This guide provides an overview of ConnectiCare’s Dental Plans. You’ll find helpful information on plan designs, eligibility, underwriting guidelines and other topics. This guide is not all-inclusive and is subject to change.

ConnectiCare Dental Plans are PPOs, offering the ideal balance of choice and cost control. And, with the combination of ConnectiCare Dental Plans and Medical Plans, you gain the convenience of two lines of business with one carrier.

**Choices for participants**

ConnectiCare Dental Plans offer familiar PPO-style, open access to broad, quality provider networks. Participants are free to choose preferred providers, including specialists. No gatekeepers, no referrals, no paperwork. There’s also coverage for out-of-network care.

And, the ConnectiCare Dental Premium Network is the third largest in the state.

**Cost controls for your clients**

There’s a range of plans and price points, from value-priced preventive care plans to high-option plans that include orthodontia. You can even offer dual-option and customized plans for larger groups. With efficient administration and automated claims adjudication, ConnectiCare Dental Plans effectively manage costs for large and small groups.

**Plans that make sense**

ConnectiCare Dental Plans are designed to be simple and sensible. Our plan designs offer the right range of costs and coverages and can be matched with a variety of network options.

**BeneCare**

BeneCare, a respected eastern region dental plan administrator, manages ConnectiCare’s suite of dental products. With BeneCare, your clients can expect a commitment to service and technology, with the goal of fast, accurate claims handling and smooth, trouble free administration.
Dental Plan Designs

ConnectiCare Dental Plans offer three network options, each defined by the level of network access and provider compensation.

**Premium Network** – the plan for people who want the broadest access and coverage that provides reimbursement at approximately 90% of area fees.

**Plus Network** – the mid-level plan that adds improved provider access through an enhanced network at approximately 80% of area fees.

**Value Network** – the most economical network that provides reimbursement at approximately 70% of area fees.

Within each network option, clients in our comprehensive plan options may choose from a number of standard fully-insured benefit plans.

With ConnectiCare Dental Plans there's a wide variety of plan options and price points to meet the needs of large- and small-employers alike. Customized plans are also available for large groups. In addition, we can duplicate your client’s current plan.

*These plans are available to Connecticut groups only.*

**Small-Group Options**

ConnectiCare Dental Plans are available for small groups with 3-9 and 10-50 full-time, enrolled employees. Small-group members will enjoy the same level of benefits as large groups with our comprehensive coverage and competitive pricing.

Groups with 3-9 employees must purchase a ConnectiCare medical plan along with the dental plan to be eligible for dental benefits.

Groups with 10-50 employees do not need to purchase a ConnectiCare medical plan to be eligible for dental benefits. Dental benefit plans can be purchased as a stand alone option.

**ConnectiCare Dental Plans — Basic Plans**

ConnectiCare has a convenient, effective way for small employers to introduce a dental plan into their benefits package. ConnectiCare Dental — Basic Plans. Our Basic Plans provide cost-effective plan designs specifically targeted to meet the demands of small employers. The Basic plans are available for small groups with 3-9 and 10-50 employees and provide a $0 deductible with a $1,000 annual maximum and coverage for preventive and basic services. There are plan designs available for all three networks — Value, Plus and Premium.

**Large-Group Plans**

**Customized Plan Designs**

In addition to a variety of standard plan designs, ConnectiCare can provide customized plan designs for any group of over 50 eligible employees. For example, out-of-network benefit levels can be adjusted to meet the employer’s need.

**Self-Funded Plans**

ConnectiCare also offers the option to self-fund dental plans for large group sponsors. If your client is interested in a self-funding option, please contact your ConnectiCare Sales Representative for more information.

**Voluntary Plans**

ConnectiCare has published voluntary rates available for the 10-50 employee market. This option provides your clients with a viable alternative to introduce or maintain quality dental benefits into their benefit portfolios.

Note: All dental plans are administered on a contract-year basis.

**Annual maximum look back program**

This program allows your clients to access additional benefit dollars.

*Here’s how it works:*

If your clients’ employees use less than 50% of their available annual maximum in a specific benefit year, they will be able to access up to $250 of that remaining benefit if they reach the annual maximum in the following benefit year. That means up to an additional $250 that can be applied to their annual maximum creating more benefit flexibility and that maximizes their benefit dollars.

Some preventive services must be used in the prior year in order to be eligible for the additional $250 benefit rollover the following year.

*For example:*

Members who use up to 50% of their available annual maximum in 2011 will be able to access as much as $250 of the remaining dollars if they reach their annual maximum in 2012. Some preventive services must be accessed in 2011 to be eligible for the benefit rollover in 2012.
Standard Plan
Exclusions and Limitations

The following is a list of services, supplies, etc., excluded and/or limited under ConnectiCare Dental Plans.

1. Experimental or investigational procedures are excluded.
2. Appliances, restorations, and procedures to alter vertical dimension, including, but not limited to, occlusal guards and periodontal splinting are excluded.
3. Space maintainers for dependent children age ten or over are excluded.
4. Services or supplies rendered or furnished in connection with any duplicate prosthesis or any other duplicate appliance are excluded.
5. Restorations which are not of any dental health benefit, but primarily cosmetic treatment in nature, including, but not limited to, laminate veneers and posterior composites are excluded. Payment of the applicable cost-share of this plan’s maximum allowable amount for the alternate service, if any, will be made toward such treatment and the balance of the cost remains the responsibility of the member.
6. Personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, including the use of fixed bridgework, where a conventional clasp designed removable partial denture would restore the arch are excluded. Payment of the applicable cost-share of this plan’s maximum allowable amount for the alternate service, if any, will be made toward such treatment and the balance of the cost remains the responsibility of the member.
7. General anesthesia, except for the following reasons, is excluded:
   a. Removal of one or more impacted teeth;
   b. Removal of four or more erupted teeth;
   c. Treatment of a physically or mentally impaired person;
   d. Treatment of a child under age 11; and
   e. Treatment of a member who has a medical problem, when the attending physician requests in writing that the treating dentist administer general anesthesia. This request must accompany the dental claim form.
8. Duplicate charges are excluded.
9. Services incurred prior to the effective date of coverage are excluded.
10. Services incurred after cancellation of coverage, or loss of eligibility are excluded.
11. Services incurred in excess of the benefit year maximum are excluded.
12. Services or supplies that are not dentally necessary according to accepted standards of dental practice are excluded.
13. Services that are incomplete are excluded.
14. Orthodontic services for persons age 19 or over, when orthodontics is a covered dental service are excluded.
Standard Plan Exclusions and Limitations, continued

15. Sealants on teeth other than the first and second permanent molars, or applications applied more frequently than every thirty-six months or a service provided outside of ages five through fourteen are excluded.

16. Services such as trauma which are customarily provided under medical-surgical coverage are excluded.

17. More than two oral examinations in any 12-month period are excluded.

18. More than two prophylaxes in any 12-month period are excluded.

19. More than one full mouth X-ray series in any period of 36 consecutive months is excluded.

20. More than one bitewing X-ray series in any 12-month period is excluded.

21. Adjustments or repairs to dentures performed within six months of the installation of the denture are excluded.

22. Services or supplies in connection with periodontal splinting are excluded.

23. Expenses incurred for the replacement of an existing denture which is or can be made satisfactory are excluded.

24. Expenses incurred for a temporary denture are excluded.

25. Expenses incurred for the replacement of a denture, crown, or bridge for which benefits were previously paid, if such replacement occurs within five years from the date the expense was originally benefited are excluded.

26. Training in plaque control or oral hygiene, or for dietary instruction is excluded.

27. Completion of reporting forms is excluded.

28. Charges made by the attending dentist for the member's failure to appear as scheduled for an appointment are excluded.

29. Charges for services and supplies which are not necessary for treatment of the injury or disease, or are not recommended and approved by the attending dentist, or charges which are not reasonable are excluded.

30. Scaling and root planing which is not followed, where indicated, by definitive pocket elimination procedures are excluded. In the absence of continuing periodontal therapy, scaling and root planing will be considered a prophylaxis and subject to the limitations of that procedure and are excluded.

31. Periodontal surgery procedures more than once per quadrant in any period of 36 consecutive months are excluded.

32. More than one periodontal scaling and root planing per quadrant in any consecutive 36 month period is excluded.

33. More than two periodontal maintenance procedures in any consecutive 12-month period are excluded. In the absence of benefited comprehensive periodontal therapy, periodontal maintenance procedures are excluded.

34. Services for any condition covered by workers' compensation law or by any other similar legislation are excluded.

35. Claims submitted more than 11 months (335 days) following the date of service are excluded.
Important Guidelines

Please note the following guidelines for employer sponsors and employee eligibility for ConnectiCare Dental Plans.

Underwriting Guidelines
- The minimum group size is three enrolled employees. Minimum participation is three employees for groups of three to nine employees and 10 employees for groups of 10 or more.
- Prospective groups must be domiciled in Connecticut.
- The employer sponsor must contribute a minimum of 50% of the premium for single subscribers and a minimum of 25% of the premium for dependents.
(Notes: there is an exception for Voluntary Plan Options.)

Additional underwriting guidelines for comprehensive plans 10-50 enrolled employee-sized groups
- The following groups are NOT eligible for coverage under the ConnectiCare Dental Plans small group rates without underwriting approval:
  - Groups without prior dental coverage
  - Groups in the following industries will not be underwritten without approval:
    - Legal services (SIC 8100-8199)
    - Educational services (SIC 8200-8299)
    - Social services (SIC 8300-8399)
    - Membership organizations (SIC 8600-8699)
    - Justice, public service and safety (SIC 9200-9299)
- Effective dates for coverage are the 1st of the month.
- COBRA will be administered by the group.

Additional underwriting guidelines for Basic Plans 3-9 and 10-50 enrolled employee-sized groups
- There are no SIC restrictions
- The Basic plan can be sold to groups with no prior coverage

Additional underwriting guidelines for 3-9 enrolled employee-sized groups
- There are no SIC restrictions
- Groups must purchase a ConnectiCare medical plan to be eligible for ConnectiCare Dental Plans
- Can be sold to groups with no prior coverage

Eligibility Requirements

Wondering who is eligible for membership? The plan covers employees, and eligible family members such as spouses and children.

Who is eligible for membership under the plan?
Subject to the Employers rules, employees working 30 hours or more per week are eligible. The employer must be domiciled in Connecticut.

Spouses
- The spouse of an employee is also eligible for coverage if the employee and spouse are in a legally valid existing marriage and the spouse resides with the employee, or in the service area.
- A partner under a legally valid civil union recognized by the State of Connecticut who resides with the employee.

Children
Children under age 26 who meet one of the conditions/criteria below and are not enrolled as employees on a group health plan. However, if that group health plan is a self-funded plan with a private employer, the under 26 age dependent may remain eligible under this plan, if he or she chooses to:
- Natural children.
- Adopted children who are legally adopted by the employee and meet the requirements for natural children once the adoption is final. Before the adoption is final, the children are eligible for coverage when you become legally responsible for at least partial support.
- Stepchildren who are natural or adopted children of your spouse, or for whom your spouse is appointed legal guardian.
- Children for whom the employee or spouse are appointed legal guardians.

Coverage for children enrolled in Connecticut Group Plans will end on the last day of the month following the month in which the child:
- Becomes covered under his/her own group insurance plan, see exception above;
- Turns age 26.

Coverage for handicapped children may be extended beyond the age when it would normally end if the children:
- Reside in the Service Area or with the employee;
- Are unable to support themselves by working because of a mental or physical handicap as certified by the children’s physician;
- Are chiefly dependent on the employee or spouse for support and maintenance due to the mental or physical handicap; and
- Have become and continuously remained handicapped while they would have been eligible for dependent children coverage if they were not disabled.
Rates and Quote Requests

Important Note Regarding Producer Appointment: Producers must be appointed with ConnectiCare in order to quote and sell ConnectiCare Dental Plan products. If you are not a ConnectiCare appointed producer, Appointment Packets are available on the ConnectiCare Web site at www.connecticare.com.

All plans are administered on a contract-year basis.

**Small-Group – Employer Sponsors with 3-50 Enrolled Employees**


Small-group quote requests may also be obtained by completing a Small-Group Quote Request form, found on the Dental page “forms section” of the producer Web site, including all required information, and submitting it to ConnectiCare via fax or e-mail as noted on the form. E-mailing quote requests will result in the most efficient response time from ConnectiCare.

**Large-Group – Employer Sponsors with more than 50 Enrolled Employees**

Quotes for large groups may be obtained by completing a Dental Plan Quote Request form, found on the Dental page “forms section” of the producer Web site, and submitting it to ConnectiCare with all required information. Quote requests may be sent via fax or e-mail as noted on the form. E-mailing quote requests will result in the most efficient response time from ConnectiCare.
New Group Implementation

Small-Group – Employer Sponsors with 3-50 Enrolled Employees

Small-group employer sponsors should complete the Small-Group Employer Application and send it to Small-Group Sales with a check for the first month’s premium and completed Enrollment Applications. Once the Employer Application is reviewed and the group is accepted, BeneCare will produce the Evidence of Agreement and return it to the producer.

Enrollment materials, including the Enrollment Applications, are available on the ConnectiCare Web site at www.connecticare.com.

Large-Group – Employer Sponsors with more than 50 Enrolled Employees

Large-group employer sponsors who select a ConnectiCare Dental Plan should confirm their selection by signing and returning to ConnectiCare one copy of the Evidence of Agreement along with a check for the first month’s premium.

Your ConnectiCare Sales Representative will then work with you and the employer sponsor to coordinate the enrollment process to insure that it goes smoothly. Enrollment materials may be ordered online at www.connecticare.com or through your representative.

Once employees have enrolled in the plan, they will receive a Dental Plan ID card (one card per family) benefit summary and Certificate of Coverage at their home.

All new employer sponsors will receive a Welcome Kit from ConnectiCare Dental Plans that includes an Administrative Guide with important telephone numbers and addresses as well as helpful information on a number of administrative topics.
Renewals

Large Groups (50+ enrollees) renewals

Rates are determined based on a number of different factors, including: changes in group size and enrollment; claims experience; expected changes in the cost of dental services; and expected changes in utilization. Renewals are sent to the ConnectiCare account manager if the renewal is a combined medical/dental package. Renewals are sent directly to the producer if dental only customers.

Small Groups (10+ enrollees) renewals

Rates are determined based on a number of different factors, including: changes in group size and enrollment; claims experience; expected changes in the cost of dental services; and expected changes in utilization. Renewals are sent from BeneCare to the producer and the group 60 days prior to renewal.

Small Groups (3-9 enrollees) renewals

This segment is community rated. Rates are determined based on a number of different factors of the group, as well as the other groups in this rating segment or block of business. They include changes in group size and enrollment; claims experience; expected changes in the cost of dental services; and expected changes in utilization. Rate change notifications are sent from BeneCare to the producer and the group 60 days prior to renewal. Rates change for all groups at the same time. Prior notification is provided.
Self-service transactions

As a ConnectiCare Dental Plans sponsor, your clients have access to www.benecare.com. This Web site has been designed to make benefit administration easier, saving them time in gathering information on their plans while minimizing efforts with other requests. Within the sponsors’ secure section of www.benecare.com your clients will find the following useful tools for administering their benefits:

• manage the group’s contact information;
• submit enrollment and eligibility changes;
• download a printable claim form;
• retrieve real time reports of subscribers and their dependents;
• view or print a dental benefit description for the plan;
• locate participating BeneCare dentists by specialty and distance;
• assist subscribers with claims inquiries; and
• manage their www.benecare.com account profile.

Your clients’ subscribers (employees and/or their dependents) can also access www.benecare.com. They can:

• locate participating BeneCare dentists by specialty;
• access information about their dental claims;
• view or print a dental benefit description for their plan;
• access a variety of resources and links for oral health information;
• download a printable claim form; and
• manage their www.benecare.com account profiles.
Enrollment

All eligible employees must enroll by filling out and signing a ConnectiCare Dental Plan Enrollment Application. All applications must be complete and must be signed by the employer sponsor. Completed applications should be returned to your ConnectiCare Sales or Account Management Representative.

We will also accept electronic forms of enrollment. Please contact BeneCare at 1-800-426-0947 to discuss data formats and procedures.

**SAMPLE ENROLLMENT FORM**
ID Cards

Members should provide the ConnectiCare Dental Plan ID number, group name and group number to the dentist to facilitate billing.

Sample ID Card

1. ID number
2. Effective date
3. Name and address
4. Employer group name
5. Employer group number

Member Services

Members with inquiries and questions about ConnectiCare Dental Plan eligibility, ID cards, claims, or the dental network should contact Member Services at 1-888-843-4727. You can also go to our Web site, at www.connecticare.com and click on Find a Doctor, our online participating provider directory.

Most questions and complaints can be resolved informally. If a member has a question or a complaint, the first step should be to contact Member Services by telephone or, members can write to ConnectiCare Dental Plans at:

Member Services
ConnectiCare
175 Scott Swamp Road
Farmington, CT 06032-3124

If a question or complaint cannot be resolved informally, the member may use the appeals process. This process is available to members who disagree with a decision made regarding covered benefits or claims processing. Please see the Certificate of Coverage or other plan document for more details about the appeals process.
Pre-Determination of Benefits

When dental services are expected to exceed $300, or when services such as orthodontics, dentures, crowns, periodontics or bridgework are required, it is recommended that dentists submit a request to BeneCare for a pre-determination estimate of covered benefits. While there is no explicit prior approval required to obtain benefits, this step protects both the member and the dentist by advising in advance what portion of dental treatment costs will be covered. This is a common practice with dental plans and requires no action on the part of the member.

While there is no explicit prior approval required to obtain benefits, this step protects both the member and the dentist by advising in advance what portion of dental treatment costs will be covered. It can help to plan when to have treatment and what the costs may be.
Claims

Care Received from Participating Providers

Participating providers will bill ConnectiCare directly for covered services. Members are responsible only for the applicable deductibles, coinsurance amounts, or copayments.

Care Received from Nonparticipating Providers

Members may receive services from dentists who do not participate in the ConnectiCare Dental Plan networks. Nonparticipating dentists may submit claims on the member’s behalf or they may request payment at the time of service, in which case the member is responsible for submitting the claim for reimbursement. Members are responsible for any deductible, coinsurance, and balance remaining after reimbursement is made by ConnectiCare up to the billed charges.

All claims must be submitted no later than 335 days following the date of service. Claims must include, at a minimum, the following information to be considered for reimbursement:

- The subscriber’s name.
- The name of the person who received services and their ConnectiCare Dental Plan ID number.

A complete itemized bill that includes a description of the service and the appropriate ADA Current Dental Terminology (CDT) code, the date service was rendered, the treatment details, and the charges.

Please note that credit card receipts and “balance due” statements are not acceptable.

Claims should be submitted to:
ConnectiCare Dental Plans
c/o BeneCare
615 Chestnut Street, Suite 1001
Philadelphia, PA  19106-4404

Coordination of Benefits

If a member is eligible to receive benefits under another plan — including group dental plans, and Workers’ Compensation — Coordination of Benefits will apply. A member’s ConnectiCare benefits will be coordinated with the other plan’s benefits.

When ConnectiCare Dental is the secondary plan, the member must send a copy of the Explanation of Benefits (EOB) form received from the primary dental plan, along with the claim form. If the claim is received without an EOB from the primary carrier, the claim will be denied. It is the member’s responsibility to ensure that the claim is processed by the primary plan. If ConnectiCare is the secondary carrier, the member has 335 days (11 months) from the date the primary carrier processed the claim to submit the claim to ConnectiCare. The rules and guidelines for Coordination of Benefits are described in the Certificate of Coverage or other plan document.
Explanation of Benefits (EOB) Statement

Members will receive an Explanation of Benefits (EOB) statement whenever a claim is submitted for payment and processed according to benefits, rules and guidelines described in the Evidence of Coverage or other plan document. (Nonparticipating providers will not receive an EOB when submitting a claim that is denied.)

1. **This is not a bill** – This is a reminder that the Explanation of Benefits is not a bill. It provides information on how a claim is paid.

2. **Group name** – The name of the employer sponsor.

3. **Claim number** – The internal number used by the plan to identify this claim.

4. **Patient name** – The name of the patient for whom services were rendered.

5. **Dentist name** – The name of the dentist that rendered services.

6. **Procedure description** – A description of the dental services rendered.

7. **Service date** – The date services were rendered.

8. **Doctor’s fee** – The amount billed by the dentist providing services.

9. **Covered fee** – The amount allowed by the plan for the services rendered.

10. **Percent covered** – The percentage of the covered fee that is paid by the plan according to the benefit schedule in the Certificate of Coverage or other plan document.

11. **Plan payment** – The dollar amount that the plan will pay for the services rendered based on the covered percent of the covered fee.

12. **Ex. No. and Exclusion Description** – Further explanation, if necessary, as to how the claim was paid or declined for coverage.

13. **Deductible** – Any deductible amount owed by the member for the services rendered according to the benefit schedule in the Certificate of Coverage or other plan document.

14. **Total** – The total amount paid by the plan for this claim.
Billing Procedures and
Premium Payments

Here are important rules and guidelines regarding premium billing and payments.

• Employers will receive an invoice on a monthly basis detailing the premium due on or about the 10th of the month in the month for which premium is due.

• The “Please Pay This Amount”, which is the total premium due, is due and payable upon receipt.

• Eligibility changes may not appear on the bill if ConnectiCare does not receive and process the Enrollment/Change Form before the Invoice Date (the date the bill is produced.)

• Payment, along with the invoice’s payment voucher, should be sent to the lockbox address noted on the voucher. Premium payment may be sent via overnight mail to the ConnectiCare Lockbox Address on the invoice using the United States Postal Service (USPS.) Private carriers (Fed Ex, UPS, etc.) cannot deliver to a P.O. Box.

• Enrollment forms should be sent separately to:
  ConnectiCare
c/o BeneCare
  615 Chestnut Street, Suite 1001
  Philadelphia, PA 19106-4404.

• The billing system works on a “wash method” for new hires, in accordance with the following ConnectiCare new hire eligibility and termination guidelines:
  – New hires and additions — If the effective date is on or before the 15th of the month, we will bill for the entire month. If the effective date is after the 15th, there will be no premium charge for that month.
  – Terminations — If the termination date is on or before the 15th of the month, there will be no premium charge for that month. If the termination date is after the 15th, we will bill for the entire month.

• Retroactive changes will only be allowed up to 60 days calculated from the date on which ConnectiCare receives notification of change.
**Sample Invoice**

**Company:** ABC Company  
**Sponsor Number:** 123

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sponsor Name and Number</td>
<td>The company’s name and sponsor number</td>
</tr>
<tr>
<td>2</td>
<td>Invoice Number</td>
<td>The company’s sponsor number and billing month and year</td>
</tr>
<tr>
<td>3</td>
<td>Total Number of Employees Added</td>
<td>The total number of employees added since the last invoice</td>
</tr>
<tr>
<td>4</td>
<td>Total Number of Employees Terminated</td>
<td>The total number of employees terminated since the last invoice</td>
</tr>
<tr>
<td>5</td>
<td>Tiers and Premium Rate Calculations</td>
<td>The total number of employees per premium tier, the premium amount and monthly total</td>
</tr>
<tr>
<td>6</td>
<td>Composite Rate</td>
<td>The total number of employees and composite rate</td>
</tr>
<tr>
<td>7</td>
<td>Retroactive Premium Adjustment for Additions</td>
<td>Premium adjustments resulting from retroactive additions</td>
</tr>
<tr>
<td>8</td>
<td>Retroactive Premium Adjustments for Terminations</td>
<td>Premium adjustments resulting from retroactive terminations</td>
</tr>
<tr>
<td>9</td>
<td>Please Pay This Amount</td>
<td>Total amount due to be paid including the monthly premium and all adjustments</td>
</tr>
<tr>
<td>10</td>
<td>Statement as of</td>
<td>The date the statement was produced – premium payment is due in the month the statement was produced</td>
</tr>
<tr>
<td>11</td>
<td>Remittance Address</td>
<td>Premium payments should be sent to this address</td>
</tr>
</tbody>
</table>

**Total Number of Employees**

Terminated

The total number of employees terminated since the last invoice

**Tiers and Premium Rate Calculations**

The total number of employees per premium tier, the premium amount and monthly total

**Composite Rate**

The total number of employees and composite rate

**Retroactive Premium Adjustment for Additions**

Premium adjustments resulting from retroactive additions

**Retroactive Premium Adjustments for Terminations**

Premium adjustments resulting from retroactive terminations

Please Pay This Amount for the Month of 1/2005

This Statement Reflects All Changes, Terminations, and Added Eligibility Received Through 1/05/2005

Please remit the above amount to:

ConnectiCare, Inc. & Affiliates
P.O. Box 33402
Hartford, CT 06150-3402
Terminating Coverage

Group Coverage
If an employer group wishes to terminate its group policy, written notification must be provided to ConnectiCare 30 days before the identified termination date. The signed notification must be submitted on company letterhead with the signature of the authorized group representative and include the date requested for termination of the policy. Please note that a group termination is effective the last day of the month requested.

In addition, group policies will terminate on the earliest day that any of the following events occur:

• At the end of the grace period, if the employer fails to make any premium payments that are due, or at another date after the grace period that we specify in writing.

• If the company commits fraud or willfully conceals or misrepresents any material fact or circumstance in applying for coverage with ConnectiCare.

• In the event the employer fails to comply with employer contribution requirements or group participation rules.

• In the event that ConnectiCare terminates coverage for all employers in accordance with applicable state law.

• In the event the employer’s membership in a bona fide association through which coverage is provided ceases.

• On the date the company is liquidated, ceases to operate or no longer covers or employs any eligible employees.

• On the date agreed upon by the company and ConnectiCare.

The above is a summary of group termination rules. For more detailed information, please refer to the Certificate of Coverage or other plan document.

Member-Initiated Termination of Coverage
Employees or dependents who want to terminate their coverage must submit the request to their employer in writing within 30 days of the event effecting coverage.

The employer must:

• Complete and sign an Enrollment/Change Form, or

• Write a letter that indicates the member’s name, identification number, termination date and reason for termination.

The employer must then submit the Enrollment/Change Form to ConnectiCare requesting termination or submit the change on their electronic eligibility update file.

Eligibility changes may not appear on the next bill if ConnectiCare does not receive the Enrollment/Change Form before the next bill is produced. Membership terminations can be processed retroactively up to 60 days, as long as no plan benefits were provided to the member for that period. If plan benefits were provided after the date of requested termination, ConnectiCare will adjust the requested termination to reflect coverage during the utilization period and seek premium for that period.

COBRA Continuation Coverage
In accordance with the federal Consolidated Omnibus Budget Reconciliation Act of 1985 and Connecticut state law (referred to here as COBRA), subscribers and members must be offered the opportunity to continue their group coverage when it ends for certain reasons. Connecticut state law also mandates that COBRA rights and privileges will apply to all employers covered by ConnectiCare, regardless of the employer size or whether the employer’s plan is subject to ERISA or COBRA.

The employer is responsible for notifying members of their COBRA rights and privileges and administering the COBRA rules.

Outlined on page 18 are the COBRA provisions that pertain to continuing coverage.
The Right to Continue Coverage

- COBRA gives subscribers and members the right to continue coverage when it ends because of a “qualifying event,” such as a layoff, reduction in work hours or termination of employment, death, or divorce. Coverage for subscribers and members may be continued for up to 18, 29 or 36 months, depending on the type of qualifying event involved.

- Coverage may be continued for up to 18 months (30 months for subscribers and members enrolled in ConnectiCare, Inc.) when it ends due to the subscriber’s reduction in work hours, leave of absence or his/her employment is terminated for reasons other than gross misconduct.

- For a disabled person, coverage may be continued from 18 to 29 months as long as that person meets certain requirements. See the appropriate Certificate of Coverage, or other plan document for more details.

- Coverage may be continued for up to 36 months for:
  - A covered child who is no longer an eligible dependent;
  - A covered spouse and dependents if the subscriber dies;
  - A covered spouse if the subscriber and spouse divorce or separate; or
  - A covered spouse and dependents if coverage ends when the subscriber becomes eligible for Medicare.

States may have additional continuation of coverage rules. Members should review their Certificate of Coverage for more details.
**Important Numbers**

**ConnectiCare Dental Plan Sales**
For information about the Dental product, please call your ConnectiCare Sales Representative or call 1-800-723-2986.

**Member Services**
For information about membership, ID cards, benefits, claims or providers please call 1-888-843-4727.

**Enrollment Questions**
For questions about member/dependent eligibility or membership verification, please call 1-888-843-4727.

**Premium Billing**
For questions regarding premium bills, please call 1-888-843-4727.

**Important Addresses**

**Enrollment Forms**
For initial enrollment, please return forms to your ConnectiCare Sales or Account Management Representative. For new employee or changes, please send forms to BeneCare at:
ConnectiCare Dental Plans
c/o BeneCare
615 Chestnut Street, Suite 1001
Philadelphia, PA 19106-4404

**Premium Payments**
ConnectiCare
P.O. Box 33402
Hartford, CT 06150-3402

**Dental Claims**
ConnectiCare Dental Plans
c/o BeneCare
615 Chestnut Street, Suite 1001
Philadelphia, PA 19106-4404

**Member Complaints/Appeals**
Member Services
ConnectiCare
175 Scott Swamp Road
Farmington, CT 06032-3124

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**www.connecticare.com**

Don’t forget to visit the Producer page of our web site at www.connecticare.com to access plan design and rate information, forms, and other important information about ConnectiCare Dental Plans.