

Cigna Health and Life Insurance Company (“Cigna”)

Individual Services
P. O. Box 30365
Tampa, FL 33630
1-877-484-5967

Cigna Dental 1500

POLICY FORM NUMBER: INDDENTPOLNH0713

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Cigna Health and Life Insurance Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

A. Coverage is provided by Cigna Health and Life Insurance Company (referred to herein as “Cigna”), an insurance company that provides participating provider benefits.

B. To obtain additional information, including Provider information write to the following address or call the toll-free number:

Cigna
Individual Services – New Hampshire
P. O. Box 30365
Tampa, FL 33630
1-877-484-5967

C. A Participating Provider Plan enables the Insured to incur lower dental costs by using providers in the Cigna network.

A **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.

A **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.

D. Covered Services and Benefits

Benefits covered by your Dental Plan include Preventive & Diagnostic Care such as Oral Exams, Cleanings and X-Rays. Your Plan also includes Basic Restorative Care such as fillings and simple extractions. Major Restorative Care is covered under your plan and includes Crowns, Dentures and Bridges. For a complete listing of covered services, please read your plan documents.

The frequency of certain Covered Services, like cleanings, are limited. Refer to your Policy for specific limitations on frequency under your plan.

HC-NOT12.OOC

BENEFIT SCHEDULE

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.
HC-SOC188.OOC

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	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III Calendar Year Maximum	\$1,500 per person	
Class IV Lifetime Maximum	\$1,000 per person	
Calendar Year Deductible	\$50 per person Not Applicable to Class I	
Individual		
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	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
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

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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.

HC-DBW6.OOC

E. Insured's Financial Responsibility

The Insured is responsible for paying the monthly or quarterly premium on a timely basis. The Insured is also responsible to pay Providers for charges that are applied to the Deductibles, Coinsurance, and any amounts charged by Non-Participating Providers in excess of the Contracted Fee. In addition, any charges for Dentally Necessary items that are excluded under the Policy are the responsibility of the Insured
HC-POB50.OOC

F. 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 initial placement of a full denture or partial denture 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 a full or partial denture for benefit under this provision).
- the initial placement of a fixed bridge, unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. If a bridge replaces teeth that were missing prior to the date the person's coverage became effective and also teeth that are extracted after the person's effective date, benefits are payable only for the pontics replacing those teeth which are extracted while the person was insured under this plan. The removal of only a permanent third molar will not qualify a fixed bridge for benefit under this provision.
- 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 (laminare).
 - 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, as determined by Cigna.
 - 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.
- or or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- Procedures that are a covered expense under any other dental plan which provides dental benefits;
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna will take into account any adjustment option chosen under such part by you or any one of your Dependents.

HC-DEX24.OOC

G. Predetermination of Benefits Program

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.

HC-DEN82.OOC

H. General Provisions

For the purposes of this section, any reference to "You," "Your," or "Yourself" also refers to a representative or provider designated by You to act on Your behalf, unless otherwise noted.

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

Start with Customer 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 1-800-244-6224 and explain Your concern to one of our Customer Services representatives. You can also express that concern in writing. Please call or write us at the following:

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

We will do our best to resolve the matter on Your initial contact. If we need more time to review or investigate Your concern, we will get back to You as soon as possible but in any case within 30 days.

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

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, You must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call or write to us at the toll-free number 1-800-244-6224 or address on Your Benefit Identification Card, explanation of benefits or claim form.

Level One Appeal

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

For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a post-service coverage determination.

You have the right to proceed directly to external review if we do not issue a level one appeal decision within the stated time frames. See the provision "Independent Review Procedure" for information on how to request an external appeal.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize Your life or health or would jeopardize Your ability to regain the dental functionality that existed prior to the onset of Your current condition.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If You are not satisfied with our level-one appeal decision, You may request a level-two appeal.

Level Two Appeal

If You are dissatisfied with our level one appeal decision, You may request a second review. To initiate 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 Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Dentist reviewer. You may present Your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received Your request and schedule a committee review. For postservice claims, the committee review will be completed within 30 calendar days. You will be notified in writing of the Committee's decision within five business 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 resolution be expedited if the time frames under the above process would seriously jeopardize Your life or health or would jeopardize Your ability to regain the dental functionality that existed prior to the onset of Your current condition.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

New Hampshire law gives You the right to an external appeal when health care services are denied by Cigna on the basis that the services are not medically necessary or that the services are experimental or investigational.

What is an External Appeal?

- An external appeal is a request that You make to the state for an independent review of a denial of services by Cigna.
- Reviews are conducted by Independent Review Organizations (IROs) that are certified by the state and have a network of medical experts to review Cigna's denial of services.
- You must complete the Request for Independent External Appeal of a Health Care Decision application form, which can be obtained by calling the toll-free number 1-800-244-6224 that appears on Your Benefit identification card, and submit the application and all supporting documentation to the New Hampshire Insurance Department to request an external appeal.

Appeal to the State of New Hampshire

You have the right to contact the New Hampshire Department of Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

**New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, New Hampshire 03301
1-800-852-3416**

When is My Appeal Eligible for Independent External Review?

To be eligible for independent external review the following conditions must be met:

- The service that is the subject of the appeal request must be a covered benefit under the terms of Your health insurance policy or at least something that could be a covered benefit in some circumstances.
- You must have completed the internal appeal process provided by Your insurer and received a final decision from Your insurer. However, this requirement need not be met if Your insurer agrees in writing to submit its decision to independent external review prior to completion of internal review. In addition, if You have requested first or second level internal review and have not received a decision from Your insurer within the required time frames, You may proceed to external review without having received a decision from Your insurer on internal review.
- You must submit Your request for independent external review to the New Hampshire Insurance Department within 180 days of the date that You were first eligible to file for review. Normally, this will be the date of the health insurer's written, second-level denial decision on internal review.
- Your request for an independent external review must not be for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence, or other professional fault.

Types of Health Insurance for Which External Review is Not Available

In general, independent external review is available only for private, managed care health insurance coverage. Service denials related to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's external review law:

- Medicaid, the State Children's Health Insurance Program, Medicare, or services provided under these programs but through a contracted insurer.
- all other government-sponsored health insurance or health service programs.
- health benefit plans that are self-funded by employers.

Can Someone Else Represent Me in My External Appeal?

Yes, You may designate anyone You would like, including Your treating health care provider, to represent You. To do so, You must fill out the section of the external appeal request form entitled, "Appointment of Authorized Representative." You may also revoke this authorization at any time.

Filing the External Appeal

You, or someone acting on Your behalf with Your written consent, may request an independent external review by filling out the external appeal request form, which can be obtained by calling the toll-free number 1-800-244-6224 that appears on Your Benefit Identification card, and submitting it to the New Hampshire Insurance Department together with the required supporting documentation. There is no cost to You for an external review. Please be sure to include all of the following with Your appeal:

- a completed external appeal request form.
- a copy (if You received one) of the letter from Your health insurer denying Your request at the second and final level of the internal appeal process.

- a photocopy of Your insurance card or other evidence that You are insured by the health insurance company named in Your external appeal request form.
- a copy of Your certificate of coverage or Your insurance policy benefit booklet, which lists Your benefits.
- any medical records, statements from Your treating health care providers, or other information that You would like the independent review organization to consider in reviewing Your case.

You may call the Insurance Department at 800-852-3416 or 271-2261 if You need help with the application or if You do not have one or more of the above items and would like information on alternative ways to complete Your request for independent external review.

If You are requesting a standard appeal, send all paperwork to:

**Independent External Review
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301-7317**

If You are requesting an expedited appeal, call the Insurance Department before sending Your paperwork, and You will receive instructions on the quickest way to submit the application and supporting information.

What Is the Standard Appeal Process and Time Frame?

- Within 7 business days after receiving Your request for an independent external review, the Insurance Department will complete a preliminary review to determine whether Your request is complete and whether Your case is eligible for external review. If the request is not complete, the Insurance Department will inform You or Your representative what information or documents are needed to make the request complete and to process the request. You will have 10 days to supply the needed information or documents.
- If the request for external review is accepted, the Insurance Department will select and retain an independent review organization to conduct the review and notify You and the insurer.
- Within 10 days after receiving notice of the acceptance of the appeal, the insurer must provide the selected independent review organization and You all the information in its possession that is relevant to the appeal. You, or Your representative, will then have another 10 days to submit new or additional information to the independent review organization and the insurer if You would like. During this 10-day period, You or Your representative may also present oral testimony via teleconference to the independent review organization and the insurer. However, oral testimony will be permitted only in cases when the commissioner determines that it would not be feasible or appropriate to present only written information. If You or Your representative would like to discuss Your case with the independent review organization and Your insurer by telephone conference, You can request this by checking the appropriate box in the external appeal request form or by contacting the Insurance Department no later than 10 days after receiving notice of the acceptance of the appeal.
- At the end of this second 10-day period, the record of the case will be closed and no new information may be provided. The independent review organization will then have 20 days to review all of the information and documents received and render a decision upholding or reversing the determination of the insurer.

Expedited External Review

Because the standard process for handling external review can take over 47 days, expedited (fast-tracked) external review is available for those persons who would be significantly harmed by having to wait. You may request expedited review by checking the appropriate box on the appeal request form and by having Your treating health care provider fill out a certification form, which is attached to the appeal request form, verifying the adherence to the time frame for standard review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function. Expedited review must be completed in at most 72 hours.

If You are pursuing an internal appeal with Your insurer and anticipate that You may be requesting external review on an expedited basis, please call the Insurance Department at 800-852-3416 or 271-2261 in advance, so that accommodation can be made to receive and process Your request as quickly as possible.

What Happens When an Independent Review Organization Makes Its Decision?

If Your appeal was expedited, in most cases You and Your health insurer will be notified of the independent review organization's decision immediately by telephone or fax. Written notification will follow.

If Your appeal was not expedited, You and Your health insurer will be notified in writing.

The decision of the independent review organization is binding on the health insurer and is enforceable by the Insurance Department. The decision is binding on You as well, except that it does not prevent You from pursuing any other claim or remedy You may have under federal or state law.

If You have any questions, please contact the New Hampshire Insurance Department at 800-852-3416 or 271-2261 and ask to speak to a consumer assistant.

Additional information regarding the External Appeal process can be obtained at the New Hampshire Insurance Department web site at:

<http://www.nh.gov/insurance>

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the denial decision; (2) reference to the specific Policy provisions on which the decision is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Relevant Information

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

HC-APL200.OOC

I. Participating Providers

Cigna will provide a current list of dentists currently participating with Cigna and their locations to each Insured upon request.

To verify if a dentist is currently participating with Cigna and is accepting new Cigna Insured's, the Insured should visit our website at mycigna.com.

HC-IMP102.OOC

J. Renewability, Eligibility, and Continuation

1. The Policy will renew except for the specific events stated in the Policy. Cigna may change the premiums of the Policy with 30 days written notice to the Insured. However, Cigna will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all insured's in the same class and covered under the same Policy as You.

2. The Individual Plan is designed for residents of New Hampshire who are not enrolled under or covered by any other group or individual health coverage. You must notify Cigna of all changes that may affect any Insured Person's eligibility under the Policy.
3. You or Your Insured Family Member(s) will become ineligible for coverage:
 - 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 civil 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.
4. 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.

HC-ELG58.OOC

K. Premium

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.

HP-POL190.OOC