollee Is pregnant, CG will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each calendar year while the Enrollee is covered include: one additional oral exam and either two additional routine cleanings or one additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.



Additional cleanings available for members with heart disease and/or diabetes.

Two additional cleanings are allowed per calendar year at no cost for Enrollees with cardiovascular disease and diabetes. A medical letter must be in file in order to be eligible for these extra benefits.

Additional cleanings available for members with periodontal disease.

Four additional cleanings are provided to a member in a calendar for periodontal maintenance.

Specialist consultations.

Examination of biopsied tissue.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays – Complete series – Only one per person, including panoramic film, in any 5 calendar years.

Bitewing x-rays – Only 2 charges per person per calendar year.

Panoramic (Panorex) x-ray – Only one per person in any 3 calendar years.

Topical application of fluoride (excluding prophylaxis) – Only two per person per calendar year.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

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

Office visits for observation

Office visits after regularly scheduled hours.

Therapeutic drug injections.

Amalgam Filling

Silicate or Composite/Resin Filling – including posterior teeth

Resin in place of amalgam for posterior teeth restoration for in-network services. If services are provided by an out of network dentist this will continue to be paid based on the amalgam benefit.

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recent Bridge

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth, including pre and post-operative care

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

Treatment of tooth pulp

Class III Services - Major Restorations, Dentures and Bridgework

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered 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 calendar years old, is not serviceable and cannot be repaired.

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.



The total amount payable for all expenses incurred for Orthodontics during a person's lifetime will not be more than the Orthodontia Maximum shown in the Schedule.

Payments for comprehensive full-banded Orthodontic treatment are made in installments. Benefit payments will be made every 3 months. The first payment is due when the appliance is installed. Later payments are due at the end of each 3-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last 3-month period will be prorated.

Class VI Services – Other Basic Benefits

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old – Only one treatment per tooth in any 2 calendar years.

Periodontal Scaling and Root Planing – Entire Mouth

Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis – limited to 4 periodontal maintenance procedures per person per calendar year

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

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

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I. V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Class IX Services – Implants

Covered Dental Expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.

Implant coverage has a separate deductible amount, yearly maximum and/or lifetime maximum as shown in The Schedule.

General Limitations

1. Only the first two oral examinations, including office visits for observation and specialist consultations, or combination thereof, in a calendar year are Benefits while you and your Dependents are enrolled. Exception, additional cleanings are available during pregnancy (See Note on additional Benefits during pregnancy in the Class I Services – Diagnostic And Preventive section) and oral examinations for emergency palliative treatment with no frequency limitations are covered Benefits.

2. Full-mouth x-rays are Benefits once in a five-year period while enrolled in the Plan.

3. Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year without regard to age.

4. Diagnostic casts are a Benefit only when made in connection with subsequent orthodontic treatment covered under the Plan.

5. Only the first two (2) cleanings, or Single Procedures which include cleaning, or combination thereof, in any calendar year are Benefits while you and your Dependents are enrolled.

Additional cleaning for enrollees that are pregnant, have cardiovascular disease or diabetes or periodontal disease are entitled to additional cleanings each calendar year.

See note on additional Benefits during pregnancy and additional note regarding additional cleanings for Enrollees with cardiovascular disease and diabetes in the Class I Services – Diagnostic And Preventive section.

For enrollees who have periodontal disease, four additional cleanings for periodontal maintenance in a calendar year.

Routine prophylaxes are covered under Class I Services – Diagnostic And Preventive benefit and periodontal prophylaxes are covered under Class VI Services Other Basic Benefits.

6. Periodontal scaling and root planing is a Benefit once for each quadrant each 24-month period.

See note on additional Benefits during pregnancy in Class I Services – Diagnostic And Preventive section.

7. Fluoride treatment is a Benefit twice each calendar year.

8. Sealant benefits include the topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old – Only one treatment per tooth in any 2 calendar years

9. Direct composite (resin) restorations are Benefits on Resin in place of amalgam for posterior teeth restoration for in-network services. If services are provided by an out of network dentist this will continue to be paid based on the amalgam benefit.

10. Crowns, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you or your Dependents are enrolled, unless Connecticut General that



replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

11. A prosthetic device, supported by an implant or implant abutment is a Covered 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 calendar years old, is not serviceable and cannot be repaired.

12. Plan will pay the applicable percentage of the dentist's fee for standard cast chrome or acrylic partial denture or a standard complete denture. (A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.)

13. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Connecticut General will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee.

For example: a crown where a silver filling would restore the tooth; or a precision denture where a standard denture would suffice.

14. If orthodontic treatment is begun before you become eligible for coverage, Connecticut General's payments will begin with the first payment due to the dentist following your eligibility date.

15. Connecticut General's orthodontics payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.

16. X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits, but may be covered under Class I Services – Diagnostic And Preventive or Class II Services – Basic Restorations, Endodontics, Prosthodontics maintenance and Oral Surgery.

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or 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;

- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semi precision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Coordination of Benefits

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



Definitions

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

Plan

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

- (1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- (2) Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- (3) Medical benefits coverage of group, group-type, and individual automobile contracts.

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

- (1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- (2) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

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

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

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



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

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

Effect on the Benefits of This Plan

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

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

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

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

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

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for

which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

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

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with information requested applicable to the coordination of your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Expenses for Which a Third Party May Be Responsible

This plan does not cover:

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

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- 1. Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.



2. Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

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

- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Payment of Benefits

To Whom Payable

All Dental Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

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

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

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

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

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

Miscellaneous

If you are a CIGNA Dental plan member you may be eligible for additional dental benefits during certain episodes of care.



For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the last day of the Pay Period in which you have less than 41 hours of paid time.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Your coverage may be continued if you qualify for and pay for **OPTIONAL CONTINUATION OF COVERAGE**.

Injury or Sickness

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

Dependents

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

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

Your Dependents' coverage ends when yours does, or the pay period in which they are no longer eligible Dependents, unless they choose to pay for **OPTIONAL CONTINUATION OF COVERAGE**.

Plan Cancellation

The County may cancel the dental plan at any time. Cigna Dental may cancel their administrative services agreement with the County any time the County does not make payment as required by the Contract.

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.

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling Cigna Member Services at (800) 238-5834.

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

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

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

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 60 days of the QMCSO being issued.

B. Qualified Medical Child Support Order Defined

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

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;



4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

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

C. Payment of Benefits

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

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

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

A. Continuation of Health Insurance During Leave

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

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

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

B. Reinstatement of Canceled Insurance Following Leave

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

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

You can continue coverage for up to 24 months, if you take a leave governed by the Uniformed Services Employment and Re-employment Rights Act of 1994. If you make this election, you must submit any Dues necessary, which may include administrative costs, to your employer. If you do not continue your coverage during a military leave, it will be reinstated at the same Benefit level you received before your leave.

Dependent coverage is also extended to any child who is recognized under a Qualified Medical Child Support Order (QMCSO).

Dependents in military service are not eligible. When You Have a Complaint or an Appeal

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

"Physician Reviewers" are licensed Dentists depending on the care, service or treatment under review.

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

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call Member Services at (800) 238-5834, and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Grievance Procedure

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



Level-One Appeal

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

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination

by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level-two appeal review denial. CG will then forward the file to the Independent Review organization. The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by CG's Dentist reviewer, the review shall be completed within 3 days. The Independent Review Program is a voluntary program arranged by CG.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most



instances, you may not initiate a legal action against CG until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. You or your dependents may be entitled to continue coverage under this plan, at the qualified beneficiary’s expense, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

When is COBRA Continuation Available?

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

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.
- This 18 month period can be extended for a total of 29 months, provided:
 - a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and
 - notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.
 - This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify the employer within 30 days of any such determination.

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

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

- as to your dependents only, your entitlement to Medicare
- Your Dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of above events.
 - When an employer has filed for bankruptcy under Title II, United States Code, benefits may be substantially reduced or eliminated for retired employees and their Dependents, or the surviving Spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after the filing, it is considered a Qualifying Event. If you are the retiree, and you have lost coverage because of this Qualifying Event, you may choose to continue coverage until your death. Your Dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following your death.

Who is Entitled to COBRA Continuation?

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

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

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

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

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and



2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

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

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

Election of Continued Coverage

Your employer will provide a Qualified Beneficiary with the necessary benefits information, monthly Dues charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give the employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial Dues to the employer, which includes the Dues for each month since the loss of coverage. Failure to pay the required Dues within the 45 days will result in the loss of the right to continue coverage, any Dues received after that will be returned to the Qualified Beneficiary.

Continued Coverage Benefits

The Benefits under the continued coverage will be the same as those provided to active employees and their Dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Dues will be adjusted to reflect the changes made.

Termination of COBRA Continuation

A Qualified Beneficiary’s coverage will terminate at the end of the month in which any of the following events first occurs:

1. the allowable number of consecutive months of continued coverage is reached;
2. failure to pay the required Dues in a timely manner;
3. the employer ceases to provide any group dental plan to its employees;
4. the individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or Dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this Plan; or
5. entitlement to Medicare.

Once continued coverage ends, it cannot be reinstatedV2

You Must Give Notice of Certain Qualifying Events

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

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

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

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

Newly Acquired Dependents

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



COBRA coverage ceases and they are not eligible for a secondary qualifying event.

Trade Act of 2002

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

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Definitions

Active Service

You will be considered in Active Service:

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

CIGNA Dental Health

(herein referred to as CDH)

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

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee - CIGNA Dental Preferred Provider

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

Dentist

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

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any unmarried child of yours who is less than 26 years old;

26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

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

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

Domestic Partner

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

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank



account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by CG to be sufficient to establish financial interdependency under the circumstances of your particular case;

- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit which can be made available to CG upon request.

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

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

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

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

Employee

The term Employee means an Employee who is in a regular position scheduled for a minimum of forty hours and has received pay for at least one half plus one hour of scheduled hours in a Pay Period. The term does not include employees who are part-time or temporary.

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

Maximum Reimbursable Charge - Dental

The Maximum Reimbursable Charge is the lesser of:

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

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

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

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

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

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare

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

In-Network Provider - CIGNA Dental Preferred Provider

The term In-Network Provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with CG to provide dental services at predetermined fees.

The providers qualifying as In-Network Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

Out-of -Network Provider

The term Out-of-Network Provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which has not entered into a contract with CG to provide dental services at predetermined fees.

{

Cigna Dental Benefit Summary

County of San Bernardino – Employees - Eff. 7/28/2012



All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Benefits

CIGNA Dental PPO

Network	In-Network		Out-of-Network	
	CIGNA DPPO -Radius		CIGNA Savings - Radius	
Calendar Year Maximum	\$1,700		\$1,700	
Annual Deductible	None		None	
Individual	None		None	
Family	None		None	
Reimbursement Levels**	Based on Reduced Contracted Fees		80th percentile of Reasonable and Customary Allowances	
	Plan Pays	You Pay	Plan Pays	You Pay
Class I - Preventive & Diagnostic Care	100%	No Charge	100%	No Charge
Oral Exams				
Routine Cleanings				
Routine X-Rays				
Non-Routine X-Rays				
Fluoride Application				
Space Maintainers (limited to non-orthodontic treatment)				
Class II - Basic Restorative Care	100%	No Charge	90%	10%
Fillings - Amalgams & Composite				
Surgical Extraction of Impacted Teeth				
Oral Surgery				
Root Canal Therapy / Endodontics				
Relines, Rebases, and Adjustments				
Repairs to Bridges, Crowns, Inlay/Onlays, Dentures				
Class III - Major Restorative Care	75%	25%	70%	30%
Crowns				
Dentures				
Bridges				
Inlays / Onlays				
Prosthesis Over Implant				
Class IV - Orthodontia	50%	50%	50%	50%
Lifetime Maximum	\$1,700		\$1,700	
No orthodontic deductible	Covered for eligible adults & dependants		Covered for eligible adults & dependants	
Class VI - Other Basic Benefits	90%	10%	90%	10%
Major & Minor Periodontic				
Anesthesia				
Sealants				
Class IX - Implant Coverage	75%	25%	70%	30%
Implants				

Important Notes:

Dental Network Savings Program (DNSP): Using an out-of-network dental health care professional will cost you more than using in-network care. You may be able to save some money on out-of-pocket expenses if you use a dental health care professional that participates in CIGNA's Dental Network Savings Program.

Missing Tooth Limitation- The amount payable is 50% of the amount otherwise payable until insured for 24 months; thereafter, considered a Class III expense.

Pretreatment review is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.

* Subject to annual deductible

**For services provided by a CIGNA Dental PPO network dentist, CIGNA Dental will reimburse the dentist according to a Contracted Fee Schedule. For services provided by an out-of-network dentist, CIGNA Dental will reimburse according to Reasonable and Customary Allowances but the dentist may balance bill up to their usual fees.

CIGNA Dental PPO Exclusions and Limitations

Procedure	Exclusions and Limitations
Exams	Up to 4 per Calendar year
Prophylaxis (Cleanings)	Two per Calendar year; Periodontal Maintenance up to an additional 4 times per Calendar year.
Fluoride	Two per Calendar year.
Histopathologic Exams	Various limits per Calendar year depending on specific test
X-Rays (routine)	Bitewings: 2 per Calendar year
X-Rays (non-routine)	Full mouth: 1 every 5 Calendar Years; Panorex: 1 every 3 Calendar years.
Model	Payable only when in conjunction with Ortho workup.
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Bridges	Replacement every 5 years
Dentures and Partial	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior teeth. One treatment per tooth every 2 years under age 14.
Space Maintainers	Limited to non-Orthodontic treatment
Prosthesis Over Implant	1 per 60 consecutive months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, CIGNA HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses

Benefit Exclusions:

- Services performed primarily for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge or denture within five years following the date of its original installation
- Replacement of a bridge or denture which can be made useable according to accepted dental standards
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations; precision or semi-precision attachments; splinting
- Instruction for plaque control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Charges which the person is not legally required to pay
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
- Experimental or investigational procedures and treatments
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- For charges which would not have been made if the person had no insurance;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. CIGNA HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
- In addition, these benefits 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 medical expense plan or prepaid treatment program sponsored or made available by your Employer.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description. Benefits are insured and/or administered by Connecticut General Life Insurance Company.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, CIGNA Health and Life Insurance Company, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

BSD25966

© 2012 CIGNA