

Cigna Health and Life Insurance Company may change the premiums of this Policy after 31 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")

Cigna Dental Pediatric

If You Wish To Cancel Or If You Have Questions

If You are not satisfied, for any reason, with the terms of this Policy You may return it to Us within 10 days of receipt. We will then cancel Your coverage as of the original Effective Date and promptly refund any premium You have paid. This Policy will then be null and void. If You wish to correspond with Us for this or any other reason, write:

**Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630
1-866-484-5967**

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224).

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health and Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. Pediatric coverage and benefits are only available to Insured Persons up to the age of 19. Please note that benefits will apply until the end of the calendar year in which this limiting age is reached. If You know of any misstatement in Your application You should advise the Company immediately regarding the incorrect or omitted information; otherwise, Your Policy may not be a valid contract.

Guaranteed Renewable

This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. Coverage under this Policy is effective at 12:01 a.m. Eastern time on the Effective Date shown on the Policy's specification page.

Signed for Cigna by:


Matthew G. Manders, President


Anna Krishtul, Corporate Secretary

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Introduction

About This Policy

Your dental coverage is provided under a Policy issued by Cigna Health and Life Insurance Company (“Cigna”) This Policy is a legal contract between You and Us.

Under this Policy, “We”, “Us”, and “Our” mean Cigna. “You” or “Your” refers to the Policyholder whose application has been accepted by Us under the Policy issued. When We use the term “Insured Person” in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(s) covered under this Policy are listed on the Policy specification page.

The benefits of this Policy are provided only for those services that are Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as “Dentally Necessary” and “Covered Service”) that are defined in the section entitled “Definitions”. Before reading through this Policy, be sure that You understand the meanings of these words as they pertain to this Policy.

We provide coverage to You under this Policy based upon the answers submitted by You and Your Family Member(s) on Your signed individual application. In consideration for the payment of the premiums stated in this Policy, We will provide the services and benefits listed in this Policy to You and Your Family Member(s) covered under the Policy.

Choice of Dentist: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Dentist of their choice. You may pay more for Covered Services, if the Insured Person receives them from a Dentist that is a Non-Participating Provider.

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of South Carolina. The Insured must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy if you are up to the age of 19 and when You have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Member(s) up to the age of 19:

- Your lawful spouse.
- Your children
- Your stepchildren
- Your own, or Your spouse's children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of placement for adoption or initiation of a suit of adoption, and paying any additional premium.
- If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the Month following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured Person **will become ineligible for coverage** under the Policy:

- When premiums are not paid according to the due dates and grace periods described in the premium section.
- With respect to Your spouse: when the spouse is no longer married to the Insured.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Benefit Schedule

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to the age of 19. Benefits will apply until the end of the calendar year in which this limiting age is reached.

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.

If you select a Participating Provider, your cost will be less than if you select a Non-Participating Provider.

| Benefit | Cigna DPPO Advantage Participating Provider | | Cigna DPPO Participating Providers** and Non –Participating Provider |
|-------------------------------------------------|----------------------------------------------|-----------------------------|----------------------------------------------------------------------|
| | Calendar Year Maximum: Class I, II, III & IV | None | |
| Lifetime Maximum: Class IV | None | | |
| Calendar Year Deductible: Class I, II, III & IV | \$50 per person | | |
| | \$150 per family | | |
| Separate Lifetime Deductible for Class IV | None | | |
| Out of Pocket Maximum: Class I, II, III & IV | \$700 per person | | |
| | \$1400 per family | | |
| Benefit | Percentage of Covered Expenses the Plan Pays | | |
| | Participating Provider | Non –Participating Provider | |
| Class I - Preventive/Diagnostic Services | 100%* after Deductible* | 100%* after Deductible | |
| Class II - Basic Restorative Services | 50%* after Deductible | 50%* after Deductible | |
| Class III - Major Restorative Services | 50%* after Deductible | 50%* after Deductible | |
| Class IV – Medically Necessary Orthodontia | 50%* after Deductible | 50%* after Deductible | |

*For explanation of any additional payment responsibility to the covered person, see section entitled **Dental PPO – Participating and Non-Participating Providers.**

**If you choose to visit a Cigna DPPO provider, you will receive a discounted rate. For the greatest potential savings, please see a Cigna DPPO Advantage provider.

Waiting Periods

An Insured Person may access their dental benefit insurance once he or she has satisfied the following waiting periods.

- there is no waiting period for Class I, II, III
- after 24 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures

What the Policy Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Policy. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Policy, some of which may limit benefits or result in benefits not being payable.

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, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

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

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

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

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed \$500.

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.

Dental PPO – Participating and Non-Participating Providers

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Cigna. Based on the provider's Contracted Fee, a higher level of plan payment may be made to a Participating Provider resulting in a lower payment responsibility for you. To determine how your Participating Provider compares refer to your provider directory. Provider information may change annually; refer to your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.

Plan payment for a covered service delivered by a [Cigna DPPO Advantage] Participating Provider is the Contracted Fee for that procedure, 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.

Plan payment for a covered service delivered by a [Cigna DPPO] Participating Provider is the lesser of the Contracted Fee or the Maximum Allowable Charge. The Maximum Allowable Charge is the fee for that procedure as listed on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, times the benefit percentage that applies to the class of service, as specified in the Schedule. The Primary Schedule is the fee schedule with the lowest Contracted Fees currently being accepted by a Participating Provider in the relevant 3-digit zip code.

The covered person is responsible for the [Cigna DPPO] Participating Provider Contracted Fee minus what the plan pays.

Plan payment for a covered service delivered by a non-Participating Provider is the lesser of the non-Participating Provider's actual charge or the Maximum Allowable Charge. The Maximum Allowable Charge is the fee for that procedure as listed on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, times the benefit percentage that applies to the class of service, as specified in the Schedule. The Primary Schedule is the fee schedule with the lowest Contracted Fees currently being accepted by a Participating Provider in the relevant 3-digit zip code.

The covered person is responsible for the non-Participating Provider's actual charge minus what the plan pays.

Covered Dental Expenses

The following section lists covered dental services, if a service is not listed there is no coverage:

South Carolina Statutory Provision

In the case of an insured Dependent, covered services will include: teeth capping, prosthodontics, and orthodontics Necessary for the care and treatment of cleft lip and cleft palate.

Class I - Preventive/Diagnostic Services

| CLINICAL ORAL EVALUATIONS | | |
|------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Claim Code | Description | Frequency |
| D0120 | Periodic oral evaluation | 1 per 6 consecutive month period |
| D0140 | Limited oral evaluation - problem focused | 1 per 6 consecutive month period |
| D0150 | Comprehensive oral evaluation - new or established patient | 1 per 6 consecutive month period |
| D0180 | Comprehensive periodontal evaluation - new or established patient | 1 per 6 consecutive month period |
| RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION) | | |
| Claim Code | Description | Frequency |
| D0210 | Intraoral - complete series (including bitewings) | 1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays |
| D0220 | Intraoral - periapical first film | |
| D0230 | Intraoral - periapical each additional film | |
| D0240 | Intraoral - occlusal film | |
| D0270 | Bitewing - single film | 1 set per calendar year. For Children, 1 per 6 consecutive month period |
| D0272 | Bitewings - two films | 1 set per calendar year. For Children, 1 per 6 consecutive month period |
| D0273 | Bitewings - three films | 1 set per calendar year. For Children, 1 per 6 consecutive month period |
| D0274 | Bitewings - four films | 1 set per calendar year. For Children, 1 per 6 consecutive month period |
| D0277 | Vertical bitewings - 7 to 8 films | 1 set per calendar year. For Children, 1 per 6 consecutive month period |
| D0330 | Panoramic film | 1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays |
| D0340 | Cephalometric film | |
| D0350 | Oral / facial photographic images | |
| TESTS AND EXAMINATIONS | | |
| Claim Code | Description | Frequency |
| D0470 | Diagnostic casts | |

| DENTAL PROPHYLAXIS | | |
|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| Claim Code | Description | Frequency |
| D1110 | Prophylaxis – adult | 1 per 6 consecutive month period (includes periodontal maintenance). |
| D1120 | Prophylaxis - child | 1 per 6 consecutive month period (includes periodontal maintenance). |
| TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE) | | |
| Claim Code | Description | Frequency |
| D1206 | Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization. | 1 per 12 consecutive month period. |
| D1208 | Topical application of fluoride (prophylaxis not included) | 2 per 12 consecutive month period |
| OTHER PREVENTIVE SERVICES | | |
| Claim Code | Description | Frequency |
| D1351 | Sealant-per tooth | 1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only |
| D1352 | Preventative resin restorations in a moderate to high caries risk patient - | 1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only. |
| SPACE MAINTENANCE (PASSIVE APPLIANCES) | | |
| Claim Code | Description | Frequency |
| D1515 | Space maintainer - fixed - bilateral | Non-orthodontic treatment for prematurely removed or missing teeth. |
| D1520 | Space maintainer - removable - unilateral | Non-orthodontic treatment for prematurely removed or missing teeth. |
| D1525 | Space maintainer - removable - bilateral | Non-orthodontic treatment for prematurely removed or missing teeth. |
| D1550 | Re-cementation of space maintainer | Non-orthodontic treatment for prematurely removed or missing teeth. |
| UNCLASSIFIED TREATMENT | | |
| Claim Code | Description | Frequency |
| D9110 | Palliative (emergency) treatment of dental pain - minor procedure | |

Class II - Basic Restorative Services

| AMALGAM RESTORATIONS (INCLUDING POLISHING) | | |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Claim Code | Description | Frequency |
| D2140 | Amalgam - one surface, primary or permanent | |
| D2150 | Amalgam - two surfaces, primary or permanent | |
| D2160 | Amalgam - three surfaces, primary or permanent | |
| D2161 | Amalgam - four or more surfaces, primary or permanent | |
| RESIN-BASED COMPOSITE RESTORATIONS - DIRECT | | |
| Claim Code | Description | Frequency |
| D2330 | Resin-based composite - one surface, anterior | |
| D2331 | Resin-based composite - two surfaces, anterior | |
| D2332 | Resin-based composite - three surfaces, anterior | |
| D2335 | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | |
| OTHER RESTORATIVE SERVICES | | |
| Claim Code | Description | Frequency |
| D2910 | Recement inlay, onlay, or partial coverage restoration | |
| D2920 | Recement crown | |
| D2930 | Prefabricated stainless steel crown - primary tooth | Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons under 15 years of age . |
| D2931 | Prefabricated stainless steel crown - permanent tooth | Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons under 15 years of age . |
| D2940 | Sedative filling | |
| D2951 | Pin retention - per tooth, in addition to restoration | |
| PULPOTOMY | | |
| Claim Code | Description | Frequency |
| D3220 | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only |

| | | |
|--------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| D3222 | Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only |
| ENDODONTIC THERAPY ON PRIMARY TEETH | | |
| Claim Code | Description | Frequency |
| D3230 | Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | 1 per tooth per lifetime. Allowable on primary incisor teeth for members up to age 6 and for primary molars and cuspids for members up to age 11 . |
| D3240 | Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | 1 per tooth per lifetime. Allowable on primary incisor teeth for members up to age 6 and for primary molars and cuspids for members up to age 11 . |
| NON-SURGICAL PERIODONTAL SERVICE | | |
| Claim Code | Description | Frequency |
| D4341 | Periodontal scaling and root planing - four or more teeth per quadrant | 1 per 24 consecutive month period. |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant | 1 per 24 consecutive month period. |
| OTHER PERIODONTAL SERVICES | | |
| Claim Code | Description | Frequency |
| D4910 | Periodontal maintenance | |
| ADJUSTMENTS TO DENTURES | | |
| Claim Code | Description | Frequency |
| D5410 | Adjust complete denture - maxillary | |
| D5411 | Adjust complete denture - mandibular | |
| D5421 | Adjust partial denture - maxillary | |
| D5422 | Adjust partial denture - mandibular | |
| REPAIRS TO COMPLETE DENTURES | | |
| Claim Code | Description | Frequency |
| D5510 | Repair broken complete denture base | |
| D5520 | Replace missing or broken teeth - complete denture (each tooth) | |
| REPAIRS TO PARTIAL DENTURES | | |
| Claim Code | Description | Frequency |
| D5610 | Repair resin denture base | |
| D5620 | Repair cast framework | |
| D5630 | Repair or replace broken clasp | |
| D5640 | Replace broken teeth - per tooth | |
| D5650 | Add tooth to existing partial denture | |
| D5660 | Add clasp to existing partial denture | |

| DENTURE REBASE PROCEDURES | | |
|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| Claim Code | Description | Frequency |
| D5710 | Rebase complete maxillary denture | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| D5720 | Rebase maxillary partial denture | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| D5721 | Rebase mandibular partial denture | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| DENTURE RELINE PROCEDURES | | |
| Claim Code | Description | Frequency |
| D5730 | Reline complete maxillary denture (chairside) | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| D5731 | Reline complete mandibular denture (chairside) | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| D5740 | Reline maxillary partial denture (chairside) | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| D5741 | Reline mandibular partial denture (chairside) | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| D5750 | Reline complete maxillary denture (laboratory) | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| D5751 | Reline complete mandibular denture (laboratory) | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| D5760 | Reline maxillary partial denture (laboratory) | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| D5761 | Reline mandibular partial denture (laboratory) | 1 per 36 consecutive month period. Covered if more than 6 months after initial installation. |
| OTHER REMOVABLE PROSTHETIC SERVICES | | |
| Claim Code | Description | Frequency |
| D5850 | Tissue conditioning, maxillary | |
| D5851 | Tissue conditioning, mandibular | |
| OTHER FIXED PARTIAL DENTURE SERVICES | | |
| Claim Code | Description | Frequency |
| D6930 | Recement fixed partial denture | |
| D6980 | Fixed partial denture repair, by report | |
| EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE) | | |
| Claim Code | Description | Frequency |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | |
| D7210 | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | |
| D7220 | Removal of impacted tooth - soft tissue | |
| D7230 | Removal of impacted tooth - partially bony | |
| D7240 | Removal of impacted tooth - completely bony | |

| | | |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------|
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical complications | |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | |
| D7251 | Coronectomy - Intentional partial tooth removal | |
| OTHER SURGICAL PROCEDURES | | |
| Claim Code | Description | Frequency |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | |
| D7280 | Surgical access of an unerupted tooth | |
| ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES | | |
| Claim Code | Description | Frequency |
| D7310 | Alveoplasty in conjunction with extractions - per quadrant | |
| D7311 | Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | |
| D7320 | Alveoplasty not in conjunction with extractions - per quadrant | |
| D7321 | Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | |
| EXCISION OF BONE TISSUE | | |
| Claim Code | Description | Frequency |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | |
| SURGICAL INCISION | | |
| Claim Code | Description | Frequency |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | |
| REPAIR OF TRAUMATIC WOUNDS | | |
| Claim Code | Description | Frequency |
| D7910 | Suture of recent small wounds up to 5 cm | |
| OTHER REPAIR PROCEDURES | | |
| Claim Code | Description | Frequency |
| D7971 | Excision of pericoronal gingiva | |

Class III - Major Restorative Services

| CLINICAL ORAL EVALUATIONS | | |
|-----------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Claim Code | Description | Frequency |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report | |
| INLAY/ONLAY RESTORATIONS | | |
| Claim Code | Description | Frequency |
| D2510 | Inlay - metallic - one surface | Alternate benefit to D2140 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2520 | Inlay - metallic - two surfaces | Alternate benefit to D2150 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2530 | Inlay - metallic - three or more surfaces | Alternate benefit to D2160 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2542 | Onlay - metallic-two surfaces | 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2543 | Onlay - metallic-three surfaces | 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2544 | Onlay - metallic-four or more surfaces | 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| CROWNS - SINGLE RESTORATIONS ONLY | | |
| Claim Code | Description | Frequency |
| D2740 | Crown - porcelain/ceramic substrate | Anterior/Bicuspids: Alternate Benefit to D2751 Molars: Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2750 | Crown - porcelain fused to high noble metal | Anterior/Bicuspids: Alternate Benefit to D2751 Molars: Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |

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| D2751 | Crown - porcelain fused to predominantly base metal | Molars: Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2752 | Crown - porcelain fused to noble metal | Anterior/Bicuspid: Alternate Benefit to D2751 Molars: Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2780 | Crown - 3/4 cast high noble metal | Alternate Benefits to D2781 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2781 | Crown - 3/4 cast predominantly base metal | 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2783 | Crown - 3/4 porcelain/ceramic | Molars: Alternate Benefits to D2781 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2790 | Crown - full cast high noble metal | Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2791 | Crown - full cast predominantly base metal | 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2792 | Crown - full cast noble metal | Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| D2794 | Crown - titanium | Alternate Benefits to D2791 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture. |
| OTHER RESTORATIVE SERVICES | | |
| Claim Code | Description | Frequency |
| D2950 | Core buildup, including any pins | 1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure |
| D2954 | Prefabricated post and core in addition to crown | 1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure |
| D2980 | Crown repair, by report | |

| ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE) | | |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| Claim Code | Description | Frequency |
| D3310 | Endodontic therapy, anterior (excluding final restoration) | |
| D3320 | Endodontic therapy, bicuspid (excluding final restoration) | |
| D3330 | Endodontic therapy, molar (excluding final restoration) | |
| ENDODONTIC RETREATMENT | | |
| Claim Code | Description | Frequency |
| D3346 | Retreatment of previous root canal therapy - anterior | |
| D3347 | Retreatment of previous root canal therapy - bicuspid | |
| D3348 | Retreatment of previous root canal therapy - molar | |
| APEXIFICATION/RECALCIFICATION PROCEDURES | | |
| Claim Code | Description | Frequency |
| D3351 | Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) | |
| D3352 | Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) | |
| D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | |
| D3354 | Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration | |
| APICTOMY/PERIRADICULAR SERVICES | | |
| Claim Code | Description | Frequency |
| D3410 | Apicoectomy/periradicular surgery - anterior | |
| D3421 | Apicoectomy/periradicular surgery - bicuspid (first root) | |
| D3425 | Apicoectomy/periradicular surgery - molar (first root) | |
| D3426 | Apicoectomy/periradicular surgery (each additional root) | |
| D3450 | Root amputation - per root | |
| OTHER ENDODONTIC PROCEDURES | | |
| Claim Code | Description | Frequency |
| D3920 | Hemisection (including any root removal), not including root canal therapy | |
| SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE) | | |
| Claim Code | Description | Frequency |
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant | 1 per 36 consecutive month period. |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant | |

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| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant | |
| D4249 | Clinical crown lengthening - hard tissue | 1 per 36 consecutive month period. |
| D4260 | Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant | 1 per 36 consecutive month period. |
| D4270 | Pedicle soft tissue graft procedure | 1 per 36 consecutive month period. |
| D4271 | Free soft tissue graft procedure (including donor site surgery) | 1 per 36 consecutive month period. |
| D4273 | Subepithelial connective tissue graft procedures, per tooth | 1 per 36 consecutive month period. |
| NON-SURGICAL PERIODONTAL SERVICE | | |
| Claim Code | Description | Frequency |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | 1 per lifetime per patient. |
| COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE) | | |
| Claim Code | Description | Frequency |
| D5110 | Complete denture - maxillary | 1 per arch per 60 consecutive month period. |
| D5120 | Complete denture - mandibular | 1 per arch per 60 consecutive month period. |
| D5130 | Immediate denture - maxillary | 1 per arch per 60 consecutive month period. |
| D5140 | Immediate denture - mandibular | 1 per arch per 60 consecutive month period. |
| PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE) | | |
| Claim Code | Description | Frequency |
| D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | 1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth. |
| D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | 1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth. |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth. |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth. |
| D5281 | Removable unilateral partial denture - one piece cast metal (including clasps and teeth) | 1 per arch per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth. |
| IMPLANT SUPPORTED PROSTHETICS | | |
| Claim Code | Description | Frequency |
| D6010 | Surgical placement of implant body: endosteal implant | 1 per 60 consecutive month period, |

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| D6012 | surgical placement of interim implant body for transitional prosthesis: endosteal implant | 1 per 60 consecutive month period, |
| D6040 | Surgical placement: epostal implant | 1 per 60 consecutive month period, |
| D6050 | Surgical placement: transosteal implant | 1 per 60 consecutive month period, |
| D6053 | Implant/abutment supported removable denture for completely edentulous arch | |
| D6054 | Implant/abutment supported removable denture for partially edentulous arch | |
| D6055 | Dental implant supported connecting bar | 1 per 60 consecutive month period, |
| D6056 | Prefabricated abutment – includes placement | 1 per 60 consecutive month period, |
| D6058 | Abutment supported porcelain/ceramic crown | Anterior/Bicuspid: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | Anterior/Bicuspid: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal) | Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6061 | Abutment supported porcelain fused to metal crown (noble metal) | Anterior/Bicuspid: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6062 | Abutment supported cast metal crown (high noble metal) | Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6063 | Abutment supported cast metal crown (predominantly base metal) | 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6064 | abutment supported cast metal crown (noble metal) | Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6065 | Implant supported porcelain/ceramic crown | Anterior/Bicuspid: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6066 | Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) | Anterior/Bicuspid: Alternate Benefit to D6060 Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |

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| D6067 | Implant supported metal crown (titanium, titanium alloy, high noble metal) | Molars: Alternate Benefits to D6063 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6068 | Abutment supported retainer for porcelain/ceramic FPD | Anterior/Bicuspid: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6069 | Abutment supported retainer for porcelain fused to metal FPD (high noble metal) | Anterior/Bicuspid: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6070 | Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) | Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6071 | Abutment supported retainer for porcelain fused to metal FPD (noble metal) | Anterior/Bicuspid: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6072 | Abutment supported retainer for cast metal FPD (high noble metal) | Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6073 | Abutment supported retainer for cast metal FPD (predominantly base metal) | 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6074 | Abutment supported retainer for cast metal FPD (noble metal) | Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6075 | Implant supported retainer for ceramic FPD | Anterior/Bicuspid: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6076 | Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) | Anterior/Bicuspid: Alternate Benefit to D6070 Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6077 | Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) | Molars: Alternate Benefits to D6073 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6078 | Implant/abutment supported fixed denture for completely edentulous arch | 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6079 | Implant/abutment supported fixed denture for partially edentulous arch | 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |

| OTHER IMPLANT SERVICES | | |
|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Claim Code | Description | Frequency |
| D6080 | Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis | 1 per 60 consecutive month period, |
| D6090 | Repair implant supported prosthesis, by report | 1 per 60 consecutive month period, |
| D6091 | Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment | 1 per 60 consecutive month period, |
| D6095 | Repair implant abutment, by report | 1 per 60 consecutive month period, |
| D6100 | Implant removal, by report | 1 per 60 consecutive month period, |
| D6190 | Radiographic/surgical implant index, by report | 1 per 60 consecutive month period, |
| PROSTHODONTICS - FIXED | | |
| Claim Code | Description | Frequency |
| D6210 | Pontic - cast high noble metal | Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6211 | Pontic - cast predominantly base metal | 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6212 | Pontic - cast noble metal | Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6214 | Pontic – titanium | Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6240 | Pontic - porcelain fused to high noble metal | Anterior/Bicuspid: Alternate Benefit to D6241 Molars: Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6241 | Pontic - porcelain fused to predominantly base metal | Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6242 | Pontic - porcelain fused to noble metal | Anterior/Bicuspid: Alternate Benefit to D6241 Molars: Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6245 | Pontic - porcelain/ceramic | Anterior/Bicuspid: Alternate Benefit to D6241 Molars: Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |

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| D6250 | Pontic - resin with high noble metal | Anterior/Bicuspids: Alternate Benefit to D6241 Molars: Alternate Benefits to D6211 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS | | |
| Claim Code | Description | Frequency |
| D6519 | Inlay/onlay – porcelain/ceramic | 1 per tooth per 60 consecutive month period. |
| D6520 | Inlay – metallic – two surfaces | 1 per tooth per 60 consecutive month period. |
| D6530 | Inlay – metallic – three or more surfaces | 1 per tooth per 60 consecutive month period. |
| D6543 | Onlay – metallic – three surfaces | 1 per tooth per 60 consecutive month period. |
| D6544 | Onlay – metallic – four or more surfaces | 1 per tooth per 60 consecutive month period. |
| D6545 | Retainer - cast metal for resin bonded fixed prosthesis | 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6548 | Retainer - porcelain/ceramic for resin bonded fixed prosthesis | Alternate Benefits to D6545 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| FIXED PARTIAL DENTURE RETAINERS - CROWNS | | |
| Claim Code | Description | Frequency |
| D6740 | Crown - porcelain/ceramic | Anterior/Bicuspids: Alternate Benefit to D6751 Molars: Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6750 | Crown - porcelain fused to high noble metal | Anterior/Bicuspids: Alternate Benefit to D6751 Molars: Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6751 | Crown - porcelain fused to predominantly base metal | Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6752 | Crown - porcelain fused to noble metal | Anterior/Bicuspids: Alternate Benefit to D6751 Molars: Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6780 | Crown - 3/4 cast high noble metal | Alternate Benefits to D6781 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6781 | Crown - 3/4 cast predominantly base metal | 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6782 | Crown - 3/4 cast noble metal | Alternate Benefits to D6781 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |

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| D6783 | Crown - 3/4 porcelain/ceramic | Alternate Benefits to D6781 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6790 | Crown - full cast high noble metal | Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6791 | Crown - full cast predominantly base metal | 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6792 | Crown - full cast noble metal | Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| D6794 | Crown - titanium | Alternate Benefits to D6791 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired |
| ANESTHESIA | | |
| Claim Code | Description | Frequency |
| D9220 | Deep sedation/general anesthesia - first 30 minutes | |
| D9221 | Deep sedation/general anesthesia - each additional 15 minutes | |
| D9242 | Intravenous conscious sedation/analgesia - each additional 15 minutes | |
| MISCELLANEOUS SERVICES | | |
| Claim Code | Description | Frequency |
| D9940 | Occlusal guard, by report | 1 per 12 consecutive month period. Allowable for persons 13 to 19 years of age. |

Class IV - Medically Necessary Orthodontia

| LIMITED ORTHODONTIC TREATMENT | | |
|-------------------------------------------|------------------------------------------------------------------------------------------|-----------|
| Claim Code | Description | Frequency |
| D8010 | Limited orthodontic treatment of the primary dentition | |
| D8020 | Limited orthodontic treatment of the transitional dentition | |
| D8030 | Limited orthodontic treatment of the adolescent dentition | |
| INTERCEPTIVE ORTHODONTIC TREATMENT | | |
| Claim Code | Description | Frequency |
| D8050 | Interceptive orthodontic treatment of the primary dentition | |
| D8060 | Interceptive orthodontic treatment of the transitional dentition | |
| COMPREHENSIVE ORTHODONTIC TREATMENT | | |
| Claim Code | Description | Frequency |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition | |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition | |
| MINOR TREATMENT TO CONTROL HARMFUL HABITS | | |
| Claim Code | Description | Frequency |
| D8210 | Removable appliance therapy | |
| D8220 | Fixed appliance therapy | |
| OTHER ORTHODONTIC SERVICES | | |
| Claim Code | Description | Frequency |
| D8660 | Pre-orthodontic treatment visit | |
| D8670 | Periodic orthodontic treatment visit (as part of contract) | |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | |

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

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

Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of "Covered Dental Expenses".
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary.
- 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. Except in cases where it is Dentally Necessary.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment, except in cases where it is Dentally Necessary.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

- For services or supplies that are not Dentally Necessary.
- For services received before the Effective Date of coverage.

- For services received after coverage under this Policy ends.
- For services for which You have no legal obligation to pay or for which no charge would be made if You did not have dental insurance coverage.
- For Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Dentist, from any of the following:
 - Yourself or Your employer;
 - a person who lives in the Insured Person's home, or that person's employer;
 - a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer.
- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Procedures that are a covered expense under any other dental plan which provides dental benefits
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna will take into account any adjustment option chosen under such part by you or any one of your Dependents.

General Provisions

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our complaint and adverse determination appeal procedures. Complaints and adverse determination appeals may be reported by telephone or in writing. All complaints and adverse determination appeals received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30 day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Grace Period: There is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

Guaranteed Renewable Except for the Stated Reasons Only: We may not renew this Policy only in the event of any of the following:

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. When We cease to offer policies of this type to all individuals in Your class, South Carolina law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation; and (3) act uniformly without regard to any health status related factors of an Insured Person or a covered individual who may become eligible for the coverage.
3. When We cease offering any plans in the individual market in South Carolina, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
4. When the Insured no longer lives in the Service Area.

Any non-renewal shall be without prejudice for any claim for Covered Expense incurred prior to termination.

Modification of Coverage: We reserve the right to modify this policy, including Policy provisions, benefits and coverages, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same Policy form. We will only modify this Policy for all Insured Persons in the same class and covered under the same Policy form, and not just on an individual basis. We will send written notice and the change will become effective on the date shown in the notice or on the next scheduled premium due date thereafter. Payment of the premiums will indicate acceptance of the change.

Reinstatement: If this Policy cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Policy. However, if We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.

If this Policy is reinstated, You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

Any premiums accepted in connection with a reinstatement will be applied to a period for which You have not previously paid premium, but not to exceed sixty days prior to the date of reinstatement. There is a \$50 fee for reinstatement.

Fraud: If the Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured Person(s) are the only persons entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.
- The Effective Date of this Policy is printed on the Policy specification page.
- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

**Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630**

- When the amount paid by Cigna exceeds the amount for which We are liable under this Policy, We have the right to recover the excess amount from the Insured Person unless prohibited by law.
- In order for an Insured Person to be entitled to benefits under this Policy, coverage under this Policy must be in effect on the date the expense giving rise to a claim for benefits is incurred. Under this Policy, an expense is incurred on the date the Insured Person(s) receives a service or supply for which the charge is made.

- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured Person assigns benefits in writing no later than the time of filing proof of loss (claim), except for Foreign Country Provider claims. If We receive a claim from a Foreign Country Provider for Emergency Services, any eligible payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured Person for those services.
- Any payment of benefits in reimbursement for Covered Expenses paid by an eligible child, or the eligible child's custodial parent or legal guardian, will be made to the eligible child, the eligible child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the eligible child.
- Cigna will provide written notice to You within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- Failure by Cigna to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.
- If Insured Person(s) were covered by a prior Individual Cigna Policy that is replaced by this Policy with no lapse of coverage:
 - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
 - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
 - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

Premiums

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals who pay monthly.

You will be responsible for an additional \$45 charge for any check or electronic funds transfer that is returned to Us unpaid.

There is a grace period of 31 days for the receipt at Our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums.

Your premium may change from time to time due to (but not limited to):

- a. Deletion or addition of a new eligible Insured Person(s)
- b. A change in age of any member which results in a higher premium
- c. A change in residence

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium on 31 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

How to File a Claim for Benefits

Notice of Claim: Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Us at the address shown on the first page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224). Notice should include the name of the Insured, and claimant if other than the Insured, and the Policy identification number.

Unpaid Premiums: At the time of payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted from the payment.

Claim Forms: When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days after the giving of such notice, the claimant shall meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section. Claim forms can be found by accessing Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 months after the date of the loss, except in absence of legal capacity. Proof of loss is a claim form or letter as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

We will recognize any assignment made under the Policy, if:

1. It is duly executed on a form acceptable to Us; and
2. a copy is on file with Us; and
3. it is made by a Provider licensed and practicing within the United States.

We assume no responsibility for the validity or effect of an assignment.

Payment for services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating Provider is responsible for filing the claim and We will make payments to the Provider for any benefits payable under this Policy. Payment for services provided by a Non-Participating Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. Any benefits due You which are unpaid at Your death will be paid to Your estate. Cigna is entitled to receive from any Provider of service information about You which is necessary to administer claims on Your behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, You have authorized every Provider furnishing care to disclose all facts pertaining to Your care, treatment, and physical condition, upon Our request. You agree to assist in obtaining this information if needed.

Payments of benefits under this Plan neither regulate the amounts charged by Providers of dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured Person for whom a claim is made, when and so often as We may reasonably require during the pendency of a claim under this Policy.

When you Have a Complaint or an Appeal

The Following Will Apply to Residents of South Carolina

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.

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 1.800.Cigna24 (1.800.244.6224)
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 days.

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

Appeals Procedure

CIGNA has a two step appeals procedure for coverage decisions. 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.

Level One Appeal

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

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

Level-Two Appeal

If You are dissatisfied with our level-one appeal decision, You may request a second review. To start 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 at least 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 CIGNA'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 will be notified in writing of the Committee's decision within 5 working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

External Review Procedure

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

There is no charge for You to initiate this external review process. CIGNA will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CIGNA. The amount payable for the denied service or treatment must be at least \$500. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. Post-service issues are not eligible for external review unless You may be held financially responsible for the denied service or treatment. You must first complete CIGNA's level-one and level-two appeal processes before You request an external review unless:

- Your treating Dentist certifies in writing that You have a serious medical condition or the coverage denial is based on a determination that the recommended or requested health care service or treatment is experimental or investigational. If the requested health care service or treatment is experimental or investigational, Your treating Dentist must include information that:
 - You have a life-threatening or seriously disabling condition;
 - at least one of the following applies:
 - standard health care services or treatments have not been effective in improving Your condition;
 - standard health care services or treatment are not medically appropriate for You; or
 - the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by CIGNA; and
 - medical and scientific evidence using accepted protocols demonstrate that the health care service or treatment requested by You that is the subject of the appeal is more beneficial to You than standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.
- You filed an appeal pursuant to CIGNA's level-one or level-two processes and CIGNA has not issued a written decision within the time frames for making a decision if CIGNA has received all the information needed to complete the appeal review and You have not agreed to a delay.
- CIGNA has agreed to waive the completion of the level-one or level-two appeal processes.

To request a review, You must notify the Appeals Coordinator within 60 days of Your receipt of CIGNA's level-two appeal denial. CIGNA will then forward the file to the Independent Review Organization. CIGNA will review all newly submitted information to determine if the appeal can be approved before being sent to the Independent Review Organization.

The Independent Review Organization will render an opinion on standard external review within 45 days.

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

Appeal to the State of South Carolina

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

South Carolina Department of Insurance
1612 Marion Street
Columbia, SC 29201
1-800-768-3467

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the denial decision; (2) reference to the specific Policy provisions on which the decision 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) 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.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; 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; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or 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.

Definitions

The following definitions contain the meanings of key terms used in this Policy. Throughout this Policy, the terms defined appear with the first letter of each word in capital letters.

Calendar Year is a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time.

Cigna. We, Our, and Us mean Cigna (Cigna Health and Life Insurance Company), or an affiliate. Cigna is a licensed and regulated insurance company operating throughout the United States.

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

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services performed on an Insured Person, according to the Insured Person's dental benefit plan.

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Contracted Fee. In addition, Covered Expenses may be limited by other specific maximums described in this Policy. Covered Expenses are subject to applicable Deductibles and other benefit limits. An expense is incurred on the date the Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

Dental Prostheses are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

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.

Effective Date is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

Emergency Services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles and non-compliance penalty charges do not apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the covered person's upper or lower arch and which is opposed in the covered person's other arch by another natural tooth or prosthetic (i.e., artificial) replacement.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles and non-compliance penalty charges do not apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Insured means the applicant who has applied for, been accepted for coverage, and who is named as the Insured on the specification page.

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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

Medically Necessary and/or Dentally Necessary are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

- (1) required for the diagnosis and/or treatment of the particular dental condition or disease; and
- (2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and
- (3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and
- (4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development for the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

Orthodontic Treatment means the corrective movement of the teeth through the alveolar bone by means of an active appliance to correct a handicapping malocclusion of the mouth.

Participating Provider - Cigna Dental Preferred Provider is a Dentist or a professional corporation, professional association, partnership, or any other entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services at predetermined fees with regard to a particular Policy under which an Insured Person is covered. The providers qualifying as Participating Providers may change from time to time.

Policy is the set of benefits, conditions, exclusions, limitations, and premiums described in this document, including the Policy specification page, the completed and accepted application for coverage attached to this Policy, and any amendments or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Service Area is any place that is within the state of South Carolina.

Simultaneous Accumulation of Amounts are 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.

You, Your, and Yourself is the Policyholder who has applied for, and been accepted for coverage, as an Insured under the Policy and is named on the specification page.