CIGNA DENTAL PREFERRED
PROVIDER INSURANCE

Base Plan

CN017

3336505

This document printed in January, 2023 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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

ð COVERAGE

3336505 - DPPO CIGNA DENTAL PREFERRED PROVIDER INSURANCE

January 1, 2023

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

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

[redacted]

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

Cigna:

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

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

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance

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

ï ATTENTION: Des services dôaide linguistique vous sont proposés gratuitement.

BE SURE

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If you, the Employee, have a newborn or adopted newborn child and Cigna receives notice of such birth within 31 days thereafter, coverage for your newborn starts at the moment of birth; otherwise, coverage begins on the date on which Cigna receives 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 31 days of the infantôs 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, if required, within 31 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 Cigna receives notice and the premium payment, if such payment is required. If a premium payment is not received as required, no benefits for expenses incurred for the newborn or adopted newborn child after the 31st day will be payable.

You, your spouse or child can also enroll for coverage within 30 days of the loss of coverage in another group health plan if coverage was terminated because you, your spouse or child are no longer eligible for coverage under the other group health plan due to:

- termination of employment;
- termination of the other group health plan;
- death of the spouse;
- legal separation, divorce or annulment;
- reduction of hours of employment;
- employer contributions toward the group health plan were terminated; or
- a child no longer qualifies for coverage as a child under the other group health plan.

You, your spouse or child can also enroll 30 days from exhaustion of your COBRA or continuation coverage-5( )-2(g)6(r)-3(o)-5(u)8078}TJET-[ )]TJETBT/F1 pf80-5( )-ild( )-14(f)8(r)-3(o)-17(m)19(

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

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

If you change options during open enrollment, you (and your Dependents) will become insured on the effective date of the plan. If you change options other than at open enrollment (as allowed by your plan), you will become insured on the first day of the month after the transfer is processed.

[redacted]

The Dental Benefits Plan offered by your Employer 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.

X-rays ï Complete series or Panoramic (Panorex) ï Only one per person, including panoramic film, in any 36 consecutive months.

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

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) ï Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) ï Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral ï Limited to nonorthodontic treatment.

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy ï 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.

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

Periodontal Scaling and Root Planing ï Entire Mouth

Routine Extractions

[redacted]

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

services performed solely for cosmetic reasons; 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 appeals sections of this certificate unless medical information is submitted.

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: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or 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 semiprecision attachments; or splinting.

instruction for plaque control, oral hygiene and diet.

dental services that do not meet common dental standards.

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.

services and supplies received from a Hospital.

services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

orthodontic treatment.

the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.

services for which benefits are not payable according to the ñGeneral Limitationsò section.

No coverage is available under this certificate for the following:

for services if benefits for such services are provided under any state or federal Workersô Compensation, employersô liability or occupational disease law.

for 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.

for an illness, treatment or medical condition due to war, declared or undeclared; services for which no charge is normally made.

for 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 the certificate for non-investigational treatments. See the utilization review and external appeal sections of this certificate for a further explanation of your appeal rights.

for any illness, treatment or medical condition due to your participation in a felony, riot or insurrection.

for an illness, treatment or medical condition due to service in the armed forces or auxiliary units.

[redacted]

for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

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.

This section applies when you or any one of your Dependents also have group dental coverage with another plan. When you or any one of your Dependents receives a covered service, Cigna 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.

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.

is other group dental coverage with which Cigna will coordinate benefits. The term ñplanò includes:

Group dental benefits and group 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 ñno-faultò and traditional liability ñfaultò type contracts.

Dental benefits coverage of Medicare or 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.

is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: the plan has no order of benefits rules or its rules differ from those required by regulation; or 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).

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.

The first of the rules listed below in the following six paragraphs that applies will determine which plan will be primary:

If the other plan does not have a provision similar to this one, then the other plan will be primary.

If the person receiving benefits is the subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

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.

If a child is covered by both parentsô plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the childôs 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-parentôs plan, the plan of the parent with custody will pay first, the step-parentôs plan will pay second, and the plan of the parent without custody will pay third.

If a court decree between the parents says which parent is responsible for the childôs dental care expenses, then that

For me

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

If you have a Cigna Dental plan member and you have one or more of the conditions listed below, you may apply for 100% reimbursement of your copayment or coinsurance for certain periodontal or caries-protection procedures (up to the applicable plan maximum reimbursement level and annual plan maximums.)

For members with diabetes, cerebrovascular or cardiovascular disease:

- periodontal scaling and root planing (sometimes referred to as ñdeep cleaningò)
- 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 ñdeep cleaningò)
- treatment of inflamed gums around wisdom teeth.
- an additional cleaning during pregnancy.
- palliative (emergency) treatment ï

[redacted]

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:

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.

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

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 Employeeôs military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental d 7:<

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

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

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

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

ñSecondary Qualifying Eventsò and ñMedicare Extension For Your Dependentsò are not applicable to these individuals.

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

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 u

[redacted]

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

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

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

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

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

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

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

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

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

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

Your divorce or legal separation; or

Your child ceases to qualify as a Dependent under the Plan.

The occurrence of a secondary qualifying event as discussed under ñSecondary Qualifying Eventsò 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 ñDisability Extensionò 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 docu

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

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

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

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, 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

advice or statement was relied upon in making the benefit determination.

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

HC-APL250 07-14
V1

An accidental injury means an injury that is caused by biting on a foreign object not expected to be a normal constituent of food, or by biting down on an item such as a pencil, eyeglass frame, or dislodged or loose dental prosthesis.

HC-DFS497 04-10
V1

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.

[redacted]

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

HC-DFS7 04-10
V3

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

The term External Appeal Agent means 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.

HC-DFS776 07-14
V1

The term Hospital means:

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.

HC-DFS775

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or other entity which is entered into a contract with Cigna to provide dental services at predetermined fees.

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

HC-DFS136 04-10
V1

The term Physician or Physician Services means health care services a licensed medical Physician (M.D. ï Medical Doctor or D.O. ï Doctor of Osteopathic Medicine) provides or coordinates.

HC-DFS777 07-14
V1