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, including assistance in resolving complaints, write or call:

Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630
1.800.Cigna24 (1.800.244.6224)

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).

IMPORTANT NOTICE
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. 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 us 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 Illinois. 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 or partner to a civil union who resides in the Service Area.
- Your children by birth, adoption, or foster care.
- Your stepchildren.
- Your unmarried military veteran dependent if the veteran (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge. To be eligible, the eligible dependent shall submit to Us a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.
- Your own, Your spouse's or Your partner to a civil union's unmarried children who are incapable of self-sustaining employment and are dependent upon his/her parents or other care providers for lifetime care and supervision. Cigna may require written proof of such disability or dependency.
- Your own, Your spouse's or Your partner to a civil union's Newborn children are automatically covered for the first 31 days of life. To continue coverage past that time, You must enroll the child as a dependent Member by applying for his or her enrollment as a dependent within 60 days of the date of birth, and pay any additional premium. Coverage for a newborn dependent child enrolled within 60 days of birth will be retroactive to the date of the child's birth.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of adoption or initiation of a suit of adoption. To continue coverage past that time, You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 60 days of the date of adoption, and pay any additional premium. Coverage for an adopted dependent child enrolled within 60 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption.
- 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 past that time, You must enroll the child as a dependent within 60 days of the court order date and pay any additional premium. Court-ordered coverage for a dependent child enrolled within 60 days of the court order will be retroactive to the date of the court order.

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, intentional 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, intentional 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 have coverage effective dates determined as follows:

- in the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care;

- in the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective for a qualified individual or enrollee on the first day of the following month.

For all other triggering events the effective dates are:

- 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:

- If Cigna determines that any Insured Person covered under this Policy has engaged in fraud or intentional misrepresentation of facts with respect to the Insured Person's application for, coverage under, or receipt of benefits pursuant to this 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 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 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.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a Non-Participating Provider for a covered service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional Providers and information on out-of-pocket expenses by calling 1.800.Cigna24 (1.800.244.6224).

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

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	
	Cigna DPPO Advantage Participating Providers	**Cigna DPPO Participating Providers** ** **and Non-Participating Providers**
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** of the Policy**.**

**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 usually the fee schedule with the lowest Contracted Fees available for acceptance 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 examination –Only 1 per person per 6 consecutive months.
- X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.
- Bitewing x-rays – Only 1 set in any consecutive 12-month period. Limited to a maximum of 4 films per set.
- Vertical Bitewing x-rays – Only 1 set in any consecutive 36-month period. Limited to a maximum of 7 to 8 films per set.
- Prophylaxis (Cleaning) – Only 1 per person per 6 consecutive months.
- Topical application of fluoride (excluding prophylaxis) – Only 1 per person per 12 consecutive months.
- Topical application of sealant, per tooth, on an unrestored permanent posterior tooth - Only 1 treatment per tooth per lifetime.
- Topical application of varnish - Only 3 treatments per 12 consecutive months for ages 0-2. Only 1 treatment per 12 consecutive months for ages 3-19.
- Space Maintainers – Limited to nonorthodontic treatment. Only 1 per lifetime per quadrant.
- Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)
- Periodontal Maintenance Procedures – Only following active periodontal therapy.

Class II - Basic Restorative Services

Fillings

- Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.

- Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed.
- Sedative Fillings
- Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Repairs to Crowns, Inlays and Space Maintainers

- Recement Inlays - No limitation.
- Recement Crowns - No limitation.
- Recement Space Maintainer - No limitation.

Endodontic Procedures

- Root Canal Therapy (excluding final restoration) - Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service. Only 1 treatment per tooth per lifetime.
- Therapeutic Pulpotomy (excluding final restoration and not in conjunction with a root canal)- Payable for deciduous teeth only.
- Partial Pulpotomy for apexogenesis – Only 1 per lifetime.
- Pulpal therapy (resorbable filling) – anterior excluding final restoration.
- Apexification - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Only 1 per tooth per lifetime.
- Apicoectomy - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Only 1 per tooth per lifetime.

Periodontal Procedures

- Periodontal Scaling and Root Planing – Entire Mouth. Only 1 time in any consecutive 24-month period.
- Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service. Only 1 periodontal surgical procedure is covered per area of the mouth or per Provider in any consecutive 24-month period.
- Gingivectomy - Only one periodontal surgical procedure is covered per area of the mouth in any consecutive 24-month period.
- Gingival Flap Procedure Including Root Planing - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 24-month period.
- Bone Replacement Graft - First Site in Quadrant.
- Bone Replacement Graft - Each Additional Site in Quadrant.
- Pedicle Soft Tissue Graft - No limitation.
- Free Soft Tissue Graft (including donor site surgery) - No limitation.
- Subepithelial Connective Tissue Graft Procedure (including donor site surgery) - No limitation.
- Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area) - No limitation.
- Intracoronal and extracoronal provision splinting.

Oral Surgery - Extractions

- Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.
- Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

- Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Other Oral Surgery

- Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption - Includes an allowance for local anesthesia and routine postoperative care.
- Alveoloplasty - Includes an allowance for local anesthesia and routine postoperative care. Only 1 per lifetime per quadrant.
- Removal of Odontogenic Cyst or Tumor - Includes an allowance for local anesthesia and routine postoperative care.
- Incision and Drainage - Includes an allowance for local anesthesia and routine postoperative care. Only 1 per day per tooth.
- Frenectomy (Frenulectomy, Frenotomy), Frenuloplasty, Separate Procedure - Includes an allowance for local anesthesia and routine postoperative care. Only 1 per arch per lifetime.
- Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth.

Surgical Extraction of Impacted Teeth

- Surgical Removal of Impacted Tooth - Soft Tissue - The benefit includes an allowance for local anesthesia and routine postoperative care.
- Surgical Removal of Impacted Tooth - Partially Bony - The benefit includes an allowance for local anesthesia and routine postoperative care.
- Surgical Removal of Impacted Tooth - Completely Bony - The benefit includes an allowance for local anesthesia and routine postoperative care.
- Surgical Removal of Residual Tooth Roots (Cutting Procedure) - Includes an allowance for local anesthesia and routine postoperative care.

Anesthesia and Sedation

- General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- I. V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- Inhalation of Nitrous Oxide – Paid as a separate benefit only when Medically or Dentally Necessary, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- Non-intravenous Conscious Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, and for patients who are extremely apprehensive, mentally or physically disabled, or those having extensive treatment in a single appointment.
- Therapeutic Drug Injection, by report.

Denture Relining and Repairs

- Relining Dentures - Limited to one time in any consecutive 24-month period.
- Add tooth to existing partial denture to replace newly extracted Functional Natural Tooth — Only if more than 12 consecutive months have elapsed since the insertion of the partial denture.
- Repairs to Full and Partial Dentures - Limited to repairs performed more than 12 consecutive months after initial insertion.
- Recement Fixed Partial Denture - Limited to one time in any consecutive 60-month period.

Class III - Major Restorative Services

Crowns

- Crowns - Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 60 consecutive months have elapsed since the last placement.
- Benefits for crowns are based on the amount payable for nonprecious metal substrate.
- Prefabricated Stainless Steel Crowns, Resin Crowns - Covered only when the tooth cannot be restored by filling and then only 1 time per lifetime.
- Prefabricated Post and Core (in conjunction with a crown or inlay) - Covered only for endodontically treated teeth with total loss of tooth structure.

Removable Prosthetics

- Complete (Full) Dentures, Upper or Lower - Limited to one time per 60 consecutive months.
- Partial Dentures - Limited to one time per 60 consecutive months.
    - Lower, Resin Base or Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
    - Upper, Resin Base or Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth).

Fixed Prosthetics

- Fixed prosthodontic procedures
- Bridge Pontics - Cast High Noble Metal, Cast Noble Metal, Cast Base Metal
- Bridge Pontics - Porcelain Fused to High Noble Metal, Metal, Noble Metal
- Bridge Pontics - Resin with Base Metal
- Retainer Crowns - Resin with Base Metal
- Retainer Crowns - Porcelain Fused to High Noble Metal, Metal, Noble Metal
- Retainer Crowns - Full Cast High Noble Metal, Base Metal, Noble Metal

Class IV - Medically Necessary Orthodontia

Orthodontia coverage is limited to children meeting or exceeding a score of 42 from the Modified Salzman Index or meeting criteria for medical necessity.

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

- Orthodontic work-up including treatment plan and the first month of active treatment including all active treatment and retention appliances – Only one treatment per lifetime per person.
- Continued active treatment after the first month – Only one visit per 45 days per person.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

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.
- procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- 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.
- 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.
- 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;
- 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. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

General Provisions

Third Party Liability

You agree to advise Us, in writing, within a reasonable time of Your claim against the third party and to take such action, provide such information and assistance, and execute such documents as We may reasonably require to facilitate enforcement of the claim. You also agree to take no action that may prejudice the rights or interests of Us under this Policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice our rights or interests, may be considered to be a material breach by Us and may subject You to legal action.

We may have a right to a lien, to the extent of benefits advanced, upon any recovery that You receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Policy for the treatment of the Illness, disease, Injury or condition for which the third party is liable. We will be entitled to collect on our lien even if the amount recovered by or for the Insured Person (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the Injury, Illness or condition is less than the actual loss suffered by the Insured Person.

In addition, if an Insured Person incurs expenses for Illness or Injury that occurred due to the negligence of a third party:

- We have the right to reimbursement for all benefits we paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Insured Person, Insured Person's parents, if the Insured Person is a minor, or Insured Person's legal representative as a result of that Illness or Injury; and
- We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits we paid for that Illness or Injury.
- We shall have the right to first reimbursement out of all funds the Insured Person, the Insured Person's parents, if the Insured Person is a minor, or the Insured Person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that Illness or Injury.
- You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

Right of Reimbursement

If an Insured Person incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Insured Person may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

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

Any controversy between Cigna and an enrolled Member (including any legal representative acting on the Member's behalf), arising out of or in connection with this Policy may be submitted to arbitration upon mutual agreement of Cigna and You. Such arbitration shall be subject to and administered in accordance with the Uniform Arbitration Act (710 ILCS 5/1, *et seq.*) to the extent not inconsistent with the Uniform Arbitration Act, in accordance with the Commercial Arbitration Rules of the American Arbitration Association.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of the written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30 day period and the 2 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 3rd arbitrator in accordance with these requirements. **Any arbitrator must be fair, impartial, and free of any conflicts of interest or the appearance of a conflict of interest.** The arbitrator or arbitrators shall not have authority to conduct a class action, combine or aggregate similar claims of an entity or person not a party to this agreement, or make an award to any person or entity not a party to this agreement.

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. **The decision of the arbitrator, or the decision of any 2 arbitrators if there are 3 arbitrators, shall be binding upon both parties in accordance with the Uniform Arbitration Act (710 ILCS 5/1 *et seq.*) and shall be conclusive of the controversy in question and enforceable in any court of competent jurisdiction.**

Arbitration under the Policy is voluntary and is available only if both Cigna and You agree. The availability of arbitration is not a substitute for Your right to maintain a legal action if You so desire and in no way affects or limits Your ability to take legal action in a court of law prior to entering into arbitration proceedings.

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. Changes will not be made to the Policy without receiving Your written consent. 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.

Cancellation: We may cancel 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. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class. In this event Illinois 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.
6. When We cease offering all dental plans in the individual market in Illinois in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area.

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, then We may, upon Your request and at Our discretion, agree to reinstate coverage under this Policy.

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 $45 fee for 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

- 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, 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: In accordance with state law, We may not prevent an Insured Person from making an assignment of benefits to the Provider. Dental Benefits are assignable to the Provider; when you assign benefits to a Provider, you have assigned the entire amount of the benefits due on that claim. If the Provider is overpaid because of accepting a patient's payment on the charge, it is the Provider's responsibility to reimburse the patient. Because of Cigna's contracts with Providers, all claims from contracted Providers should be assigned.

We will recognize and consider any assignment made under the Policy, only 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 may, at Our option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the provider and Our payment to You will be considered fulfillment of Our obligation.

Time Payment of Claims: Claims shall be paid within 30 days following receipt of written due proof of loss. Failure to pay within such period shall entitle the insured to interest at the rate of 9% per annum from the 30th day.

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 (for Illinois residents)

(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's why We've established a process for addressing your concerns and solving Your problems.

Start with Customer Service

We're 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 Us at Our toll-free number and explain Your concern to one of Our Customer Services representatives. You can also express that concern in writing. Please call Us at the 1.800.Cigna24 (1.800.244.6224, or write to:

Cigna
Individual Services
PO Box 182223
Chattanooga TN 37422

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).

We'll do our best to resolve the matter on Your initial contact. If We need more time to review or investigate Your concern, We'll 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 non-expedited appeals procedure; this timeframe does not apply to expedited appeals. You can file an expedited appeal at any time.

Appeals Procedure

Cigna has a single level appeals procedure for coverage decisions. An appeal can be filed by a Member, the Member's designee or guardian, the Member's Primary Care Physician or the Member's health care Provider. To initiate an appeal, You, or the person filing the appeal on Your behalf, must submit a request for an appeal in writing within 180 days after receipt of a denial notice, to the following address:

Cigna HealthCare of Illinois Inc.
National Appeals Unit (NAO)
PO Box 188011
Chattanooga, TN 37422
Toll Free Telephone: (866) 494-2111
Fax: (877) 815-4827
Email: NationalAppealsOrganization@Cigna.com

The deadlines indicated within this EOC for requesting an appeal or External Independent Review are not postponed or delayed by Primary Care Physician or health care Provider appeals unless Your Primary Care Physician or health care Provider is acting as Your authorized representative.

You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal.

If You are unable to or choose not to write, You may ask to register Your appeal by calling 1.800.Cigna24 (1.800.244.6224).

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. For all other coverage plan-related appeals, a 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 appeal request.

We will acknowledge in writing that We have received Your request. For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days. For post service claims, Cigna's review will be completed within 30 calendar days. If more time or information is needed to make the determination, We will notify the Insured Person in writing to request an extension of up to 15 calendar days and to specify any additional information needed by Us to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Us in connection with the appeal, we will provide this information to You as soon as possible and sufficiently in advance of the decision, so that You will have an opportunity to respond. Also, if any new or additional rationale is considered by Us, we will provide the rationale to You as soon as possible and sufficiently in advance of the decision so that You will have an opportunity to respond.

The Member will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

Expedited Appeal

You can file an expedited appeal orally or in writing if:

a) the time frames under this process would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or in the opinion of his or her Physician would cause severe pain which cannot be managed without the requested services; or

b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If You request that Your appeal be expedited based on (a) above, You may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to Your medical condition.
Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, We will respond orally with a decision within 24 hours, followed up in writing.
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 expedited appeals, We will notify You within no later than 24 hours Your submission, of all information required to evaluate Your appeal. We will notify You, Your Primary Care Physician and any health care Provider who recommended the health care service involved in the appeal orally with a decision within 24 hours after We receive the required information for an expedited appeal. Written notice of the determination will follow. The written notice of determination will include:

(i) reasons for the determination,

(ii) the medical or clinical criteria for the determination, and

(iii) in the case of an adverse determination, the procedures for requesting an external independent review as provided by the Illinois Health Carrier External Review Act.

External Independent Review Procedure

External Review Procedure

If You are not fully satisfied with the decision of Cigna's appeal review regarding medical necessity, experimental/investigational, pre-existing condition, initial eligibility determination, rescission of health coverage, a determination of whether You are entitled to a reasonable alternative standard for a reward under a wellness program, or a determination of whether Your plan is complying with the non-quantitative treatment limitation provisions and parity in the application of medical management techniques consistent with the Mental Health Parity and Addiction Equity Act, You or Your authorized representative 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 or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for You to initiate this independent review process. 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, experimental/investigational, pre-existing condition, initial eligibility determination or rescission of health coverage determination by Cigna. Administrative or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, You must send a written request to the Illinois Department of Insurance within 4 months of Your receipt of Cigna's appeal review denial. You or your authorized representative may include all relevant documentation with Your appeal request. The Independent Review Organization will render an opinion within 45 days after receiving all necessary information. When requested and when determined a delay would be detrimental to Your condition, the review shall be completed within 72 hours or 5 days for expedited experimental/investigational reviews.

The Independent Review Program is voluntary for You and is arranged by the Illinois Department of Insurance.

Expedited External Review Procedure

If You have a medical condition where the timeframe for completion of an expedited internal review of a grievance involving an adverse determination, a final adverse determination or a standard external review would seriously jeopardize Your life, health or ability to regain maximum function, then You or Your authorized representative may file a request for an expedited external review.

You may have the right to request an expedited external review of a final adverse determination for the following:

- coverage has been denied due to Cigna’s finding that the requested health care service is experimental or investigational, and Your treating physician certifies in writing, and supports the certification with evidence that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or
- an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility

To request an External Review or an Expedited External Review, You must send a request to

The Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767

Toll-free Telephone: (877) 850-4740
Fax: (217) 557-8495
Email: DOI.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Once the Illinois Department of Insurance receives Your request for external review, they will forward Your request to Cigna to determine if Your request is eligible for an external review. If Cigna determines You are ineligible for an external review, Your may appeal the decision at:

Ineligible for External Review:

The Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street
Springfield, Illinois 62767

Toll Free Telephone: (877) 527-9431Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Ineligible for Expedited External Review:

The Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street
Springfield, Illinois 62767

Toll Free Telephone: (877) 527-9431
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Appeal to the State of Illinois

You have the right to contact the Illinois Department of Insurance for assistance at any time. The Consumer Division may be contacted at one of the following addresses and telephone numbers:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767
Toll Free Telephone: 877-527-9431Fax: (217) 558-2083
Email: Consumer_complaints@ins.state.il.us
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided to You, Your designee or guardian, Your Primary Care Physician and the ordering health care Provider, in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the denial decision; (3) reference to the specific Policy provisions on which the decision is based; (4) 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; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding Your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health insurance consumer assistance or ombudsman available to assist You in the appeal process; (7) Cigna's address, toll-free phone number, fax number and appeal email address; (8) information that is specific and limited to appeals and external review procedures for Your plan; (9) information about the one level of appeal that is available; (10) the date of the adverse determination and, if applicable, the date of the final adverse determination; and (11) upon exhaustion of internal appeals by the Member, the final adverse determination notice shall clearly state that it is the final adverse determination, that all internal appeals have been exhausted, and that You have 4 months from the date of the letter to file an external review. A final notice of adverse determination will include a discussion of the decision.

All notices will include the following contact information for the Department of Insurance:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield IL 62767
Toll-free Telephone: (877) 850-4740
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Relevant Information

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

Legal Action

In most instances, You may not initiate a legal action against Cigna until You have completed the internal appeal process.

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.

Disabling Malocclusion means a malocclusion that severely interferes with the ability of a person to chew food.

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.

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 services are those services provided by a Dentist or physician that 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.

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 disabling 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, 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 Illinois.

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.