Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 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 1-877-484-5967

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.

NOTICE: If this policy is returned during a period of 10 days from the date of delivery, such policy may be returned for cancellation and the insurer will refund the entirety of any premium paid, including policy fees or other charges.

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 Arizona. 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 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 for whom the application and approval procedures for adoption pursuant to state law have been completed is automatically covered for Illness or Injury for 31 days from either the date of the final decree of adoption or the date a child is placed in the custody of the Insured, pursuant to an interim court order of adoption vesting temporary care of the child in the Insured regardless of whether the adoption has become final. To continue coverage, You must enroll the child as an Insured Person by notifying Us in writing within 31 days after either the date of placement or the final decree of Adoption, and pay 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 Health Insurance Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace 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 marketplace 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 marketplace 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 marketplace, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the marketplace 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

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 or when the union is dissolved.
- 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 Providers	Cigna DPPO Participating Providers** and Non –Participating Providers
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I	None	
Calendar Year Deductible: Class II, III & IV	$150 per person	
	$300 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$350 per person	
	$700 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
Class I - Preventive/Diagnostic Services	100%*	100%*
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

There are no waiting periods for Class I, II, III or IV.

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.

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

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

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

Payment for a service delivered by a non-Participating Provider is the Contracted Fee 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 balance of the provider's actual charge.

Covered Dental Expenses

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

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	
D0391	Interpretation of Diagnostic Image	
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.	2 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**
D1510	Space maintainer - fixed - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
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

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Class III - Major Restorative Services

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Class IV - Medically Necessary Orthodontia

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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.
- 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.
- 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: If You purchased Your Plan from a Health Insurance Marketplace and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "Terms of the Policy", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, 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.

Cancellation: We may cancel this Policy at any time by written notice delivered to You or mailed to Your last address as shown by Our records, stating when, not less than thirty days thereafter, such cancellation shall be effective; and after the Policy has been continued beyond its original term You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, We will return promptly the unearned portion of any premium paid. If You cancel, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where You resided when the Policy was issued. If We cancel, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

We may cancel this Policy only in the event of any of the following:

1. As of any premium due date You fail to pay Your premiums as they become due or the 31 day grace period for quarterly premium and 10 day grace period for monthly premium.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. Immediately if You have committed, or allowed someone else to commit, any fraud or have made an intentional misrepresentation of material fact in connection with this Policy or coverage.
5. If we cease to offer policies of this type to all individuals in Your class, and then, only on 90 days advance written notice to You. Modification of coverage at renewal on a uniform basis in accordance with applicable law is not a decision to discontinue offering coverage under this provision.
6. If we elect to discontinue offering all dental plans in the individual market in this state in accordance with applicable law, We will do so only on 180 days prior written notice..

7. If We cease to offer policies of this type and cancel this Policy for that reason, You will be entitled to elect coverage under any other type of individual health insurance that We then currently offer for which You are eligible. We may not decline to issue to You the type of Policy that You elect, and for which You are otherwise eligible.

Any cancellation shall be without prejudice for any claim for Covered Expense incurred before cancellation.

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.

Renewal: This Policy renews on a Calendar Year basis.

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 33630-3365

- 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 30 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, or after the termination of the period for which We are liable in case of claim for loss for which this policy provides periodic payment contingent upon continuing 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 Arizona

When You Have a Complaint Or An Appeal

For the purposes of this section, any reference to "You," "Your" or "Yourself" 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. The following describes the process by which You obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Appeals Process Information Packet ("Appeal Packet"). We will provide you a copy of the Appeal Packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call Customer Services Toll-Free Number: 1.800.Cigna24 (1.800.244.6224).

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 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 two years 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.

Within five business days after receiving Your request for review, Cigna will mail You and Your Dentist or treating Provider a notice indicating that Your request was received, and a copy of the Appeal Packet (sent to Dentist or treating Provider upon request). For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a coverage determination.

You may request that the appeal process be expedited if, your Dentist or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally and in writing with a decision within one business day.

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. Please send Your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two years of the last denial. To help us make a decision on Your appeal, You or Your provider should also send us any more information (that You haven't already sent us) to show why we should authorize the requested service or pay the claim.

If the appeal involves a coverage decision based on issues of medical necessity or clinical appropriateness, a review will be conducted by a Dentist or Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request. For level two appeals we will acknowledge in writing that we have received Your request within five business days after receiving Your request. For coverage determinations, the review will be completed within 15 calendar days. For postservice claims, review and written notification of the decision will be completed within 30 calendar days.

You may request that the appeal process be expedited if, your Dentist or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services, or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally with a decision within 3 business days, followed up in writing.

At any time during the appeal process Cigna has the option to send Your appeal directly to External Independent Review without making a decision during the appeal process.

External Independent Review

Eligibility

Under Arizona law, You may seek a Standard External Independent Review only after seeking any available level one appeal and level two appeal. Your request for a Standard External Independent Review should be submitted in writing.

Deadlines Applicable to the Standard External Independent Review Process

After receiving written notice from Cigna that Your level two appeal has been denied, You have 4 months to submit a written request to Cigna for External Independent Review. Your request must include any material justification or documentation to support Your request for the service or payment of a claim.

Medical Necessity Issues

These are cases where we have decided not to authorize a service because we think the services You (or Your treating provider) are asking for, are not medically necessary to treat Your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If Your appeal for External Independent Review involves an issue of medical necessity:

- Within five business days of receipt of Your request for External Independent Review, Cigna will:
  - mail a written notice to You, Your Dentist or treating Provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of Your request for External Independent Review, and
  - send the Director of Insurance: the request for review; Your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.
- Within five days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").
- Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.
- Within five business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, You, and Your treating Provider. If the IRO decides that Cigna should provide the service or pay the claim, Cigna must then authorize the service or pay the claim. If the IRO agrees with Cigna's decision to deny the service or payment, the appeal is over. Your only further option is to pursue Your claim in Superior Court.

Coverage Issues

These are cases where we have denied coverage because we believe the requested service is not covered under Your certificate of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If Your appeal for External Independent Review involves an issue of service of benefits coverage or a denied claim:

- Within five business days of receipt of Your request for External Independent Review, Cigna will:
  - mail a written notice to You, Your Dentist or treating Provider, and the Director of Insurance of Your request for External Independent Review, and
  - send the Director of Insurance: Your request for review; Your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.
- Within 15 business days of the Director's receipt of Your request for External Independent Review from Cigna, the Director of Insurance will:
  - determine whether the service or claim is covered, and
  - mail the decision to Cigna. If the Director decides that we should provide the service or pay the claim, we must do so.

- If the Director of Insurance is unable to determine an issue of coverage, the Director will forward Your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have five business days after receiving the IRO's decision to send the decision to us, You, and Your treating provider.
- Cigna will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether Cigna elects to seek judicial review of the decision made through the External Independent Review Process.
- If You disagree with the Insurance Director's final decision on a contract coverage issue, You may request a hearing with the Office of Administrative Hearings ("OAH"). If Cigna disagrees with the Insurance Director's final decision, Cigna may also request a hearing before the OAH. A hearing must be requested within 30 calendar days of receiving the Insurance Director's decision.
-

Expedited External Independent Review Process

You may request an external review only after you have appealed through Levels 1 and 2. You have only 5 business days after you receive our Level 2 decision to send us your written request for Expedited External Independent Review. Neither you nor your treating provider is responsible for the cost of any external independent review.

For medical necessity cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary,. we will acknowledge your request within 1 business day of receiving your request. Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external independent reviewer organization (the “IRO”). Within 72 hours of receiving the information the IRO must make a decision and send the decision to the Insurance Director. Within 1 business day of receiving the IRO’s decision, the Insurance Director will notify You of its decision. If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

For contract coverage cases where we have denied coverage because we believe the requested service is not covered under your insurance policy, within 1 business day of receiving your request we will acknowledge your request in writing. Within 2 business days of receiving this information, the Insurance Director will determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Insurance Director cannot issue a decision, your case will be forwarded to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO’s decision to send the decision to us, you, and your treating provider. If you disagree with Insurance Director’s final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings (“OAH”). A hearing must be requested within 30 days of receiving the Director’s decision. OAH must promptly schedule and complete a hearing for appeals from expedited external review decisions.

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

Under Arizona law, if You intend to file suit regarding a denial of benefit claim or services You believe are medically necessary, You are required to provide written notice to Cigna at least 30 days before filing the suit stating Your intention to file suit and the basis of Your suit. You must include in Your notice the following:

Insured Person’s Name
Insured Person’s Identification Number
Date of Birth
Basis of Suit (reasons, facts, date(s) of treatment or request)

Notice will be considered provided by You on the date received by Cigna. The notice of intent to file suit must be sent to Cigna via Certified Mail Return Receipt Request to the following address:

Attention: HealthCare Litigation Unit B6LPA
Notice of Intent to File Suit
Cigna Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means Your last known address.

Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any Insured Person who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and Cigna as described above.

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 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 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 Arizona.

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.