

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 1500 Plan

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

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 by accessing myCigna.com.

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. 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 or quarterly 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 the number shown on myCigna.com 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, however, if the Insured Person receives them from a Dentist that is a Non-Participating Provider.

Important Information Regarding Benefits

IMPORTANT NOTICE

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

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

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

Notice Regarding Provider Directories and Provider Networks

If Your Plan utilizes a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers.

You may also have access to a list of Providers who participate in the network by visiting www.cigna.com; mycigna.com.

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with Cigna HealthCare or Cigna Dental Health.

Notice Regarding Standard of Care

Under state law, Cigna is required to adhere to the accepted standards of care in the administration of health benefits. Failure to adhere to the accepted standards of care may subject Cigna to liability for damages.

PLEASE READ THE FOLLOWING IMPORTANT NOTICE: WHILE THIS DENTAL PLAN OFFERS A FULL RANGE OF DENTAL BENEFITS, IT IS NOT BEING OFFERED AS AN ESSENTIAL HEALTH BENEFIT PEDIATRIC ORAL CARE PLAN INTENDED TO SATISFY THE REQUIREMENTS UNDER THE AFFORDABLE CARE ACT.

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 accessing myCigna.com. 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 myCigna.com or by calling Member Services.

Proof of Loss: You must give Us written proof of loss within 90 days after the date of the loss. Proof of loss is a claim form or letter as described above. Canceled checks or receipts are not acceptable. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonable possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

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.

Who Is Eligible For Coverage

Conditions Of Eligibility

This Policy is for residents of the state of Washington. 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 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):

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, or Your spouse's or domestic partner's children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing developmental disability or physical handicap and are chiefly dependent upon You for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Cigna may require written proof of such disability or dependency periodically thereafter, but not more frequently than annually after the two year period following the child's attainment of the limiting age.
- Your own, or Your spouse's or domestic partner's Newborn children are automatically covered from the moment of birth. If payment of additional premium is required for coverage, You must notify Cigna within 60 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay the additional premium required.
- An adopted child is automatically covered from the date of adoptive or parental placement with You for the purpose of adoption. If payment of additional premium is required for coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 60 days of the date the child was placed with You for the purpose of adoption and paying the 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 or the child's other parent or the state agency responsible for enforcement 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. Cigna will not deny enrollment of the child on the grounds that the child was born out of wedlock, the child is not claimed as a dependent on Your federal tax return; or the child does not reside with You or in the plan's service area. Cigna will provide to the custodial parent all information necessary for a child to become enrolled. Claims will be accepted from the custodial parent, the provider or the state agency without approval of the non-custodial parent and payment will be made to the person submitting the claim. Coverage cannot be terminated until Cigna receives satisfactory written evidence that the court order is no longer in effect or the child is enrolled in another plan with comparable coverage that takes effect not later than the effective date of disenrollment.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if:

- The individual was previously enrolled under a plan offered or administered by Cigna, any direct or indirect affiliate of Cigna, and his or her enrollment was terminated for cause; or
- The individual has unpaid financial obligations to Cigna or any direct or indirect affiliate of Cigna; or
- The individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for misrepresentations or omitted information or health history; or
- The individual was previously enrolled under this Policy or another Cigna Individual Dental Policy and terminated his or her enrollment. The individual will be allowed to reenroll 12 months from the effective date of termination.

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 or domestic partner or partner to a civil union: 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 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.

CIGNA DENTAL PREFERRED PROVIDER INSURANCE <i>The Schedule</i>
For You and Your Dependents
The Schedule
If you select a Participating Provider, your cost will be less than if you select a Non-Participating Provider.
Emergency Services The Benefit Percentage payable for Emergency Services charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental 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.
Deductibles Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.
Participating Provider Payment Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and CHLIC.
Non-Participating Provider Payment Non-Participating Provider services are paid based on the Contracted Fee.
Simultaneous Accumulation of Amounts Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

BENEFIT HIGHLIGHTS	CIGNA DPPO ADVANTAGE PARTICIPATING PROVIDERS		CIGNA DPPO PARTICIPATING PROVIDERS* and NON-PARTICIPATING PROVIDERS
Classes I, II, III Calendar Year Maximum	\$1,500 per person		
Class IV Lifetime Maximum	\$1,000 per person		
Calendar Year Deductible Individual	\$50 per person Not Applicable to Class I		
Family Maximum	\$150 per family Not Applicable to Class I		
Lifetime Class IV Deductible	\$50 per person		
Class I	The Percentage of Covered Expenses the Plan Pays	The Percentage of Covered Expenses the Plan Pays	
Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100%	100%	
Class II	The Percentage of Covered Expenses the Plan Pays	The Percentage of Covered Expenses the Plan Pays	
Basic Restorative Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after plan deductible	80% after plan deductible	

BENEFIT HIGHLIGHTS	CIGNA DPPO ADVANTAGE PARTICIPATING PROVIDERS	CIGNA DPPO PARTICIPATING PROVIDERS* and NON-PARTICIPATING PROVIDERS
Class III	The Percentage of Covered Expenses the Plan Pays	The Percentage of Covered Expenses the Plan Pays
Major Restorative Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after plan deductible	50% after plan deductible
Class IV	The Percentage of Covered Expenses the Plan Pays	The Percentage of Covered Expenses the Plan Pays
Orthodontia	50% after separate Class IV deductible	50% after separate Class IV deductible

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

Waiting Periods

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

- there is no waiting period for Class I services;
- after 6 consecutive months of coverage dental benefits will increase to include the list of Class II procedures;
- after 12 consecutive months of coverage dental benefits will increase to include the list of Class III procedures;
- after 12 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures.

Covered Dental Expense: What The Policy Pays For

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.

Covered Services

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

Dental PPO – Participating and Non-Participating Providers

Plan pays Cigna DPPO Advantage Participating Providers for Covered Services based on the Contracted Fee that is agreed to by the provider and Cigna. Based on the provider's Contracted Fee, a higher level of plan payment may be made to a Participating Provider resulting in a lower payment responsibility for you. Refer to your provider directory for a list of participating providers. Provider information is subject to change; refer to your provider directory prior to receiving a service. You can access a list of all providers who participate in the Cigna DPPO Advantage network by visiting www.mycigna.com.

Plan payment for a Covered Service delivered by a Cigna DPPO Advantage Participating Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in the Schedule.

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

Plan pays Cigna DPPO Participating Providers for Covered Services based on the lesser of the Contracted Fee or the Maximum Allowable Charge. The Maximum Allowable Charge is the fee for the Covered Service as listed on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, multiplied by the benefit percentage that applies to the class of service, as specified in the Schedule. The Primary Schedule is the fee schedule with the lowest Contracted Fees currently being accepted by a Participating Provider in the relevant 3-digit zip code.

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

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

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

Insurance coverage is only for the class of service referred to in The Schedule, however the covered person is also eligible for discounts for other selected services. Discounts for these select services are not insurance. The covered person will receive discounts from Cigna's contracted health care professionals for these services. Discounts are based on Cigna Dental contracted rates. Please visit our website at mycigna.com for details about this plan.

Class I Services - Diagnostic and Preventive Dental Services

- Bitewing x-rays – Only 1 set in any consecutive 12-month period. Limited to a maximum of 4 films per set.
- Clinical oral evaluation – Only 1 per consecutive 6-month period.
- Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure per consecutive 6-month period.
- Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 14 years old. Only 1 per person per consecutive 12-month period.
- Topical application of sealant, per tooth, on an unrestored permanent bicuspid or molar tooth for a person less than 14 years old. Only 1 treatment per tooth per lifetime.
- Space Maintainers - Limited to nonorthodontic treatment for prematurely removed or missing teeth for a person less than 14 years old.

Class II Services - Diagnostic Services

- Complete mouth survey or panoramic x-rays - only 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.
- Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period.
- Intraoral occlusal x-rays - Limited to 2 films in any consecutive 12-month period.

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.
- Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least 12 consecutive months have passed since the existing filling 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. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.
- Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine 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.

Miscellaneous Services

Palliative (emergency) Treatment of Dental Pain - Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Class III Services - Diagnostic Procedures

Histopathologic Examinations - Payable only if the surgical biopsy is also covered under this plan.

Denture Adjustments, Rebasing and Relining

- Denture Adjustments - Only covered 1 time in any consecutive 12-month period and only if performed more than 12 consecutive months after the insertion of the denture.
- Relining Dentures, Rebasing Dentures - Limited to relining or rebasing done more than a consecutive 12-month period after the initial insertion, and then not more than one time in any consecutive 36-month period.
- Tissue Conditioning - maxillary or mandibular - Payable only if at least 12 consecutive months have elapsed since the insertion of a full or partial denture and only once in any consecutive 36-month period.

Repairs To Crowns and Inlays

- Recement Inlays - No limitation.
- Recement Crowns - No limitation.
- Repairs to Crowns - Limited to repairs performed more than 12 consecutive months after initial insertion.

Repairs To Dentures and Bridges

- Repairs to Full and Partial Dentures - Limited to repairs performed more than 12 consecutive months after initial insertion.
- Recement Fixed Partial Denture - Limited to repairs performed more than 12 consecutive months one calendar year after initial insertion.
- Fixed Partial Denture Repair, by Report - Limited to repairs performed more than 12 consecutive months after initial insertion.

Inlays, Onlays and Crowns

- Inlays and Onlays - 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 84 consecutive months have elapsed since the last placement.

- 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 84 consecutive months have elapsed since the last placement. For persons under 16 years of age, benefits for crowns on vital teeth are limited to Resin or Stainless Steel Crowns.
- Benefits for crowns are based on the amount payable for nonprecious metal substrate.
- Stainless Steel Crowns, Resin Crowns - Covered only when the tooth cannot be restored by filling and then only 1 time in a consecutive 36-month period. Limited to persons under the age of 16.
- Post and Core (in conjunction with a crown or inlay) - Covered only for endodontically treated teeth with total loss of tooth structure.

Endodontic Procedures

- Therapeutic Pulpotomy - Payable for deciduous teeth only.
- Root Canal Therapy, Primary Tooth (excluding final restoration) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Root Canal Therapy - Permanent Tooth - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Root Canal Therapy, Retreatment - by Report - Covered only if more than 24 consecutive months have passed since the original endodontic therapy and only if necessity is confirmed by professional review.
- Apexification - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. A maximum of 3 visits per tooth are payable.
- Apicoectomy - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Retrograde Filling (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Not separately payable on the same date and tooth as an Apicoectomy.
- Root Amputation (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Hemisection - Fixed bridgework replacing the extracted portion of a hemisected tooth is not covered. Procedure includes local anesthesia and routine postoperative care.

Minor Periodontal Procedures

- Periodontal Scaling and Root Planing (if not related to periodontal surgery) - Per Quadrant - Limited to 1 time per quadrant of the mouth in any consecutive 36-month period. Not separately payable if performed on the same treatment plan as prophylaxis.
- Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any consecutive 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

Major Periodontal Surgery

- Gingivectomy - Only one periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
- Gingival Flap Procedure Including Root Planing - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
- Clinical Crown Lengthening - Hard Tissue - No limitation.
- Mucogingival Surgery - Per Quadrant - only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.

- Osseous Surgery - only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
- Bone Replacement Graft - First Site Quadrant.
- Bone Replacement Graft - Each Additional Site in Quadrant.
- Guided Tissue Regeneration - Resorbable Barrier - per Site, per Tooth - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery.
- 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.

Oral Surgery - Surgical Extractions

- Surgical Extraction – (except for the removal of impacted teeth) - 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.

Other Oral Surgery

- Tooth Transplantation (includes reimplantation from one site to another and splinting and/or stabilization) - Includes an allowance for local anesthesia and routine postoperative care.
- Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption - Includes an allowance for local anesthesia and routine postoperative care.
- Biopsy of Oral Tissue, including brush biopsy technique - Includes an allowance for local anesthesia and routine postoperative care.
- Alveoloplasty - Includes an allowance for local anesthesia and routine postoperative care.
- Vestibuloplasty - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.
- Radical Excision of Reactive Inflammatory Lesions (Scar Tissue or Localized Congenital Lesions) - Includes an allowance for local anesthesia and routine postoperative care.
- Removal of Odontogenic Cyst or Tumor - Includes an allowance for local anesthesia and routine postoperative care.
- Removal of Exostosis - Maxilla or Mandible - Includes an allowance for local anesthesia and routine postoperative care.
- Incision and Drainage - Includes an allowance for local anesthesia and routine postoperative care.
- Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Facial bones - Autogenous or Nonautogenous, by Report - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.
- Frenectomy (Frenulectomy, Frenotomy), Separate Procedure - Includes an allowance for local anesthesia and routine postoperative care.
- Excision of Hyperplastic Tissue - Per Arch - Includes an allowance for local anesthesia and routine postoperative care.
- Excision of Pericoronal Gingiva - Includes an allowance for local anesthesia and routine postoperative care.

- Synthetic Graft - Mandible or Facial Bones, by Report - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

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.
- Removal of Impacted Tooth; Completely Bony, with Unusual Surgical Complications - The benefit includes an allowance for local anesthesia and routine postoperative care.

Prosthetics

- Full dentures — There are no additional benefits for personalized dentures or overdentures or associated procedures. Cigna will not pay for any denture until it is accepted by the patient. Limited to one time per arch per 84 consecutive months.
- Partial dentures — There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Cigna will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 84 consecutive months unless there is a necessary extraction of an additional functioning natural tooth.
- 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.
- Complete and partial overdentures — There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Cigna will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 84 consecutive months unless there is a necessary extraction of an additional functioning natural tooth.
- Post and core (in conjunction with a fixed bridge) — Covered only for endodontically treated teeth with total loss of tooth structure.
- Fixed Partial Dentures (Nonprecious Metal Pontics, Retainer Crowns and Metallic Retainers) - Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.
- Replacement: Benefits for the replacement of an existing bridge are payable only if the existing bridge is at least 84 consecutive months old, is not serviceable, and cannot be repaired.
- Benefits for retainer crowns and pontics are based on the amount payable for nonprecious metal substrates.
- Cast Metal Retainer for Resin Bonded Fixed Bridge - Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.
- Replacement: Benefits are based on the amount payable for nonprecious metal substrates. Benefits for the replacement of an existing resin bonded bridge are payable only if the existing resin bonded bridge is at least 84 consecutive months old, is not serviceable, and cannot be repaired.

Anesthesia and IV 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.

Each month of active treatment is a separate Dental Service.

Covered Orthodontic Treatment

- cephalometric x-rays;
- full mouth or panoramic x-rays taken in conjunction with an orthodontic treatment plan;
- diagnostic casts (i.e., study models) for orthodontic evaluation;
- surgical exposure of impacted or unerupted tooth for orthodontic purposes;
- fixed or removable orthodontic appliances for tooth movement and/or tooth guidance.

Orthodontia Provision

- The total amount payable for all expenses incurred for Orthodontics during a person's lifetime will not be more than the Orthodontia Maximum shown in The Schedule. Benefits are payable under this plan only for active Orthodontic Treatment and for the Orthodontic services on the list of Dental Services for persons on the date the Orthodontic Treatment is started.
- No benefits are payable for retention in the absence of full active Orthodontic Treatment.
- Charges will be considered, subject to other plan conditions, as follows:
 - 25% of the total case fee will be considered as being incurred on the date the initial active appliance is placed; and
 - the remainder of the total case fee will be divided by the number of months for the total treatment plan and the resulting portion will be considered to be incurred on a monthly basis until the plan maximum is paid, treatment is completed or eligibility ends. Payments will be made quarterly.

Replacement Provisions For Orthodontic Coverage

- Coverage will be provided if Orthodontic Treatment was started while a person was covered for Orthodontic benefits under the prior carrier's plan and:
 - Orthodontic Treatment is continued under this plan; and
 - proof that the Maximum Benefit under this plan was not equaled or exceeded by the benefits paid or payable under the previous plan is submitted to Cigna;
 - In this case the Maximum Benefit for a person will be calculated determining:
 - the lesser of the Maximum Benefit of this plan and the maximum benefit of the replacement plan; and
 - subtracting the benefit paid or payable by the prior plan from the amount in the bullet above. The remainder of the benefit is payable under this plan.
- In no event will a person receive more in Orthodontic benefits than the amount which would have received had the prior plan remained in effect.

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

Missing Teeth Limitation

There is no payment for replacement of teeth that are missing when a person first becomes insured.

Exclusions And Limitations: What Is Not Covered By This Policy

Expenses Not Covered

Covered Expenses do not include expenses incurred for:

- procedures 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, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- 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 alteration or restoration of occlusion.
- the restoration of teeth which have been damaged by erosion, attrition or abrasion.
- bite registration or bite analysis.
- 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 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.
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.
- core build-ups.
- replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
 - (a) replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or
 - (b) the partial denture is less than 84 consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
 - (c) replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional Necessary extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.

- 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.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (lamine).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- treatment of jaw fractures and orthognathic surgery.
- 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.
- diagnostic casts, diagnostic models, or study models.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of \$100 per consecutive 12-month period);
- 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 not specifically listed as Covered Services in this Policy.
- 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;
- charges for or in connection with experimental procedures or treatment methods. In determining whether services are experimental, Cigna in consultation with a dental consultant, will consider if such services: (a) are approved by the American Dental Association or the appropriate dental specialty society; (b) are in general use in the medical/dental field in the state of Washington; (c) are under continued scientific testing and research; (d) have shown a demonstrable benefit for a particular dental condition or disease; and (e) are proven to be safe and effective.
- 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.

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 from 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 only after the Insured Person has been fully compensated for his or her loss.

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. Our right to recover benefits provided by the plan will apply only after the Insured Person has been fully compensated for his or her loss.

THE FOLLOWING WILL APPLY TO RESIDENTS OF WASHINGTON

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

For the purposes of this section, any reference to "You," "Yourself" or "Insured Person" also refers to a representative or provider designated by You to act on your behalf, unless otherwise noted; and "Physician reviewers" are licensed Physicians or licensed Dentists depending on the care, treatment or service under review.

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

Start with Member Services

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

Customer Services Toll-Free Number or address that appears on mycigna.com,
explanation of benefits or claim form.

A "Grievance" is a written or an oral complaint submitted by or on behalf of an insured person regarding: (a) denial of health care services or payment for health care services; or (b) issues other than health care services or payment for health care services including, dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

We will do our best to resolve the matter on your initial contact.

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 involving Adverse Determinations and Noncertification. An Adverse Determination or Noncertification coverage decision is a decision by Cigna to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility.

To initiate an appeal, You must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal. If You are unable to 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 explanation of benefits or claim form. We will acknowledge in writing that we have received Your request.

Level One Appeal

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

For level one appeals, we will respond in writing with a decision within 14 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 14 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing, in this case, the decision will be made within 30 days. For appeals based on experimental treatment exclusions, the decision will be made within 20 working days of receipt of the fully documented appeal. Any extension beyond 20 working days will require Your informed written consent.

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

Level Two Appeal

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

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

For level two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 14 calendar days. For postservice claims, the Committee review will be completed within 14 calendar days. We may request additional information if needed by the Committee to complete the review. If more time or information is needed to make the determination, we will notify You in writing.

Any extension will not delay the decision beyond 30 days without Your informed written consent. In the case of appeals based on experimental treatment exclusions, Your informed written consent is needed for any extension beyond 20 working days of receipt of the fully documented appeal. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

Independent Review Procedure

If You are not fully satisfied with the decision of Cigna's level two appeal review regarding Your issue or if Cigna has exceeded the timelines without good cause and without reaching a decision, You may request that Your appeal be referred to an Independent Review Organization. You may also request that Your appeal be referred to an Independent Review Organization if Cigna does not handle Your Level One or Level Two Appeal within the timeframe described for the Level One or Level Two Appeal. 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.

To request a review, You must notify the Appeals Coordinator within 180 days of Your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to Your condition, as determined by your Physician or Dentist the review shall be completed within three days.

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

Appeal to the State of Washington

You have the right to contact the Office of the Insurance Commissioner for assistance at any time. The Commissioner may be contacted at the following telephone number:

Washington State
Office of the Insurance Commissioner
Toll-Free Number: 1-800-562-6900

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

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, 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 45 days prior to any premium due date that We do not intend to renew this Policy, including the reason for nonrenewal, or the Insured Person notifies 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, stating when, not less than five 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.

Termination Effective Date. Coverage under this Policy shall terminate at midnight of the date of termination provided in the written notice, except in the case of termination for non-payment of fees, in which case this Policy shall terminate immediately upon notice to Cigna.

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, benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement, or for an Illness that begins more than 10 days after the date of reinstatement. Otherwise, You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

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

Fraud: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Misstatement of Age or Sex: In the event the age and/or sex 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/or sex 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 the number on myCigna.com and We will provide the Insured Person with one, or visit our Web site, [www. Cigna.com](http://www.Cigna.com).
- 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.
- 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.

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. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

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.

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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.

Adverse Determination. An Adverse Determination is a decision made by Cigna Dental that it will not authorize payment for certain limited specialty care procedures. Any such decision will be based on the necessity or appropriateness of the care in question. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and must meet the following requirements. It must:

- be consistent with the symptoms, diagnosis or treatment of the condition present;
- conform to commonly accepted standards of treatment;
- not be used primarily for the convenience of the member or provider of care; and
- not exceed the scope, duration or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be Your responsibility at the dentist's Usual Fees.

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. The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on 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 or a Denturist, who is:

- operating within the scope of his license; and
- performing a Dental Service for which benefits are provided under the Policy when performed by a Dentist.

Denturist means a dental technician who fabricates and fits dentures without supervision of a Dentist and is practicing within the scope of his license.

Domestic Partner. A Domestic Partner is defined as a person who has a valid domestic partner registration in Washington.

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

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?"

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.

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 provided by a Dentist or physician 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 diagnosis, treatment and 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.

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 Contracted Fee 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 the insurance company 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 Washington.

Usual and Prevailing Charge

A charge will be considered Usual and Prevailing if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the charge made by most providers of such service or supply in the geographic area where the service is received as compiled in a database selected by Cigna.

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.