METRO-I.L.A. FRINGE BENEFIT FUND

WELFARE PLAN

PPO/CDC (DHMO) DENTAL PLANS

FOR ACTIVE TIER I PARTICIPANTS

EFFECTIVE JANUARY 1, 2008

Any Statements in this Booklet that Disagree with the Fringe Benefit Fund's Summary Plan Description Are Superseded by the Fringe Benefit Fund's Summary Plan Description.

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IMPORTANT NOTICES

ATTENTION

Your health plan provides that you will not be held financially liable for payments to health care providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered expenses, if Connecticut General (CG) fails to pay for the covered expenses for any reason.

If you or your dependent(s) are in need of emergency care, whether or not you use a participating provider in the network, your covered expenses will be reimbursed to you as if you or your dependent(s) had been treated by a preferred provider.

Subsequent changes in your coverage shall be evidenced in a separate benefit rider issued to you or your dependent(s).

HOW TO FILE YOUR CLAIM

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

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

DENTAL EXPENSES

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

For Predetermination of Benefits, you should follow the Predetermination of Benefits procedure when major dentistry is recommended, by indicating so on your dental claim forms.

CLAIM REMINDERS

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

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

SECTION 1: ACCIDENT AND HEALTH PROVISIONS

CLAIMS

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

Where CG has followed the terms of the policy, no action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG or, if applicable, as described in the section "Complaints and Administrative Appeals Regarding Contractual Benefits, Quality of Care and Services." No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

ELIGIBILITY — EFFECTIVE DATE

Eligibility for Member Insurance

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

- you are in a Class of Eligible Member; and
- you are an eligible, full-time Member; and
- you have accrued the required credit hours during the prior calendar year as determined by the Fund.

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

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

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

WAITING PERIOD

The first day of the calendar year following the year you attain the required credit hours.

Classes of Eligible Members

Each Member as reported to the insurance company by the Fund.

IMPORTANT INFORMATION ABOUT YOUR DENTAL PLAN

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

- **CIGNA Dental Care; or**
- **CIGNA Dental Preferred Provider.**

Details of the benefits under each of the options are described in separate certificates within this booklet.

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

You and your Dependents may enroll for only one of the options, not for both options.

Your Dependents will be insured only if you are insured and only for the same option.

Change in Option Elected

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

Effective Date of Change

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

SECTION 2: METRO-ILA FRINGE BENEFIT FUND WELFARE PLAN

CIGNA PREFERRED PROVIDER DENTAL INSURANCE (PPO PLAN) FOR ACTIVE TIER I PARTICIPANTS, EFFECTIVE JANUARY 1, 2008

Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

Connecticut General Life Insurance Company: A CIGNA company (called CG) certifies that it insures certain Members for the benefits provided by the following policy(s):

Policyholder: Metro-I.L.A. Fringe Benefit Fund

Group Policy(s) — Coverage: 3165176 - DPPO1 CIGNA DENTAL PREFERRED PROVIDER INSURANCE

Effective Date: January 1, 2008

Notice: Any insurance benefits in this certificate will apply to a Member 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.

Certificate Subject to the Laws of the State of New Jersey: 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.

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.

SECTION 3: CIGNA DENTAL PREPARED PROVIDER INSURANCE

THE SCHEDULE

PARTICIPATING PROVIDER PAYMENT

Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and CG.

NON-PARTICIPATING PROVIDER PAYMENT

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge.

SIMULTANEOUS ACCUMULATION OF AMOUNTS

Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule.

Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

Benefit Highlights	Participating Provider	Non-Participating Provider
Classes I, II, III Combined; Calendar Year Maximum	**$1,000**	
Calendar Year Deductible		
Individual	**$50 per person**	
Family Maximum	**$150 per family**	
Class I		
Preventive Care	**100%**	**100%**
Class II		
Basic Restorative	**80% after plan deductible**	**80% after plan deductible**

COVERED DENTAL EXPENSE

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

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

ALTERNATE BENEFIT PROVISION

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

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

PREDETERMINATION OF BENEFITS

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

PREDETERMINATION OF BENEFITS (Continued)

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

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

Review of proposed treatment is advised whenever extensive dental work is recommended (when charges exceed $200).

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

COVERED SERVICES

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

DENTAL PPO – PARTICIPATING AND NON-PARTICIPATING PROVIDERS

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

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

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

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

NEW JERSEY - CONTRACTED FEE AMOUNTS

The contracted fee amount may vary based on geographical area. This sample list of procedures contains the lowest amounts that CG will use as the basis for its payments in New Jersey. These amounts may be higher in your geographical area.

D0150	Comprehensive oral evaluation	$31
D0240	Intraoral occlusal film	$17
D0274	Bitewing x-rays-4 films	$27
D0330	Panoramic film	$47
D0501	Histopathological Exam	$77
D1110	Prophylaxis (cleaning)-adult	$47
D2140	Amalgam restoration-one surface permanent	$47
D2330	Resin Based composite restoration-one surface anterior	$61
D2910	Recement Inlays	$45
D2920	Recement Crowns	$41
D3220	Therapeutic Pulpotomy	$72
D3330	Root Canal Therapy, molar (excluding final restoration)	$498
D3450	Root amputation-per root	$220
D4210	Gingivectomy or gingivoplasty-per quadrant	$177

NEW JERSEY - CONTRACTED FEE AMOUNTS (Continued)

D4260	Osseous surgery-per quadrant	$518
D4267	Guided tissue regeneration-Resorbable barrier - per site	$289
D4341	Periodontal scaling and root planing-per quadrant	$101
D5110	Complete denture-maxillary	$631
D5120	Complete denture-mandibular	$631
D5211	Maxilary partial denture-resin base	$368
D5213	Mandibular partial denture-resin base	$368
D6520	Inlay - metallic two surfaces	$367
D6790	Crown - full cast high noble metal	$482
D7110	Oral surgery-extraction-single tooth	$56
D7220	Surgical removal of impacted tooth-soft tissue	$139
D7250	Surgical removal of residual tooth roots	$114
D9110	Palliative (emergency) treatment of dental pain	$36

CLASS I SERVICES – DIAGNOSTIC AND PREVENTIVE

- **Clinical oral examination** - Only 2 per person per calendar year.
- **Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed.** (Any x-ray taken in connection with such treatment is a separate Dental Service.)
- **X-rays - Complete series** - Only one per person, including panoramic film, in any 3 calendar years.
- **Bitewing x-rays** - Only 2 charges per person per calendar year.
- **Panoramic (Panorex) x-ray** - Only one per person in any 3 calendar years.
- **Prophylaxis (Cleaning)** - Only 2 per person per calendar year.
- **Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.**
- **Topical application of fluoride (excluding prophylaxis)** - Limited to persons less than 19 years old. Only one per person per calendar year.
- **Topical application of sealant, per tooth, on a posterior tooth** - Only one treatment per tooth in any 3 calendar years.
- **Space Maintainers, fixed unilateral** - Limited to nonorthodontic treatment.

CLASS II SERVICES – BASIC RESTORATIONS, ENDODONTICS, PERIODONTICS, PROSTHODONTIC MAINTENANCE AND ORAL SURGERY

- **Amalgam Filling**
- **Composite/Resin Filling**
- **Root Canal Therapy** - Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.
- **Osseous Surgery** - Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.
- **Periodontal Scaling and Root Planing** - Entire Mouth
- **Adjustments** - Complete Denture
- **Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.**
- **Recement Bridge**
- **Routine Extractions**
- **Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth**
- **Removal of Impacted Tooth, Soft Tissue**
- **Removal of Impacted Tooth, Partially Bony**
- **Removal of Impacted Tooth, Completely Bony**
- **Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.**

CLASS II SERVICES – BASIC RESTORATIONS, ENDODONTICS, PERIODONTICS, PROSTHODONTIC MAINTENANCE AND ORAL SURGERY (Continued)

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

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

CLASS III SERVICES - MAJOR RESTORATIONS, DENTURES AND BRIDGEWORK

Crowns

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

- Porcelain Fused to High Noble Metal
- Full Cast, High Noble Metal
- Three-Fourths Cast, Metallic

Removable Appliances

- Complete (Full) Dentures, Upper or Lower
- Partial Dentures
- Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
- Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

- Bridge Pontics - Cast High Noble Metal
- Bridge Pontics - Porcelain Fused to High Noble Metal
- Bridge Pontics - Resin with High Noble Metal
- Retainer Crowns - Resin with High Noble Metal
- Retainer Crowns - Porcelain Fused to High Noble Metal
- Retainer Crowns - Full Cast High Noble Metal

EXPENSES NOT COVERED

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

- services performed solely for cosmetic reasons, except for the treatment of congenital defects in a newborn child;

- replacement of a lost or stolen appliance;

- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or

- the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;

- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;

- procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;

- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;

- bite registrations; precision or semiprecision attachments; or splinting;

- instruction for plaque control, oral hygiene and diet

- dental services that do not meet common dental standards;

- services that are deemed to be medical services;

- services and supplies received from a Hospital;

EXPENSES NOT COVERED (Continued)

- orthodontic treatment;

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

- services for which benefits are not payable according to the "General Limitations" section.

GENERAL LIMITATIONS

Dental Benefits

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

- 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 prov to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;

- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;

- to the extent that payment is unlawful where the person resides when the expenses are incurred;

- for charges which the person is not legally required to pay;

Dental Benefits (Continued)

- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;

- for charges for unnecessary care, treatment or surgery;

- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;

- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

COORDINATION OF BENEFITS

Purpose of This Provision

You or any one of your Dependents may be covered for health benefits or services by more than one Plan. For instances, you may be covered by this plan as a member and by another plan as a Dependent of your spouse. If you or your Dependents are covered by more than one Plan, this provision allows CG to coordinate what CG pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which plan is the primary plan and which plan is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which you or your Dependent are covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

Allowable Expense: The charge for any health care services, supply or other item of expense for which you or your Dependent are liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

Definitions (Continued)

When this Plan is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids. Allowable Expense is limited to like items of expense.

CG will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and appropriate.

When this Plan is coordinating benefits with a plan that restricts coordination of benefits to a specific coverage, CG will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense

Claim Determination Period: A Calendar Year, or any portion of a Calendar Year, during which you or your Dependent(s) are covered by this Plan and at least one other Plan and incur one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

- Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- Group hospital indemnity benefit amounts that exceed $150 per day;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

PLAN DOES NOT INCLUDE:

- Individual or family insurance contracts or subscriber contracts;
- Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
- Group or group-type coverage where the cost of coverage is paid solely by the member or subscriber, except that coverage being continued pursuant to a Federal or State continuation law will be considered a Plan;
- Group hospital indemnity benefit amounts of $150 per day or less;
- School accident-type coverage;
- A State plan under Medicaid.

PRIMARY PLAN:

A Plan whose benefits you or your dependent's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exist:

- The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this coordination of Benefits and Services provision; or
- All Plans which cover the covered person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by CG, based on a standard which is most often charged for a given service by a Provider within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If you or your Dependent(s) are covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision will be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

CG considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan will not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the person as a member, subscriber or retiree will be determined before those of the Plan that covers the person as a Dependent. The coverage as a member, subscriber or retiree is the Primary Plan.

RULES FOR THE ORDER OF BENEFIT DETERMINATION (Continued)

The benefits of the Plan that covers the person as a member who is neither laid off nor retired, or as a dependent of such person, will be determined before those for the Plan that covers the person as a laid off or retired member, or such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision will be ignored.

The benefits of the Plan that covers the person as a member, subscriber or retiree, or Dependent of such person, will be determined before those of the Plan that covers the person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision will be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year will be determined before those of the parent whose birthday falls later in the Calendar Year.

- If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time will be determined before those of the plan which covered the other parent for a shorter period of time.

- "Birthday," as used above, refers only to month and day in a calendar year, not the year in which the parent was born.

- If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision will be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- The benefits of the Plan of the parent with custody of the child will be determined first.

RULES FOR THE ORDER OF BENEFIT DETERMINATION (Continued)

The benefits of the Plan of the spouse of the parent with custody will be determined second.

- The benefits of the Plan of the parent without custody will be determined last.

- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan will be determined first. The benefits of the plan of the other parent will be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision will be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the member or subscriber for a longer period of time will be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS

In order to determine which procedure to follow it is necessary to consider:

- The basis on which the Primary Plan and the Secondary Plan pay benefits; and

- Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R & C), or some similar term. This means that the provider bills a charge and the covered person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an “R & C Plan.”

PROCEDURES TO BE FOLLOWED BY THE SECONDARY PLAN TO CALCULATE BENEFITS (Continued)

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the covered person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the covered person uses the services of a non-network provider, the plan will be treated as an R & C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation." This means that the HMO or other plan pays the provider a fixed amount per covered person. You or your dependent will be liable only for the applicable deductible, coinsurance or copayment. If you or your dependent uses the services of a non-network provider, the HMO or other plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

PRIMARY PLAN IS R & C PLAN AND SECONDARY PLAN IS R & C PLAN

The Secondary Plan will pay the lesser of:

- The difference between the amount of the billed charges and the amount paid by the Primary Plan; or

- The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit will be reduced in proportion, and the amount paid will be charged against any applicable benefit limit of the plan.

PRIMARY PLAN IS FEE SCHEDULE PLAN AND SECONDARY PLAN IS FEE SCHEDULE PLAN

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense will be the fee schedule of the Primary Plan. The Secondary Plan will pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or

- The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the covered person will not exceed the fee schedule of the Primary Plan. In no event will you or your dependent be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

PRIMARY PLAN IS R&C PLAN AND SECONDARY PLAN IS FEE SCHEDULE PLAN

If the provider is a network provider in the Secondary Plan, the Secondary Plan will pay the lesser of:

- The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or

- The amount the Secondary Plan would have paid if it had been the Primary Plan.

You or your dependent will only be liable for the copayment, deductible or coinsurance under the Secondary Plan if you or your dependent have no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event will you or your dependent be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

PRIMARY PLAN IS FEE SCHEDULE PLAN AND SECONDARY PLAN IS R & C PLAN

If the provider is a network provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan will be the fee schedule of the Primary Plan. The Secondary Plan will pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

PRIMARY PLAN IS FEE SCHEDULE PLAN AND SECONDARY PLAN IS R & C PLAN OR FEE SCHEDULE PLAN

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply you or your dependent receive from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan will pay benefits as if it were the Primary Plan.

PRIMARY PLAN IS CAPITATION PLAN AND SECONDARY PLAN IS FEE SCHEDULE PLAN OR R & C PLAN

If you or your dependent receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan will pay the lesser of:

- The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- The amount the Secondary Plan would have paid if it had been the Primary Plan.

PRIMARY PLAN IS CAPITATION PLAN OR FEE SCHEDULE PLAN OR R & C PLAN AND SECONDARY PLAN IS CAPITATION PLAN

If you or your dependent receive services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan will be liable to pay the capitation to the provider and will not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. You or your dependent will not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

PRIMARY PLAN IS AN HMO AND SECONDARY PLAN IS AN HMO

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care of emergency care and the service or supply you or your dependent receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan will pay benefits as if it were the Primary Plan, except that the Primary Plan will pay out-of-Network services, if any, authorized by the Primary Plan.

DOMESTIC PARTNERS

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan. Therefore, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CIGNA is the Secondary Plan.

PAYMENT OF BENEFITS

To Whom Payable

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

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

To Whom Payable (Continued)

the person or institution appearing to have assumed his custody and support.

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

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

Time of Payment

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

Recovery of Overpayment

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

TERMINATION OF INSURANCE

Members

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Members or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar year if you have not attained the required credit hours except as described below.

Members (Continued)

- 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 the Fund cancels your insurance.

Injury or Sickness

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

Dependents

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

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

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

Special Continuation of Dental Insurance

If your insurance would otherwise cease due to total disability, and if you have been insured for at least three consecutive months under the policy, and if you pay the Fund the required premium, your Dental Insurance will be continued until the earliest of:

Special Continuation of Dental Insurance (Continued)

the last day for which you have paid the required premium;

- the date you become employed and eligible for similar insurance under another group policy for dental benefits;

- the date the policy is canceled.

Within 31 days after the date the insurance would otherwise cease, you may elect such continuation by completing a continuation notification and by paying the required premium to the Fund.

If your insurance is being continued as outlined above, the Dental Insurance for any of your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the above provisions. The Dependent Dental Insurance will be continued until the earlier of:

- the date your insurance ceases; or

- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

This option will not operate to reduce any continuation of insurance otherwise provided.

DENTAL BENEFITS EXTENSION

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

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.

- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.

DENTAL BENEFITS EXTENSION (Continued)

- 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 a dental condition which causes an insured to be Totally Disabled on the day insurance ends, in the event the group policy cancels, and the expenses are incurred within 90 days after his insurance cancels.

TOTALLY DISABLED

A person is considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to perform the basic duties of his occupation; and

- he is not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of same age, sex and ability; or

- in the case of a Dependent who normally works for wage and profit, he is not performing such work.

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

ERISA REQUIRED INFORMATION

The name of the Plan is: Metro-I.L.A. Fringe Benefit Fund

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

ERISA REQUIRED INFORMATION (Continued)

Metro-I.L.A. Fringe Benefit Fund
301 Route 17 North
Rutherford, NJ 07070
(201) 842-0202

Fund Identification Plan Number (EIN): 133050863 501

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

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

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 to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if the Fund 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.

Plan Modification, Amendment and Termination

The Fund 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 members 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 the which the eligibility of classes of members may be changed or terminated, or by which part of all of the Plan may be terminated, is contained in the Fund's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Fund. 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 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. (A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Plan Modification, Amendment and Termination (Continued)

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

- the last day of the calendar year if you have not attained the required credit hours;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

STATEMENT OF RIGHTS

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

Receive Information about Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive Information about Your Plan and Benefits (Continued)

- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

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

- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the member 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 the Fund, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

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

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

Assistance with Your Questions

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

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.

When You Have a Concern or Complaint

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 and a “Physician Reviewer” is a licensed Physician or a licensed Dentist, depending on the care, treatment or service under review who is also a Medical Director or his or her designee who rendered the initial adverse determination.

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.

SECTION 4: COMPLAINTS AND ADMINISTRATIVE APPEALS REGARDING CONTRACTUAL BENEFITS, QUALITY OF CARE AND SERVICES

START WITH MEMBER SERVICES

We are here to listen and help. If you have a specific concern or complaint regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy or contractual benefits, you or your designated representative (including your treating Provider) can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

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

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

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

ADMINISTRATIVE APPEALS PROCEDURE

CG has a two step appeals procedure for coverage decisions. To initiate an Administrative appeal, you must submit a request for an appeal in writing within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Benefit Identification card. If you choose to designate a representative to appeal on your behalf, including your provider, all correspondence related to your appeal will be sent to your designated representative and you. If you do not want such representative to pursue the appeal on your behalf, you must notify CG that you do not want this representative appealing this issue on your behalf.

LEVEL ONE APPEAL

Your appeal will be reviewed and the decision made by someone not involved in the initial decision.

For level one appeals, we will acknowledge in writing that we have received your request within 10 business days and respond in writing with a decision within 30 calendar days after we receive an appeal for a post-service coverage determination or within 15 calendar days for a pre-service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

LEVEL TWO APPEAL

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal, except that such a request must be submitted within 60 days from your receipt of a Level One Appeal decision.

Requests for a second review will be acknowledged in writing that we have received your request within 10 business days. Post-service requests will be completed within 30 calendar days, while most pre-service requests will be completed within 15 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 to complete the review. You will be notified in writing of the decision.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond with a decision within 72 hours.

APPEAL TO THE STATE OF NEW JERSEY

For appeals regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy, or the contractual benefits, if you remain dissatisfied after exhausting CG's Complaint and Appeal procedure, you may appeal to the State of New Jersey Department of Banking and Insurance at the following address and telephone number:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

You may also wish to access an online New Jersey complaint form at: www.state.nj.us/dobi/enfcon.htm.

SECTION 5: APPEALS REGARDING REQUIRED MEDICAL NECESSITY AND UTILIZATION REVIEW DETERMINATIONS

INITIAL DETERMINATION

CG is responsible for making decisions about the appropriateness, medical necessity and efficiency of health care services provided to Members under this Certificate. All decisions to deny or limit coverage for an inpatient admission, a service, a procedure or an extension of inpatient stay, are made by a New Jersey-licensed Dentist.

The health care determinations made by CG are directly communicated to the treating or requesting Provider (including a Provider acting on your behalf with your consent, if such Provider is the requesting Provider) on a timely basis appropriate to the Member's medical needs. CG will not reverse its initial determination of medical necessity or appropriateness unless misrepresented or fraudulent information was submitted to CG as part of the request for health care services.

You or your designated representative (including a provider acting on your behalf with your consent) may request a written notice of an initial determination made by CG, including an explanation of the Medical Necessity Appeal process.

MEDICAL NECESSITY APPEALS PROCEDURE

CG has a two step procedure for coverage decisions. To initiate a Medical Necessity appeal, you must submit a request for an appeal in writing to the address that appears on your Benefit Identification card, explanation of benefits or claim form within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your Benefit Identification card. If you choose to designate a representative to appeal on your behalf, including your provider, all

MEDICAL NECESSITY APPEALS PROCEDURE (Continued)

correspondence related to your appeal will be sent to your designated representative and you. If you do not want such representative to pursue the appeal on your behalf, you must notify CG that you do not want this representative appealing this issue on your behalf.

LEVEL ONE APPEAL

You have the opportunity to speak with, and may request appeal review by, CG's Dentist reviewer.

For level one appeals, we will respond in writing with a decision within five business days after we receive an appeal.

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, except that such a request must be submitted within 60 days from your receipt of a Level One Appeal decision.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least one Dentist reviewer and two other Dentists/health care professionals. Anyone involved in the prior decision may not participate on the Appeal Committee. 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 Dentist reviewer. You may request that the same or similar specialist be a participant on the committee. 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 within 10 business days and schedule a committee review. The committee review will be completed within 15 calendar days for pre-service appeals and 20 business days for post-service appeals. If more time or information is needed to make the determination, we will notify the

LEVEL TWO APPEAL (Continued)

Department of Banking and Insurance and you in writing to request an extension of up to 15 calendar days for pre-service appeals and 20 business days for post-service appeals and to specify any additional information needed by the Appeals Committee to complete the review. You will be notified in writing of the Appeals Committee's decision.

EXTERNAL APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

After exhausting CG's Medical Necessity Appeal procedure, if you remain dissatisfied with CG's health care determination, you may initiate a review by an independent utilization review organization (IURO) within 60 calendar days from the receipt of CG's final written decision. To initiate a review, you or your Provider, on your behalf, should complete the State of New Jersey IURO forms provided by CG and mail the completed forms to:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

along with a check or money order for $25 payable to the "New Jersey Department of Banking and Insurance" (this fee may be reduced to $2 in cases of financial hardship). If a Provider is appealing to the IURO on your behalf, the Provider is responsible for paying your portion of the cost of the IURO appeal (e.g. $25, or $2 if financial hardship). CG will bear the remaining costs of the review.

You or your Provider, on your behalf, may also request review of your appeal by the IURO if CG has missed any timeframes associated with the processing of your medical necessity appeal. If this is the case, you must certify to the IURO that you or your Provider, on your behalf, did not hinder CG from making a timely determination by failing to provide the information required for CG to make its decision.

EXTERNAL APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS (Continued)

Once the IURO communicates its decision, CG will respond within 10 business days to you (or the Provider, on your behalf) the IURO and the Department of Banking and Insurance with a written report describing how CG will implement the IURO's decision.

The External Appeals Program is a voluntary program. The decision of the IURO is binding on CG.

APPEAL TO THE STATE OF NEW JERSEY

You have the right to contact the New Jersey Department of Banking and Insurance for assistance at any time. The New Jersey Department of Banking and Insurance may be contacted at the following address and telephone number:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

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: (a) the procedure to initiate the next level of appeal; (b) any voluntary appeal procedures offered by the plan; and (c) the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination

NOTICE OF BENEFIT DETERMINATION ON APPEAL (Continued)

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 Level Two Appeal decision (or with the Level One Appeal decision if expedited). You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

RELEVANT INFORMATION

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

LEGAL ACTION FOLLOWING APPEALS

If your plan is governed by ERISA, you have the right to bring a civil action in federal court 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 in federal court.

LEGAL ACTION FOLLOWING APPEALS (Continued)

If your plan is governed by New Jersey P.L.2001, c.187 (2A:53A-30 et seq), you have the right to bring action in state court accordance with that statute. You must exhaust the Independent Health Care Appeals Program procedures created pursuant to section 11 of P.L.1997, c.192 (C26:2S-11), before filing an action in state court, unless serious or significant harm to the covered person has occurred or will imminently occur, before filing an action in state court for economic and non-economic loss that occurs as a result of CG's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of a covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition resulting in chronic and significant pain; or (7) substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care.

SECTION 6: METRO-ILA FRINGE BENEFIT FUND

CIGNA DENTAL CARE BENEFITS FOR ACTIVE TIER I PARTICIPANTS RESIDING IN NEW YORK

CHOICE OF PARTICIPATING DENTAL FACILITY

When you elect Member 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 his own designated Participating Dental Facility. 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.

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.

DENTAL BENEFITS – CIGNA DENTAL CARE FOR YOU AND YOUR DEPENDENTS (Continued)

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.

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 are 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.

Covered specialists include:

- **pediatric dentists** – children's dentistry;
- **endodontists** – root canal treatment;
- **periodontists** – treatment of gums and bone;
- **oral surgeons** – complex extractions and other surgical procedures;
- **orthodontists** – tooth movement.

There is no coverage for prosthodontists or other specialists not listed above.

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.

SPECIALTY REFERRALS (Continued)

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.

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

If your Patient Charge Schedule indicates coverage for orthodontic treatment, 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; and

Orthodontics (Continued)

- **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.

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.

SERVICES NOT COVERED

Covered Dental Services will not include or, where applicable, no payment will be made for any:

- services performed solely for cosmetic reasons.
- replacement of fixed and/or removal 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 purposes 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 specially 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.

SERVICES NOT COVERED

- procedures or appliances for minor tooth guidance or to control harmful habits.
- procedures or services associated with the placement or prosthodontic restoration of a dental implant.
- crowns or bridges used solely for splinting.
- resin bonded retainers and associated pontics.
- hospitalization, including any associated increment charges for dental services performed in a hospital.

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;
- Dental Benefits (Continued)
- 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 the United States Government: (a) unless there is a legal obligation to pay such charges whether or not there is insurance; or (b) such charges are directly related to a military-service-connected Sickness or Injury;
- 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;

Dental Benefits (Continued)

- when charges would not have been made if the person had no insurance;

- for care, treatment or surgery not prescribed as necessary by a Dentist;

- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;

- all clinical lab services, pharmacy services, x-ray or imaging services, if referred by a practitioner who has a financial relationship (or whose immediate family member has a financial relationship) with the provider of those services;

- due to Injuries that are intentionally self-inflicted.

Coordination of Benefits

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

DEFINITIONS

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

Plan

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

- Group insurance and/or group-type coverage, whether insured or self-insured, including closed panel coverage which neither can be purchased by the general public, nor is individually underwritten.

- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.

Plan (Continued)

- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

Allowable Expense (Continued)

- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year or that part of a calendar year in which the person has been covered under this Plan.

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or a member shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;

- For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent as an enrollee or member whose birthday falls first in the calendar year;

Order of Benefit Determination Rules (Continued)

- For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

  - then, the Plan of the parent with custody of the child;

  - then, the Plan of the spouse of the parent with custody of the child;

  - then, the Plan of the noncustodial parent.

- The Plan that covers you as an active member (or as that member's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired member (or as that member's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active member or retiree (or as that member's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

Effect on the Benefits of This Plan

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

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

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

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

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

Right of Recovery

If the amount of payments made by an insurer is more than it should have paid under its COB provision, it may recover the excess from one or more of:

- the persons it has paid or for whom it has paid;
- insurance companies; or
- other organizations.

Right to Receive and Release Information

The Plan, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits.

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:

- 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.

- 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:

    - the amount actually paid for such Covered Expenses by CG; or

    - the amount you actually receive from the third party for such Covered Expenses;

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

CG will only exercise its subrogation rights if the amount received by you is specifically identified in the settlement or judgment as amounts paid for medical expenses.

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.

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.

ERISA REQUIRED INFORMATION

The name of the Plan is: Metro-I.L.A. Fringe Benefit Fund

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

Metro-I.L.A. Fringe Benefit Fund
301 Route 17 North
Rutherford, NJ 07070
(201) 842-0202

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

ERISA REQUIRED INFORMATION (Continued)

Fund Plan Identification Number (EIN): 133050863 501

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 paid by the Fund.

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 to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan Collective Bargaining Agreements

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

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.

When You Have a Complaint or an Appeal

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

When You Have a Complaint or an Appeal (Continued)

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

Start With Member Services

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

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate a complaint about: (1) a denial of, or failure to pay for, a referral; or (2) a determination as to whether a benefit is covered under the Policy, we will get back to you on the same day we receive your complaint, or use the "Grievances and Appeals of Administrative and Other Matters" process described in the following section to provide a Grievance resolution if we cannot resolve your complaint on the same day.

If you submit a written concern about any matter in writing, we will use the "Grievances and Appeals of Administrative and Other Matters" process described in the following section to provide a Grievance resolution.

Concerns regarding the quality of care, choice of or access to providers, or provider network adequacy, will be forwarded to CG's Quality Management Staff for review, and CG will provide written acknowledgment of your concern within 15 days with appropriate resolution information to follow in a timely manner.

SECTION 7: GRIEVANCE AND APPEALS OF ADMINISTRATIVE AND OTHER MATTERS

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

We will acknowledge your appeal in writing within five working days after we receive the appeal. Acknowledgments include the name, address, and telephone of the person designated to respond to your appeal, and indicate what additional information, if any, must be provided.

LEVEL ONE ADMINISTRATIVE APPEAL/GRIEVANCE

You or your representative, with your acknowledgment and consent, must submit your Level One Administrative Appeal in writing or by telephone:

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

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving clinical appropriateness will be considered by a health care professional of the same or similar specialty as the care under consideration.

For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive the appeal.

This notification will include the reasons for the decision, including clinical rationale if applicable, as well as additional appeal rights, if any.

LEVEL TWO ADMINISTRATIVE APPEAL

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

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

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

SECTION 8: APPEALS OF UTILIZATION REVIEW DECISIONS

CG has a two-step appeals procedure to review any dispute you may have regarding a CG utilization review determination. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal or ask for information about utilization review decisions by calling the toll-free number on your Benefit Identification card, explanation of benefits or claim form, Monday through Friday, during regular business hours. If calling after hours, follow the recorded instructions if you wish to leave a message.

We will acknowledge your appeal in writing within five working days after we receive the appeal. Acknowledgments include the name, address, and telephone of the person designated to respond to your appeal, and indicate what additional information, if any, must be provided.

If no decision is made within the applicable time frames described below regarding your appeal of an adverse utilization review determination, the adverse determination will be deemed to be reversed.

LEVEL ONE APPEAL (FINAL ADVERSE DETERMINATION)

You or your representative with your acknowledgment and consent must submit your Level One appeal in writing or by telephone to:

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

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 of the same or similar specialty as the care under consideration.

LEVEL ONE APPEAL (FINAL ADVERSE DETERMINATION (Continued)

We will respond in writing with a decision within 15 calendar days after we receive an appeal. If more information is needed to make the determination, we will notify you in writing or request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You are not obligated to grant CG an extension or to provide the requested information.

If you remain dissatisfied with the Level One decision of CG, you have the right to request an External Appeal as well as a Level Two Appeal as described in the following paragraphs. You may also request an External Appeal application from the New York Insurance Department toll-free at 800-400-8882, or its website (www.ins.state.ny.us); or the New York Department of Health at its website (www.health.state.us).

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 Appeals 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 reviewer in the same or similar specialty as the care under consideration, as determined by CG's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

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

EXTERNAL APPEAL

1. Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if CG has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative, with your acknowledgment and consent, may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

2. Your Right to Appeal a Determination That A Service Is Not Medically Necessary

If CG has denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you satisfy the following criteria:

The service, procedure or

- procedure or treatment must otherwise be a Covered Expenses under this Certificate; and
- You must have received a final adverse determination through the first level of the Plan's internal appeal process and CG must have upheld the denial or you and CG must agree in writing to waive any internal appeal.
- procedure or treatment must otherwise be a Covered Expenses under this Certificate; and
- You must have received a final adverse determination through the first level of the Plan's internal appeal process and CG must have upheld the denial or you and CG must agree in writing to waive any internal appeal.
- procedure or treatment must otherwise be a Covered Expenses under this Certificate; and

2. Your Right to Appeal a Determination That A Service Is Not Medically Necessary (Continued)

- You must have received a final adverse determination through the first level of the Plan's internal appeal process and CG must have upheld the denial or you and CG must agree in writing to waive any internal appeal.

- age of 18, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

Your attending Physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by CG or one for which there exists a clinical trial (as defined by law).

In addition, your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Expenses (only certain documents will be considered in support of this recommendation - your attending Physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

3. The External Appeal Process

If, through the first level of CG's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an experimental or

vestigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and CG have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. CG will provide an external appeal application with the final adverse determination issued through the first level of CG's internal appeal process or its written waiver of an internal appeal.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days from your receipt of the final adverse determination from the first level plan appeal regardless of whether you choose to pursue a second level internal appeal with CG.

4. The External Appeal Program Is a Voluntary Program

You may also request an external appeal application from New York State at toll-free at 800-400-8882, or its web site (www.ins.state.ny.us); or our Member Services department at the toll-free number on your Benefit ID card. Submit the completed application to State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which CG based its denial, the External Appeal Agent will share this information with CG in order for it to exercise its right to reconsider its decision. If CG chooses to exercise this right, CG will have three working days to amend or confirm its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your Dentist or CG. If the External Appeal Agent requests additional information, it will have five additional working days to make its decision. The External Appeal Agent must notify you in writing of its decision within two working days.

4. The External Appeal Program Is a Voluntary Program (Continued)

If the External Appeal Agent overturns CG's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, CG will provide coverage subject to the other terms and conditions of this document. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, CG will only cover the costs of services required to provide treatment to you according to the design of the trial. CG shall not be responsible for the costs of investigational drugs or devices, the costs of nonhealth care services, the costs of managing research, or costs which would not be covered under this certificate for nonexperimental or noninvestigational treatments provided in such clinical trial.

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

CG will charge you a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. CG will also waive the fee if CG determines that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

5. Your Responsibilities

It is your responsibility to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If utilization review was initiated after health care services have been provided, your Physician may file an external appeal by completing and submitting the "New York State External Appeal Application For Health Care Providers To Request An External Appeal Of A Retrospective Final Adverse Determination," which will require your signed acknowledgment of the provider's request and consent to release the medical records.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from CG that it has upheld a first level denial of coverage or the date upon which you receive a written waiver of any internal appeal. CG has no authority to grant an extension of this deadline.

SECTION 9: COMPLAINTS/APPEALS TO THE STATE OF NEW YORK

At any time in the Grievance/Appeals process you may contact the Department of Health (for medically related issues) or the Department of Insurance (for billing/contract related issues) at the following address and telephone number to register your complaint.

New York Department of Health
Metropolitan Regional Area Office
5 Penn Plaza, 2nd Floor
New York, NY 10001
212-268-6306 or 800-206-8125

or

New Rochelle Area Office
145 Huguenot Street, 6th Floor
New Rochelle, NY 10810
914-654-7199 or 800-206-8125

or

New York State Insurance Department
One Commerce Plaza
Albany, NY 12257
800-342-3736

NOTICE OF BENEFIT DETERMINATION ON GRIEVANCE OR APPEAL

Every notice of a determination on grievance or 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 including clinical rationale; (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: (a) the procedures to initiate the next level of appeal; (b) any voluntary appeal procedures offered by the plan; and (c) the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

In addition, every notice of a utilization review final adverse determination must include: (a) a clear statement describing the basis and clinical rationale for the denial as applicable to the insured; (b) a clear statement that the notice constitutes the final adverse determination; (c) CG's contact person and his or her telephone number; (d) the insured's coverage type; (e) the name and full address of CG's utilization review agent, if any; (f) the utilization review agent's contact person and his or her telephone number; (g) a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or Physician proposed to provide the treatment and the developer/manufacturer of the health care service; (h) a statement that the insured may be eligible for an external appeal and the time frames for requesting an appeal; and (i) a clear statement written in bolded text that the 45-day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing the request a second level internal appeal, the time may expire for the insured to request an external appeal.

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

RELEVANT INFORMATION

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

LEGAL ACTION

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two Appeal

SECTION 10: METRO-ILA FRINGE BENEFIT FUND

CIGNA DENTAL CARE BENEFITS FOR ACTIVE TIER I PARTICIPANTS RESIDING IN NEW JERSEY

CIGNA DENTAL HEALTH OF NEW JERSEY, INC.

P.O. Box 189060
Plantation, Florida 33318-9060

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between CIGNA Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also be changed. Please read the following information so you will know from whom or what group of providers dental care may be obtained.

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

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

READ YOUR PLAN BOOKLET CAREFULLY

Please call Member Services at 1-800-367-1037 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

I. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

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

II. ELIGIBILITY WHEN COVERAGE BEGINS

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

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

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

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

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

III. YOUR CIGNA DENTAL COVERAGE

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

A. Member Services

If you have any questions or concerns about the Dental Plan, Member Services Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Member Services from any location at 1-800-367-1037. The hearing impaired may contact the state TTY toll-free relay service number listed in the local telephone directory.

B. Premiums/Prepayment Fees

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

C. Other Charges – Patient Charges

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

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge

Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

C. Other Charges – Patient Charges (Continued)

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

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

D. Choice of Dentist

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

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

To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at 1-800-367-1037. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Member Services.

E. Your Payment Responsibility (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual

E. Your Payment Responsibility (General Care) – [Continued]

Fees. For non-Covered Services, you are responsible for paying Usual Fees.

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

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

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

F. Emergency Dental Care – Reimbursement

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

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

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

G. Limitations on Covered Services

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

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

2. **Specialty Care** - Payment authorization is required for coverage of services by a Network Specialty Dentist.

3. **Pediatric Dentistry** - Coverage for referral to a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 7th birthday.

4. **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.

H. Services Not Covered Under Your Dental Plan

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

1. services not listed on the Patient Charge Schedule.

2. services provided by a non-Network Dentist without CIGNA Dental's prior approval (except emergencies, as described in Section IV, F.).

3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.

4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.

H. Services Not Covered Under Your Dental Plan (Continued)

5. services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.

6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).

7. 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 are provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist.

8. prescription drugs.

9. procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule or if your Patient Charge Schedule ends in "-04" or a higher number; c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

10. replacement of fixed and/or removable appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

11. services associated with the placement or prosthodontic restoration of a dental implant.

12. services considered to be unnecessary or experimental in nature.

13. procedures or appliances for minor tooth guidance or to control harmful habits.

14. hospitalization, including any associated incremental charges for dental services performed in a Hospital. (Benefits are available for Network Dentist charges for covered services performed at a

H. Services Not Covered Under Your Dental Plan (Continued)

Hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)

15. services to the extent you, or your enrolled Dependent, are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.

16. the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental Coverage.

In addition to the above, if your Patient Charge Schedule number ends in "-04" or higher number, there is no coverage for the following:

17. crowns and bridges used solely for splinting.

18. resin bonded retainers and associated pontics.

Preexisting conditions are not excluded if otherwise covered under your Patient Charge Schedule.

IV. APPOINTMENTS

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

V. BROKEN APPOINTMENTS

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

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

VI. OFFICE TRANSFERS

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Member Services at 1-800-367-1037. To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at 1-800-367-1037.

Your transfer will take about 5 days to process. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

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

VII. SPECIALTY CARE

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

- **Pediatric Dentists** - Children's dentistry.
- **Endodontists** - Root canal treatment.
- **Periodontists** - Treatment of gums and bone.
- **Oral Surgeons** - Complex extractions and other surgical procedures.
- **Orthodontists** - Tooth movement.

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

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

VIII. SPECIALTY REFERRALS

A. In General

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

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

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

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

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

B. Pediatric Dentistry

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

Your Network Pediatric Dentist must submit each specialty treatment plan to CIGNA Dental for payment authorization. CIGNA Dental's standard payment authorization process as set out above will apply for services rendered by the Network Pediatric Dentist.

For children 7 years and older, your Network General Dentist will provide care. Exceptions for medical reasons may be considered on a case-by-case basis. For children over 7, if you continue to visit the Pediatric Dentist without a referral authorized for payment, you will be fully responsible for the Pediatric Dentist's Usual Fees.

C. Orthodontics

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

   a. Orthodontic Treatment Plan and Records - The preparation of orthodontic records and a treatment plan by the Orthodontist.

   b. Interceptive Orthodontic Treatment - Treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.

   c. Comprehensive Orthodontic Treatment - Treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.

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

2. **Patient Charges**

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

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

3. **Additional Charges**

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

a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;

b. orthognathic surgery and associated incremental costs;

c. appliances to guide minor tooth movements;

d. appliances to correct harmful habits; and

e. services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

4. **Orthodontics in Progress**

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

IX. COMPLEX REHABILITATION/MULTIPLE CROWN UNITS

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

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

X. WHAT TO DO IF THERE IS A PROBLEM

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

A. Start with Member Services

We are here to listen and to help. If you have a question about your Dental Office or the Dental Plan, you can call 1-800-367-1037 toll-free and explain your concern to one of our Member Services Representives. You can also express that concern in writing to the address listed on the cover page of this booklet. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 15 working days.

A. Start with Member Services (Continued)

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

B. Appeals Procedure

CIGNA Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to CIGNA Dental, at the address on the cover page of this booklet, within 1 year from the date of the initial CIGNA Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Member Services to register your appeal by calling 1-800-367-1037.

1. Level One Appeals

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

We will respond with a decision within 15 working days after we receive your appeal. If we need more time or information to make the decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, CIGNA Dental will respond orally with a decision within 72 hours, followed up in writing.

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

2. Level Two Appeals

To initiate a level two appeal follow the same process required for a level one appeal. Level two appeals will be conducted by an Appeals Committee consisting of at least 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the Appeals Committee will include at least one Dentist. If specialty care is in dispute, the Appeals Committee will consult with a Dentist in the same or similar specialty as the care under review.

CIGNA Dental will acknowledge your appeal in writing within 5 business days and schedule an Appeals Committee review. The acknowledgment letter will include the name, address, and telephone number of the Appeals Coordinator.

We may request additional information at that time. The Appeals Committee review will be completed within 15 working days. If we need more time or information to complete the review, 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 Appeals Committee to complete the review.

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

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

3. Appeals to the State

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

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

XI. DUAL COVERAGE

A. In General

"Coordination of benefits" is the procedure used to pay health care expenses when a person is covered by more than one plan. CIGNA Dental follows rules established by New Jersey law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow New Jersey coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you have no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

CIGNA Dental pays for dental care when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

B. How CIGNA Dental Pays As Primary Plan

When you receive care from a Network Specialty Dentist, CIGNA Dental pays the Network Specialty Dentist a contracted fee amount less your copayment for the Covered Service. When we are primary, we will pay the full benefit allowed as if you had no other coverage.

C. How CIGNA Dental Pays as Secondary Plan

1. If your primary plan pays on the basis of UCR, CIGNA Dental will pay the difference between the provider's billed charges and the benefits paid by the primary plan up to the amount CIGNA Dental would have paid if primary. CIGNA Dental's payment will first be applied toward satisfaction of your copayment of your primary plan. You will not be liable for any billed charges in excess of the sum of the benefits paid by your primary plan, CIGNA Dental as your secondary plan and the copayment you paid under either the primary or secondary plan. When CIGNA Dental pays as secondary, you will never be responsible for paying more than your copayment of the Covered Service.

2. When both your primary plan and CIGNA Dental pay network providers on the basis of a contractual fee schedule and the provider is a network provider of both plans, the allowable expense will be considered to be the contractual fee of your primary plan. Your primary plan will pay the benefit it would have paid regardless of any other coverage you may have. CIGNA Dental will pay the copayment for the Covered Service for which you are liable up to the amount CIGNA Dental would have paid if primary and provided that the total amount received by the provider from the primary plan, CIGNA Dental and you does not exceed the contractual fee of the primary plan. You will not be responsible for an amount more than your copayment.

3. When your primary plan pays network providers on a basis of capitation or a contractual fee schedule or pays a benefit on the basis of UCR, and CIGNA Dental pays network providers on the basis of capitation and a service or supply is provided by a network provider of CIGNA Dental, we will not be obligated to pay to the network provider any amount other than the capitation payment required under the contract between CIGNA Dental and the network provider and we shall not be liable for any deductible, coinsurance or copayment imposed by your primary plan. You will not be responsible for the payment of any amount for eligible services.

4. We will pay on for health care expenses that are covered by CIGNA Dental.

C. How CIGNA Dental Pays as Secondary Plan (Continued)

5. We will pay only if you have followed all of our procedural requirements, including: care is obtained from or arranged by your primary care dentists; preauthorized referrals are made to network specialists; coverage in effect when procedures begin; procedures begin within 90 days of referral.

XII. DISENROLLMENT FROM THE DENTAL PLAN – TERMINATION OF BENEFITS

A. Time Frames for Disenrollment/Termination

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

1. in which Premiums/Prepayment Fees are not remitted to CIGNA Dental;

2. in which eligibility requirements are no longer met;

3. after 30 days notice form CIGNA Dental due to permanent breakdown of the Dentist-patient relationship as determined by CIGNA Dental, after at least two opportunities to transfer to another Dental Office;

4. after 30 days notice from CIGNA Dental due to fraud or misuse of dental services and/or Dental Offices;

5. after 60 days notice by CIGNA Dental, due to continued lack of a Dental Office in your Service Area;

6. after voluntary disenrollment.

B. Effect on Dependents

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

XIII. EXTENSION OF BENEFITS

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums/Prepayment Fees.

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

XIV. CONTINUATION OF BENEFITS (COBRA)

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

XV. CONVERSION COVERAGE

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

A. Permanent breakdown of the Dentist-patient relationship;

B. Fraud or misuse of dental services and/or Dental Offices;

C. Nonpayment of Premiums/Prepayment Fees by the Subscriber;

D. Selection of alternate dental coverage by your Group; or

E. Lack of network/service area.

Benefits and rates for CIGNA Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the CIGNA Dental Conversion Department at 1-800-367-1037 to obtain current rates and to make arrangements for continuing coverage.

XVI. CONFIDENTIALITY/PRIVACY

CIGNA Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about CIGNA Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your member plan materials. You may obtain additional information about CIGNA Dental's confidentiality policies and procedures by calling Member Services at 1-800-367-1037, or via the Internet at www.cigna.com.

XVII. MISCELLANEOUS

As a CIGNA Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at www.cigna.com for details.

FEDERAL REQUIREMENTS

For an explanation of your rights and responsibilities under federal laws and regulations, please refer to the Fringe Benefit Fund and/or the Medical/ Pharmacy sections of this binder.

DEFINITIONS

CIGNA Dental Health (herein referred to as CDH)

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

Coinsurance

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

Contracted Fee - CIGNA Dental Preferred Provider

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

Dentist

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

Fund

The term Fund means an employer participating in the fund which is established under the agreement of Trust for the purpose of providing insurance. It also means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

Medicaid

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

Medicare

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

Participating Provider - CIGNA Dental Preferred Provider

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

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

Participation Date

The term Participation Date means the later of:

- The Effective Date of the policy; or
- The date on which the Fund becomes a participant in the plan of insurance authorized by the agreement of Trust.

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.

Participating General Dentist

The term Participating General Dentist means a person practicing dentistry within the scope of his license at a Participating Dental Facility, under the terms of his provider contract with CDH.

Participation Date

The term Participation Date means the later of:

- The Effective Date of the policy; or
- The date on which the Fund becomes a participant in the plan of insurance authorized by the agreement of Trust.

Patient Charge Schedule

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

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.

Usual Fee

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

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

A. It must be consistent with the symptoms, diagnosis or treatment of the condition present;

B. It Must conform to commonly accepted standards throughout the dental field;

C. It must not be used primarily for the convenience of the member or provider of care; and

D. It must not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by CIGNA Dental based upon the above criteria will be the responsibility of the member at the Dentist's Usual Fees. A licensed Dentist will make any such denial.

Contract Fees - The fees contained in the Network Specialty Dentist Agreement with CIGNA Dental.

Usual Fee (Covered) [Continued]

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

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

Dental Plan - Managed dental care plan offered through the Group Contract between CIGNA Dental and your Group.

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

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

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

Network Specialty Dentist - A licensed Dentist who has signed an agreement with CIGNA Dental under which he or she agrees to provide specialized dental care services, as outlined in Section VIII, upon payment authorization by CIGNA Dental Health.

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

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

Premiums/Prepayment Fees - Fees that your Group remits to CIGNA Dental, on your behalf, during the term of your Group Contract.

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

Subscriber/You - The enrolled Employee or member of the Group.

Usual Fee (Covered) [Continued]

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

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 Member selection of a Participating Dental Facility.