



# Patient Charge Schedule

***This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.***

## Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by CIGNA Dental as described in your plan documents.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialist (Endodontist, Periodontist, Orthodontist, Oral Surgeon or Pediatric Dentist (up to 7th birthday)). You must verify with the Network Specialist that your treatment plan has been authorized for payment by CIGNA Dental.
- Procedures NOT listed on this Patient Charge Schedule are NOT covered and are the patient's responsibility at the dentist's usual fees.
- The administration of I.V. sedation, general anesthesia, and/or Nitrous Oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- This Patient Charge Schedule is subject to *annual change* in accordance with the terms of the group agreement.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the *procedure is initiated*.

## Diagnostic/Preventive

D9310	Consultation (Diagnostic Service Provided By Dentist or Physician Other Than Practitioner Providing Treatment)	No Charge
D0120	Periodic Oral Evaluation	No Charge
D0140	Limited Oral Evaluation – Problem Focused	No Charge
D0150	Comprehensive Oral Evaluation	No Charge
D0170	Re-evaluation – Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	No Charge
D0210	X-Rays Intraoral – Complete Series (including bitewings) ★	No Charge
D0220	X-Rays Intraoral – Periapical First Film	No Charge
D0230	X-Rays Intraoral – Periapical Each Additional Film	No Charge
D0240	X-Rays Intraoral – Occlusal Film	No Charge
D0270	X-Rays (Bitewing) – Single Film	No Charge
D0272	X-Rays (Bitewing) – Two Films	No Charge
D0274	X-Rays (Bitewing) – Four Films	No Charge
D0277	X-Rays (Bitewing, Vertical) – 7 to 8 Films	No Charge
D0330	X-Rays (Panoramic) ★	No Charge
D0460	Pulp Vitality Tests	No Charge
D0470	Diagnostic Casts	No Charge
D0472	Accession of Tissue, Gross Examination, Preparation and Transmission of Written Report	No Charge
D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report	No Charge
D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical Margins for Presence of Disease, Preparation and Transmission of Written Report	No Charge
D0501	Histopathologic Examinations	No Charge
D1110	Prophylaxis – Adult ★ ★	No Charge
9999.1119	Prophylaxis – Adult (In Addition to the 1 Prophylaxis Allowed Every 6 Months)	\$50.00
D1120	Prophylaxis – Child ★ ★	No Charge
9999.1129	Prophylaxis – Child (In Addition to the 1 Prophylaxis Allowed Every 6 Months)	\$35.00
D1203	Topical Application of Fluoride – (Prophylaxis Not Included) – Child ◆ ★ ★	No Charge
D1330	Oral Hygiene Instructions	No Charge
D1351	Sealant ■ ■ ☼	\$15.00
D1510	Space Maintainer – Fixed – Unilateral	\$85.00
D1515	Space Maintainer – Fixed – Bilateral	\$85.00

## Restorative (Fillings)

D2110	Amalgam – One Surface, Primary	\$7.00
D2120	Amalgam – Two Surfaces, Primary	\$9.00
D2130	Amalgam – Three Surfaces, Primary	\$14.00
D2131	Amalgam – Four or More Surfaces, Primary	\$17.00
D2140	Amalgam – One Surface, Permanent	\$7.00
D2150	Amalgam – Two Surfaces, Permanent	\$9.00
D2160	Amalgam – Three Surfaces, Permanent	\$14.00
D2161	Amalgam – Four or More Surfaces, Permanent	\$17.00

‡ Different Codes May Be Used to Describe These Covered Procedures. ★ Limit 1 Every 3 Years.

★★ Limit 1 Every 6 Months. ◆ Up to 19th Birthday. ■■ Per Tooth. ☼ Up to 14th Birthday.

## PATIENT CHARGE SCHEDULE (W1-04)

Code ‡		Patient Charge
D2330	Resin-Based Composite - One Surface, Anterior	\$9.00
D2331	Resin-Based Composite - Two Surfaces, Anterior	\$14.00
D2332	Resin-Based Composite - Three Surfaces, Anterior	\$17.00
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	\$75.00
D2336	Resin-Based Composite Crown, Anterior - Primary	\$75.00
D2337	Resin-Based Composite Crown, Anterior - Permanent	\$90.00
D2380	Resin-Based Composite - One Surface, Posterior - Primary	\$30.00
D2381	Resin-Based Composite - Two Surfaces, Posterior - Primary	\$40.00
D2382	Resin-Based Composite - Three or More Surfaces, Posterior - Primary	\$55.00
D2385	Resin-Based Composite - One Surface, Posterior - Permanent	\$30.00
D2386	Resin-Based Composite - Two Surfaces, Posterior - Permanent	\$40.00
D2387	Resin-Based Composite - Three Surfaces, Posterior-Permanent	\$55.00
D2388	Resin-Based Composite - Four or More Surfaces, Posterior - Permanent	\$75.00

**Crown and Bridge** *All charges for crown and bridge are per unit (each replacement or supporting tooth equals one unit) - replacement limit 1 every 5 years*

D2510	Inlay - Metallic - One Surface	\$255.00
D2520	Inlay - Metallic - Two Surfaces	\$255.00
D2530	Inlay - Metallic - Three or More Surfaces	\$255.00
D2542	Onlay - Metallic - Two Surfaces	\$320.00
D2543	Onlay - Metallic - Three Surfaces	\$320.00
D2544	Onlay - Metallic - Four or More Surfaces	\$320.00
D2740	Crown - Porcelain/Ceramic Substrate	\$400.00
D2750	Crown - Porcelain Fused to High Noble Metal	\$390.00
D2751	Crown - Porcelain Fused to Predominantly Base Metal	\$320.00
D2752	Crown - Porcelain Fused to Noble Metal	\$380.00
D2780	Crown - 3/4 Cast High Noble Metal	\$390.00
D2781	Crown - 3/4 Cast Predominantly Base Metal	\$320.00
D2782	Crown - 3/4 Cast Noble Metal	\$380.00
D2790	Crown - Full Cast High Noble Metal	\$390.00
D2791	Crown - Full Cast Predominantly Base Metal	\$320.00
D2792	Crown - Full Cast Noble Metal	\$380.00
D2910	Recement Inlay	\$20.00
D2920	Recement Crown	\$20.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	\$70.00
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	\$70.00
D2932	Prefabricated Resin Crown	\$90.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	\$140.00
D2940	Sedative Filling	\$10.00
D2950	Core Buildup, Including Any Pins	\$95.00
D2951	Pin Retention ■ ■, In Addition to Restoration	\$20.00
D2952	Cast Post and Core, In Addition to Crown	\$110.00
D2954	Prefabricated Post and Core In Addition to Crown	\$95.00
D2960	Labial veneer (Resin Laminate) - Chairside	\$75.00
D6210	Pontic - Cast High Noble Metal	\$365.00
D6211	Pontic - Cast Fused to Predominantly Base Metal	\$295.00
D6212	Pontic - Cast Noble Metal	\$355.00

‡ Different Codes May Be Used to Describe These Covered Procedures. ■ ■ Per Tooth.

# CIGNA Dental Care

Code ‡		Patient Charge
D6240	Pontic – Porcelain Fused to High Noble Metal	\$365.00
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	\$295.00
D6242	Pontic – Porcelain Fused to Noble Metal	\$355.00
D6245	Pontic – Porcelain/Ceramic Substrate	\$400.00
D6740	Crown – Porcelain/Ceramic Substrate	\$400.00
D6750	Crown – Porcelain Fused to High Noble Metal	\$390.00
D6751	Crown – Porcelain Fused to Predominantly Base Metal	\$320.00
D6752	Crown – Porcelain Fused to Noble Metal	\$380.00
D6780	Crown – 3/4 Cast High Noble Metal	\$390.00
D6781	Crown – 3/4 Cast Predominantly Base Metal	\$320.00
D6782	Crown – 3/4 Cast Noble Metal	\$380.00
D6790	Crown – Full Cast High Noble Metal	\$390.00
D6791	Crown – Full Cast Predominantly Base Metal	\$320.00
D6792	Crown – Full Cast Noble Metal	\$380.00
9999.6810	Complex Rehabilitation – Additional Charge Per Unit For Multiple Crown Units/Complex Rehabilitation <i>(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)</i>	\$125.00
D6930	Recent Fixed Partial Denture	\$20.00
<b>Endodontics (Root canal treatment, excluding final restorations)</b>		
D3110	Pulp Cap – Direct (Excluding Final Restoration)	\$20.00
D3120	Pulp Cap – Indirect (Excluding Final Restoration)	\$20.00
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	\$65.00
D3221	Gross Pulpal Debridement, Primary and Permanent Teeth (Not to be Used by Provider Completing Endodontic Treatment)	\$65.00
D3310	Anterior Root Canal (Excluding Final Restoration) ●	\$215.00
D3320	Bicuspid Root Canal (Excluding Final Restoration) ●	\$265.00
D3330	Molar Root Canal (Excluding Final Restoration) ●	\$360.00
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access	\$110.00
D3332	Incomplete Endodontic Therapy; Inoperable or Fractured Tooth	\$110.00
D3333	Internal Root Repair of Perforation Defects	\$110.00
D3346	Retreatment of Previous Root Canal Therapy – Anterior	\$240.00
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	\$310.00
D3348	Retreatment of Previous Root Canal Therapy – Molar	\$435.00
D3410	Apicoectomy/Periradicular Surgery – Anterior	\$175.00
D3421	Apicoectomy/Periradicular Surgery – Bicuspid (First Root)	\$175.00
D3425	Apicoectomy/Periradicular Surgery – Molar (First Root)	\$175.00
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$100.00
D3430	Retrograde Filling – Per Root	\$45.00
<b>Periodontics (Treatment of supporting tissues [gum and bone] of the teeth)</b>		
9999.4110	Periodontal Evaluation and Treatment Plan	\$40.00
D4210	Gingivectomy or Gingivoplasty (Per Quadrant)	\$185.00
D4211	Gingivectomy or Gingivoplasty (Per Tooth)	\$75.00
D4240	Gingival Flap Procedure, Including Root Planing (Per Quadrant)	\$185.00
D4245	Apically Positioned Flap	\$185.00
D4249	Clinical Crown Lengthening – Hard Tissue	\$150.00

‡ Different Codes May Be Used to Describe These Covered Procedures.

● Permanent Tooth.

# PATIENT CHARGE SCHEDULE (W1-04)

Code ‡		Patient Charge
D4260	Osseous Surgery - Including Flap Entry and Closure (Per Quadrant)	\$465.00
9999.4265	Osseous Surgery (1 tooth)	\$185.00
9999.4269	Osseous Surgery (2 - 4 teeth)	\$280.00
D4263	Bone Replacement Graft - First Site in Quadrant	\$225.00
D4264	Bone Replacement Graft - Each Additional Site in Quadrant	\$175.00
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	\$295.00
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	\$335.00
D4270	Pedicle Soft Tissue Graft Procedure	\$225.00
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	\$225.00
D4341	Periodontal Scaling and Root Planing (Per Quadrant) ★	\$65.00
9999.4344	Periodontal Scaling and Root Planing (1 tooth) ■ ★	\$25.00
9999.4346	Periodontal Scaling and Root Planing (2-4 teeth) ■ ★	\$40.00
D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis*	\$65.00
D4381	Localized Delivery of Chemotherapeutic Agents Via a Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth, By Report	\$60.00
D4910	Periodontal Maintenance Procedure (Following Active Therapy)▲	\$55.00
D9940	Occlusal Guards - By Report	\$155.00
D9951	Occlusal Adjustment - Limited	\$40.00
D9952	Occlusal Adjustment - Complete	\$120.00

## Prosthetics (Removable tooth replacement - dentures) (Includes up to 4 adjustments within first 6 months after insertion - replacement limit 1 every 5 years)

D5110	Complete Denture - Maxillary	\$350.00
D5120	Complete Denture - Mandibular	\$350.00
D5130	Immediate Denture - Maxillary	\$350.00
D5140	Immediate Denture - Mandibular	\$350.00
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests & Teeth)	\$320.00
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests & Teeth)	\$320.00
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests & Teeth)	\$390.00
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests & Teeth)	\$390.00
D5410	Adjust Complete Denture - Maxillary	\$15.00
D5411	Adjust Complete Denture - Mandibular	\$15.00
D5421	Adjust Partial Denture - Maxillary	\$15.00
D5422	Adjust Partial Denture - Mandibular	\$15.00

## Repairs To Prosthetics

D5510	Repair Broken Complete Denture Base	\$55.00
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	\$55.00
D5610	Repair Resin Denture Base	\$55.00
D5630	Repair or Replace Broken Clasp	\$55.00
D5640	Replace Broken Teeth (Per Tooth)	\$55.00
D5650	Add Tooth to Existing Partial Denture	\$55.00
D5660	Add Clasp to Existing Partial Denture	\$55.00

‡ Different Codes May Be Used to Describe These Covered Procedures.

■ Per Quadrant.

★ Limit 4 Quadrants Per Consecutive 12 Months.

\*1 Per Lifetime.

▲ Limit 2 Within 12 Months.

## Denture Relining *(Limit 1 every 36 months)*

D5710	Rebase Complete Maxillary Denture	\$125.00
D5711	Rebase Complete Mandibular Denture	\$125.00
D5720	Rebase Maxillary Partial Denture	\$125.00
D5721	Rebase Mandibular Partial Denture	\$125.00
D5730	Reline Complete Maxillary Denture (Chairside)	\$75.00
D5731	Reline Complete Mandibular Denture (Chairside)	\$75.00
D5740	Reline Maxillary Partial Denture (Chairside)	\$75.00
D5741	Reline Mandibular Partial Denture (Chairside)	\$75.00
D5750	Reline Complete Maxillary Denture (Laboratory)	\$125.00
D5751	Reline Mandibular Complete Denture (Laboratory)	\$125.00
D5760	Reline Maxillary Partial Denture (Laboratory)	\$125.00
D5761	Reline Partial Mandibular Denture (Laboratory)	\$125.00

## Interim Dentures *(Limit 1 every 5 years)*

D5810	Interim Complete Denture (Maxillary)	\$170.00
D5811	Interim Complete Denture (Mandibular)	\$170.00
D5820	Interim Partial Denture - (Maxillary)	\$135.00
D5821	Interim Partial Denture - (Mandibular)	\$135.00

## Oral Surgery *(Includes routine post-operative treatment)*

D7110	Extraction (Single Tooth)	\$30.00
D7120	Extraction (Each Additional Tooth)	\$30.00
D7130	Root Removal - Exposed Roots	\$30.00
D7210	Surgical Extraction Erupted Tooth	\$70.00
	<i>Surgical removal of impacted tooth - (not covered unless pathology [disease] exists). Surgical removal of wisdom tooth/3rd molar for orthodontic reasons only is not covered.</i>	
D7220	Removal of Impacted Tooth - Soft Tissue	\$75.00
D7230	Removal of Impacted Tooth - Partial Bony	\$110.00
D7240	Removal of Impacted Tooth - Completely Bony	\$165.00
D7241	Removal of Impacted Tooth - Completely Bony With Unusual Surgical Complications	\$165.00
D7250	Surgical Removal of Residual Tooth Roots	\$70.00
D7260	Oroantral Fistula Closure	\$180.00
D7270	Tooth Reimplantation	\$125.00
D7280	Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons❖	\$105.00
D7281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	\$105.00
D7285	Biopsy of Oral Tissue - Hard (Bone, Tooth) ❖	\$120.00
D7286	Biopsy of Oral Tissue - Soft (All Others) ❖	\$100.00
D7310	Alveoplasty in Conjunction with Extractions (Per Quadrant)	\$80.00
D7320	Alveoplasty Not in Conjunction with Extractions (Per Quadrant)	\$110.00
D7450	Removal of Odontogenic Cyst or Tumor - Lesion Diameter Up to 1.25cm	\$115.00
D7451	Removal of Odontogenic Cyst or Tumor - Lesion Diameter Greater Than 1.25cm	\$115.00
D7471	Removal of Exostosis - Per Site	\$100.00
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	\$40.00
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	\$110.00

† Different Codes May Be Used to Describe These Covered Procedures. ❖ Excluding Wisdom Teeth.

❖ Tooth Related - Not Allowed When in Conjunction with Another Surgical Procedure.

# PATIENT CHARGE SCHEDULE (W1-04)

Code ‡		Patient Charge
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## Orthodontics *(Tooth Movement)*

9999.8010	Orthodontic Evaluation	\$40.00
9999.8020	Orthodontic Treatment Plan and Records	\$150.00
9999.8025	Removable and/or Fixed Appliance(s) Insertion for Interceptive Treatment	\$275.00
9999.8026	Fixed Appliance Insertion (Banding) for Comprehensive Treatment	\$300.00

### *Orthodontic Treatment (maximum lifetime benefit of 24 months of interceptive and/or comprehensive treatment) - can include:*

9999.8360/		
9999.8370	Interceptive Orthodontic Treatment	
9999.8460/		
9999.8470/		
9999.8480	Class I, II, III Malocclusion - Comprehensive Treatment - Combination of Primary and Permanent Teeth	
9999.8560/		
9999.8570/		
9999.8580	Class I, II, III Malocclusion - Comprehensive Treatment - Permanent Teeth	
	Children - Up to 19th Birthday	\$1,900.00
	Adults	\$2,500.00

### *Atypical cases or cases beyond 24 months require an additional payment by the patient.*

9999.8750	Retention - Post Treatment Stabilization (Includes Appliance(s) and Treatment)	\$300.00
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## General Anesthesia/IV Sedation - Covered when performed by a Periodontist or Oral Surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule.

D9220	General Anesthesia - First 30 Minutes	\$115.00
D9221	General Anesthesia - Each Additional 15 Minutes	\$60.00
D9241	Intravenous Sedation/Analgesia - First 30 Minutes	\$115.00
D9242	Intravenous Sedation/Analgesia - Each Additional 15 Minutes	\$60.00

## Emergency Services

9999.0140/		
9999.9110	Emergency Exam and Visit - Pain Relief Treatment During Regularly Scheduled Office Hours	\$40.00
D9440	Office Visit - After Regularly Scheduled Hours	\$65.00

## Broken Appointment

*(Note: This fee will not be charged if patient is unable to provide 24-hours' notice through no fault of his or her own.)*

9999.0095	Broken Appointment - Less Than 24-hours' Notice (Per 15-Minute Appointment)	\$10.00
	Maximum Fee For Broken Appointment:	
	Sealant	\$10.00
	Prophylaxis	\$20.00
	Any Other Appointment	\$40.00

‡ Different Codes May Be Used to Describe These Covered Procedures.

### *After your enrollment is effective:*

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling CIGNA Dental at 1.800.367.1037. **EMERGENCY:** If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

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### Connecticut General Life Insurance Company CIGNA HealthCare, CIGNA Dental Health

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**CIGNA Dental**







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### **Notice Regarding Provider Directories and Provider Networks**

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

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.

NOT86

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

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

#### **Continuation of Coverage**

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

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

If your Employer is subject to federal continuation requirements called COBRA, you may continue benefits according to the federal continuation benefits shown in your certificate.

If your Employer is not subject to COBRA, you may continue benefits, by paying the required premium to your Employer, until the earliest of the following:

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

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

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

NOT73

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

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

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

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

NOT74

### **Time Frames for Requesting Reemployment**

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

- For leaves of less than 31 days or for a fitness exam, by reporting to your Employer by the next regularly scheduled work day following 8 hours of travel time;
- For leaves of 31 days or more but less than 181 days, by submitting an application to your Employer within 14 days; and
- For leaves of more than 180 days, by submitting an application to your Employer within 90 days.

Consult your Employer for more details regarding your rights and your Employer's obligations for re-employment.

This section will be superseded in whole or in part by any richer state-required provision shown in this certificate.

NOT104

### **Notice of an Appeal or a Grievance**

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

NOT90

### **Notice of Federal Requirements**

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective.



**CIGNA HealthCare**

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This includes premiums for continuation coverage required by federal law.

NOT99





*Home Office: Bloomfield, Connecticut  
Mailing Address: Hartford, Connecticut 06152*

**CONNECTICUT GENERAL LIFE INSURANCE COMPANY**

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

**POLICYHOLDER:** El Paso Corporation

GROUP POLICY(S) - COVERAGE

3171032-DHMOLA            CIGNA DENTAL CARE INSURANCE

**NOTICE**

Any insurance benefits in this Certificate will apply to an Employee only if: a) he has elected that benefit; and b) he has a "Final Confirmation Letter," with his name, which shows his election of that benefit.

**EFFECTIVE DATE** January 1, 2003

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

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

*Susan L. Cooper*  
Corporate Secretary

GM6000 CER7V23



### **Explanation of Terms**

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

### **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.**



## Effect of Section 125 Regulations on this Plan

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

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

### Coverage Elections

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

### Special Enrollment

Special Enrollment per federal requirements as described in the Section entitled "Eligibility - Effective Date/Exception to Late Entrant Definition" **if** included in this document.

SCT125V1

### Change in Status

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

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

### Court Order

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

### Medicare Eligibility/Entitlement

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

### Change in Cost of Coverage

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

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

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

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

SCT125V2

## Eligibility - Effective Date

### Eligibility for Employee Insurance

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

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

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

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

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



### Eligibility for Dependent Insurance

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

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

### Waiting Period

Initial Employee Group: None

New Employee Group: Date of hire

### Classes of Eligible Employees

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

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ELI5 M

## Eligibility - Effective Date

### For Dental Insurance -Employees

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

### Effective Date of Your Insurance

You will become insured on the first day of the month after the later of: (a) the date you elect the insurance by signing an approved payroll deduction form; or (b) the date you become eligible. If you are a Late Entrant, you may elect the insurance only during an Open Enrollment Period. Your insurance will become effective on the first day of the month after the end of that Open Enrollment Period in which you elect it.

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

### Late Entrant

You are a Late Entrant if:

- you do not elect the insurance within 30 days after you become eligible;
- you again elect it after you cancel your payroll deduction. CG may require evidence of good dental health at your expense if you are a Late Entrant.

### Open Enrollment Period

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

### Choice of Participating Dental Facility

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

GM6000 EF 17

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## Eligibility - Effective Date

### For Dental Insurance - Dependents

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

### Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the first day of the month after the later of: (a) the date you elect it by signing an approved payroll deduction form; or (b) the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, you may elect that insurance only during an Open Enrollment Period. The insurance for each of your Dependents will become effective on the first day of the month after the later of: (a) the end of that Open Enrollment Period; or (b) the date CG agrees in writing to insure that Dependent.

Your Dependents will be insured only if you are insured.

### Late Entrant

You are a Late Entrant for Dependent Insurance if:

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

CG may require evidence of your Dependent's good dental health at your expense if you are a Late Entrant.

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

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

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

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

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

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

### Qualified Medical Child Support Order

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

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

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

### Payment of Benefits

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

### B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

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

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## Dental Benefits - CIGNA Dental Care

### For You and Your Dependents

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

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

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

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

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

### Covered Dental Service

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

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

GM6000 DEN48

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

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth fully prepared.

- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

### Frequency

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

### Specialty Referrals

When specialized dental care services are required, a Participating General Dentist must initiate the referral process. Specialized dental services include endodontics, oral surgery, orthodontia, pedodontics, and periodontics. Upon payment approval by CDH, you and your Dependent will be liable for applicable fees including fees for any dental service rendered but not listed in the Patient Charge Schedule. All fees correspond to the Patient Charge Schedule in effect on the date the procedure is initiated. If CDH does not approve payment, you must pay the Dentist's usual fees.

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

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

GM6000 DEN112

### Pediatric Dentistry

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

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

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



authorized for payment, you will be fully responsible for the Pediatric Dentist's usual fees.

### Orthodontics

The following definitions apply:

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

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

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

GM6000 DEN113

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

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

### Orthodontics in Progress

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

### Oral Surgery

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

### Complex Rehabilitation

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

GM6000 DEN114

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

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



- hospitalization, including any associated incremental charges for dental services performed in a Hospital;

GM6000 DEN115



## General Limitations

### Dental Benefits

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

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

GM6000 GEN340

No payment will be made for expenses incurred or services received by you or any one of your Dependents:

- to the extent that benefits are paid or payable for those expenses or services under the mandatory part of any auto insurance policy written to comply with:
  - a "no-fault" insurance law; or
  - an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

GM6000 GL6

GEN238V2

### Coordination of Benefits

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

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of:

- (a) the benefits that would be payable from this Plan in the absence of coordination; and
- (b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

- (a) those reduced benefits; and
- (b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

GM6000 CB7 COR83

CG reserves the right to release to or obtain from any other Insurance Company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other Insurance Company or organization, as it may determine.



**Plan**

Plan means any of the following which provides medical or dental benefits or services: (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trustee plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

**Allowable Expense**

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

**Claim Determination Period**

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

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The rules below establish the order in which benefits will be determined:

- (1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.
- (2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.
- (3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:
  - (a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.

- (b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

GM6000 CB10

(2)  
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- (4) The benefits of a policy or plan which covers a person as an employee or as that employee's dependent are determined before those of a policy or plan which covers that person as a former employee or as a former employee's dependent provided according to the provision of the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA).
- (5) When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that:
  - (a) The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.
  - (b) If the other Plan does not have the rule in item (5)(a), which results in each Plan determining its benefits after the other, then item (5)(a) will not apply.

GM6000 CB11

COR35V1

**Expenses For Which A Third Party May Be Liable**

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CG, another party may be liable:

- 1. CG shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights.
- 2. Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:
  - a. the amount actually paid for such Covered Expenses by CG; or
  - b. the amount you actually receive from the third party for such Covered Expenses;



at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

GM6000 CCP7

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## Payment of Benefits

### To Whom Payable

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

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

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

GM6000 POB5

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### Miscellaneous

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

GM6000 POB2

## Termination of Insurance

### Termination of Insurance - Employees

Your insurance will cease on the earliest date below:

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

- the last day of the calendar month in which your Active Service ends except as described below.

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

### Temporary Layoff or Leave of Absence

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

### Injury or Sickness

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

### Retirement (for Medical Insurance)

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

GM6000 TRM15

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### Termination of Insurance - Dependents

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

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

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

### Dependent Dental Insurance After Your Death

If you are insured for Dental Insurance when you die, any of your Dependents who are then insured for such insurance will remain so insured without further payment of premiums for them. The insurance on any of those Dependents will remain in force until the earliest date below:



- the last day of the 24th month after your death;
- the date of remarriage of a surviving spouse, if any;
- the date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you.

The Dependent benefits payable after you die will be those in effect for your Dependents on the day prior to your death.

GM6000 TRM72

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## Termination of Insurance - Continuation

### Continuation of Dental Insurance During Active Military Duty

If your coverage would otherwise cease because you are a Reservist in the United States Armed Forces and are called to active duty, the insurance for you and your Dependents will be continued during your active duty only if you elect it in writing, and will continue until the earliest of the following dates:

- 90 days from the date your military service ends;
- the last day for which you made any required contribution for the insurance; or
- the date the group policy cancels.

### Reinstatement of Dental Insurance

If your coverage ceases because you are a Reservist in the United States Armed Forces and are called to active duty, the insurance for you and your Dependents will be automatically reinstated after your deactivation, provided that you return to Active Service within 90 days.

Such reinstatement will be without the application of: a) a new waiting period, or b) a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not be applied to any condition that you or your Dependent developed while coverage was interrupted. The remainder of a Pre-existing Condition Limitation which existed prior to interruption of coverage may still be applied.

GM6000 TER1

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## Continuation Required by Federal Law For You and Your Dependents

**The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.**

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for

gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

### A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; (b) the date notice of the right to continue insurance is sent; or (c) the date the insurance would otherwise cease. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

### B. Dependent Continuation Provision

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

- 1) your death;
- 2) divorce or legal separation; or
- 3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

COBRA13



such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

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

**C. Subsequent Events Affecting Dependent Coverage**

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

COBRA14

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

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

**Disabled Individuals Continuation Provisions**

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

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

To be eligible you or your Dependent must:

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

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

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

COBRA4

**D. Effect of Employer Chapter 11 Proceedings on Retiree Coverage**

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

COBRA15

**E. Payment of Premium**

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

Applicable Premium is determined as follows:

- 1. if the Employee alone elects to continue coverage, the Employee will be charged the active Employee rate;
- 2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate;



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

**Timely Payment**

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

**F. Providing Notification of Your Status to Health Care Providers During the Grace Period**

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

COBRA17

**G. Notification Requirements**

Your Employer should send you initial notification of coverage continuation rights as required by federal law; (a) when the Plan first becomes subject to federal continuation requirements; (b) when you are hired; and (c) when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

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

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

COBRA18

**Interaction With Other Continuation Benefits**

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the

longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

**Newly Acquired Dependents**

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

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

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

COBRA10

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

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

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

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

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

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

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

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

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing



Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

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

GM6000 TER5

TRM191V1

## Benefits Extension

### Dental Benefits Extension

A Dental Service that is completed after a person's benefits cease will be deemed to be completed while he is insured if:

- for fixed bridgework and full or partial dentures, the final impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.
- for Orthodontic Services, the treatment commences while the person is insured and the expenses are incurred within 60 days after his insurance ceases.

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

This extension of benefits does not apply if insurance ceases due to nonpayment of premiums.

GM6000 BEX184

## Problems and Grievances

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

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

### Appeals Procedure

The Dental Plan has a two-step procedure for complaints and appeals.

#### 1. Level One Appeal (Complaint)

To initiate an appeal, you must submit a request in writing to the Dental Plan within one year from the date of the initial Dental Plan decision or occurrence. You should state the reason why you feel your request should be approved and

include any information supporting your request. If you are unable or choose not to write, you may ask CDH to register your request by calling the toll-free number.

Your level one appeal will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

We will respond with a decision within 30 calendar days after we receive your request. If the review cannot be completed within 30 days, we will notify you of the reason for the delay on or before the 30th day. The review will be completed within 15 calendar days after that.

If you are not satisfied with our decision, you may request a second level review. To initiate a level two appeal, you must submit your request in writing to CDH within 60 days after receipt of CDH's level one decision.

GM6000 APL177

#### 2. Level Two Appeal

Second level reviews will be conducted by a CDH Appeals Committee, which consists of a minimum of three (3) people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the Committee will include at least one dentist. If specialty care is in dispute, the Committee will consult with a dentist in the same or similar specialty as the care under consideration, as determined by CDH.

CDH will acknowledge your appeal in writing within 5 business days and schedule a committee review. The acknowledgement will include the name, address and telephone number of the Appeals Coordinator. Additional information may be requested at that time. The review will be completed within 30 calendar days. If the review cannot be completed within (30) calendar days, you will be notified in writing on or before the 15th calendar day, and the review will be completed no later than 45 days after receipt of your request.

You may present your situation to the Committee in person or by conference call. Please advise CDH 5 days in advance if you or your representative plans to be present. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting. The resolution will include the specific contractual or clinical reasons for the resolution, as applicable.

#### 3. Expedited Appeals

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



the Dental Plan will respond orally with a decision within 72 hours and follow up in writing within two business days of the decision.

**Appeals to the State**

You have the right to contact your state's Department of (Insurance or Health) for assistance at any time.

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

GM6000 APL178

**Independent Review Procedure**

If your appeal concerns a dental necessity issue and the Appeals Committee denies coverage, you may request that your appeal be referred to an Independent Review organization. In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a dental necessity determination by CDH. Administrative, eligibility or benefit coverage limits are not eligible for additional review under this process.

There is no charge for you to initiate this independent review process; however, you must provide written authorization permitting CDH Dental to release the information to the Independent Reviewer selected. The Independent Review Organization is composed of persons who are not employed by CG, CDH or any of its affiliates. CG and CDH will abide by the decision of the Independent Review Organization.

To request a referral to an Independent Review Organization, you must notify the Appeals Coordinator within 60 days of your receipt of the Appeals Committee's level two appeal denial. CDH will then forward the file to the Independent Review Organization within 30 days.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your dental condition, as determined by the Dental Plan's Dental Director, the review shall be completed within 3-5 days.

The Independent Review Program is a voluntary program arranged by the Dental plan and is not available in all areas.

GM6000 APL180

**Dental Conversion Privilege**

Any Employee or Dependent whose Dental Insurance ceases for a reason other than failure to pay any required contribution or cancellation of the policy may be eligible for coverage under another Group Dental Insurance Policy underwritten by CG; provided that: (a) he applies in writing and pays the first

premium to CG within 31 days after his insurance ceases; and (b) he is not considered to be overinsured.

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

Conversion is not available if your insurance ceased due to:

- (a) non-payment of required premiums;
- (b) selection of alternate dental insurance by your group;
- (c) permanent breakdown of the dentist/patient relationship; or
- (d) fraud or misuse of the Dental Plan.

GM6000 PRO64

**When You Have a Complaint or an Appeal**

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

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

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

**Start with Member Services**

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You can 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 can start the appeals procedure.

**Appeals Procedure**

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing 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 postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

GM6000 APL262

### **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 Dentist in the same or similar specialty as the care under consideration, as determined by CG's Dental 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. The Committee review of your claim will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the committee review time frames above if the Committee does not approve the requested coverage.

GM6000 APL263

### **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, certain conditions apply. 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 condition, as determined by CG's Dentist reviewer, the review shall be completed within three days.

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

### **Appeal to the State**

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

GM6000 APL264

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

GM6000 APL266

**ERISA Required Information**

The name of the Plan is:

El Paso Corporation Employees' Benefit Plan

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

El Paso Corporation  
1001 Louisiana Street  
Houston, TX 77002  
713-420-4295

Employer Identification Number (EIN)	Plan Number
76-0568816	515

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

Employer named above

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

Employer named above

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

The CG Claim Office responsible for this Plan

The cost of the Plan is shared by the Employee and the Employer.

The Plan's fiscal year ends on 12/31.

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

**Plan Trustees**

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

**Plan Type**

The plan is a healthcare benefit plan.

**Collective Bargaining Agreements**

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

**Discretionary Authority**

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

ERISA14

**Plan Modification, Amendment and Termination**

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



consent of any participant is required to terminate, modify, amend or change the Plan.

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

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

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

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

ERISA15

### Funding

The method for funding the insured parts of the Plan is for the employer to pay premiums for the insurance benefits from the general assets of the employer's business, after any required contribution for the insurance benefits is obtained from the employees by payroll deduction.

ERISA16

### Statement of Rights

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

#### Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of

Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

### Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your federal continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

ERISA19

### Prudent Actions by Plan Fiduciaries

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



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

### **Enforce Your Rights**

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

ERISA20

## **Claim Determination Procedures Under ERISA**

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

### **Procedures Regarding Medical Necessity Determinations**

In general, health services and benefits must be medically necessary to be covered under the plan. The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan.

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

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

### **Postservice Medical Necessity Determinations**

When you or your representative requests payment for services that include a medical necessity determination, CG

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 CG's control CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

GM6000 ERISA24

## **Procedures Regarding Claim Payment Determinations**

### **Postservice Claim Determinations**

When you or your representative requests payment for services which have been rendered, CG will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG 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 and your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

### **Notice of Adverse Determination**

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity,



experimental treatment or other similar exclusion or limit; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

GM6000 ERISA25

**Assistance with Your Questions**

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

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this certificate are fully guaranteed by CG.

This certificate is issued by:

Connecticut General Life Insurance Company  
900 Cottage Grove Road  
Hartford, CT 06152

ERISA26

**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.

DFS1

**CIGNA Dental Health**

**(herein referred to as CDH)**

CDH is a wholly-owned subsidiary of CIGNA Corporation that, on behalf of CG, contracts with Participating General

Dentists for the provision of dental care. CDH also provides management and information services to Policyholders and Participating Dental Facilities.

DFS592

**Dentist**

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

DFS24

**Dependent**

Dependents are:

- your lawful spouse or your Domestic Partner; and
- any unmarried child of yours who is
  - less than 25 years old.
  - 25 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.

DFS1630 M DG

A child includes any child under the age of 25 who is legally adopted by you, including; (a) an unmarried child who is placed in your home according to an adoption placement agreement executed with a licensed adoption agency effective from the date of placement in your home, or (b) any unmarried child, following execution of an act of voluntary surrender in favor of you or your legal representative effective from the date on which the act of voluntary surrender becomes irrevocable. 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;
- any unmarried grandchild of yours provided such child is under 25 years of age, and is in your legal custody and resides with you;
- any grandchild of yours who is in your legal custody and resides with you, and is incapable of self-sustaining employment by reason of mental or physical handicap which existed prior to the child's 25th birthday.



- any newborn children, or newborn grandchildren in the legal custody of the grandparent, are covered from the date of birth until age one month or until such time as the infant is well enough to be discharged from the Hospital to the home.

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

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

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

DFS1631 M DG

**Domestic Partner**

A Domestic Partner is defined as a person of the same 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 "Continuation Required By Federal Law" will not apply to your Domestic Partner and his or her Dependents.

DFS1222 DG

**Employee**

The term Employee means an active full-time salaried employee of the Employer. 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.

DFS211 M

**Employer**

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

**Medicaid**

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

DFS192

**Medicare**

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

DFS149

**Participating Dental Facility**

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

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

DFS593

**Participating General Dentist**

The term Participating General Dentist means a person practicing dentistry within the scope of his license at a



**CIGNA HealthCare**

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Participating Dental Facility, under the terms of his provider contract with CDH.

DFS594

**Patient Charge Schedule**

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

DFS1102

**Specialist**

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

DFS598

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