Cigna Health and Life Insurance Company ("Cigna")
Cigna Dental Pediatric

Schedule of Benefits (Who Pays What)

Following is a Benefit Schedule of the Policy.

The Pediatric Dental policy does not provide any dental benefits to individuals age nineteen (19) or older. This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If you want adult dental benefits, you will need to buy a plan that has adult dental benefits. This plan will not pay for any adult dental care, so you will have to pay the full price of any care you receive.
Benefits will apply until the end of the calendar year in which this limiting age is reached.

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

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

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

Benefit	Participating Providers	Non –Participating Providers
Calendar Year Maximum: Class I, II, III	None	
Calendar Year Deductible: Class I, II, III	$50 per person	
	$150 per family	
Out of Pocket Maximum: Class I, II, III	$350 per person	
	$700 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Providers	**Non –Participating Providers**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Medically necessary ortho - child, covered only for the treatment of cleft lip/cleft palate	50% after Deductible	50% after Deductible

Title Page (Cover Page)

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")

Cigna Dental Pediatric

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

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

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

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

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

Signed for Cigna by:

Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

Contact Us

You can contact Cigna at the phone number shown on your ID card, or at 1-800-Cigna24.

You can also contact Cigna at:

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

You can also get information at www.myCigna.com, including:

- Find participating providers in Your area
- View balances for Your Deductible and Out-of-Pocket Maximums
- Print an ID card
- View Your claim history

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Eligibility

Conditions Of Eligibility

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

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

- Your lawful spouse, including a partner in a civil union, or domestic partner
- Your children
- Your stepchildren
- Your own, or Your spouse's or domestic partner's children who are incapable of self-support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or domestic partner's Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, 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 any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 60 days after the date of placement for adoption or initiation of a suit of adoption, and paying any additional premium.
- A child who is placed with you for foster care, is automatically covered for 31 days from the date of placement with you for foster care. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 60 days of the date of placement with you for foster care, and pay any additional premium. Coverage for a foster child enrolled within 60 days of being placed with you for foster care will be retroactive to the date of the child's initial placement with you in foster care and paying any additional premium.
- If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 60 days after the date of the court order and paying any additional premium.

When Can I Apply?

Open Enrollment Period

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

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the

triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An individual or his or her dependent involuntarily losing existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium may apply for enrollment in a new health benefit plan during the 60 calendar days prior to the effective date of the loss of coverage;
- An individual or his or her dependent loses pregnancy-related Medicaid coverage. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage, or
- When a Marketplace enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the Marketplace enrollee, or his or her dependent dies.
- An individual or his or her dependent losing medically needy coverage as described under Section 1902(a)(10)(C) of the Social Security Act may apply, once during a calendar year, for enrollment in a new health benefit plan during the 60 calendar days prior to the effective date of the loss of coverage;
- Gaining a dependent or becoming a dependent through marriage, civil union, birth, adoption, or placement for adoption, placement in foster care, through a child support order or other court order, or by entering into a designated beneficiary agreement if the carrier offers coverage to designated beneficiaries;
- An individual's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or the Marketplace;
- Demonstrating to the Commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual;
- A qualified individual who becomes:
    - newly eligible or ineligible for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange;
    - Has a dependent enrolled in the same qualified health plan who is determined newly eligible or ineligible for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange; or
    - Is enrolled in an eligible employer-sponsored plan and is determined newly eligible for the federal advance payment tax credit based in part on a finding that such individual is ineligible for coverage in an eligible employer-sponsored plan that provides minimum creditable coverage, including as a result of his or her employer discontinuing or changing coverage within the next 60 days, provided the enrollee is able to terminate his or her existing coverage. This enrollee may apply for enrollment in a new health benefit plan during the 60 calendar days prior to the effective date of the loss of coverage.
- Gaining access to other creditable coverage as a result of a permanent change in residence;
- A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Child Health Plan Plus (CHP+);
- An individual becoming ineligible under the Colorado Medical Assistance Act;
- An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status; or
- An Indian, as defined by Section 4 of the Indian Health Care Improvement Act or their dependent on the same application, may enroll in a qualified health plan or change from one qualified health plan to another one time per month.;
- An individual or his or her dependent currently enrolled in an individual or group non-calendar year health benefit plan may apply for enrollment in a new health benefit plan during the 60 calendar days prior to the effective date of the loss of coverage, which is the last day of the plan or policy year;
- An individual or his or her dependent enrolling in a health benefit plan for the 2018 plan year may apply for enrollment in a new health benefit plan during the 2018 plan year transitional special enrollment period,;
- An individual who is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR § 1.36B-2T, including a dependent or unmarried victim within a household, who is enrolled in creditable coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;
- An individual who is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

- An individual or his or her dependent who applies for coverage during the annual open enrollment period or due to triggering event, and is assessed as potentially eligible for Medicaid or the Child Health Plan Plus (CHP+), and is determined ineligible for Medicaid or CHP+ either after open enrollment has ended or more than 60 days after the triggering or qualifying event, or applies for coverage through the State Medicaid or CHP+ agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHP+ after open enrollment has ended;
- An individual, or his or her dependent, who has purchased an off-Marketplace plan, adequately demonstrates to the Commissioner that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP; or
- An individual, or his or her dependent, who has purchased an on-Marketplace plan, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP;

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

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. When a non-qualified individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the 30 calendar days prior to the effective date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs to avoid a gap in coverage. When a qualified individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the 60 calendar days prior to the date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs to avoid a gap in coverage. A "qualified individual", means an individual who has been determined eligible to enroll through the Marketplace in a Qualified Health Plan (QHP) in the individual market.

. Persons who enroll during a special enrollment period will have coverage effective dates determined as follows:

- In the case of birth, adoption, placement for adoption, or placement in foster care, the effective date will be the date of the event or the first day of the month following the birth, adoption, placement for adoption, or placement in foster care, if requested by the Policyholder; or
- In the case of marriage, civil union, or in the case where a qualified individual loses minimum essential coverage, coverage is effective the first day of the following month;
- In the case of an involuntary loss of existing creditable coverage, coverage shall become effective either: on the first day of the month following the triggering event if plan selection is made on or before the day of the triggering event; or in accordance with the effective dates outlined in regulation, or at the option of the Marketplace, on the first day of the month following plan selection when plan selection is made after a triggering event.
- In the case of gaining a dependent or becoming a dependent through a court order, coverage shall become effective either: on the date the court order is effective; or at the election of the primary individual policyholder regarding the first and 15th of the month or 16th and last day of the month as noted below.

For all other triggering events the effective dates are:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be no later than the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be no later than the first day of the second following month.

How to Access Your Services and Obtain Approval of Benefits

About This Policy

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

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

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

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

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

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

Please Read The Following Important Notice

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

Benefits/Coverage (What is Covered)

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

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

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

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

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

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

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

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Dental PPO – Participating and Non-Participating Providers

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

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

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

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

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

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

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

Insurance coverage is only for the classes 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 call Cigna at 1.800.Cigna24 (1.800.244.6224) for details about this plan.

Covered Dental Expenses

Below, is a list of covered dental services. If a service is not listed, there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	2 per calendar year
D0140	Limited oral evaluation - problem focused	2 per calendar year
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	2 per calendar year
D0150	Comprehensive oral evaluation - new or established patient	2 per calendar year
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		

Claim Code	Description	Frequency
D0210	Intraoral - complete series (including bitewings)	1 in any 5 year period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	1 set per calendar year
D0230	Intraoral - periapical each additional film	1 set per calendar year
D0270	Bitewing - single film	1 set per calendar year
D0272	Bitewings - two films	1 set per calendar year
D0273	Bitewings - three films	1 set per calendar year
D0274	Bitewings - four films	1 set per calendar year
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year
D0330	Panoramic film	1 in any 5 year period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per calendar year (includes periodontal maintenance).
D1120	Prophylaxis - child	1 per calendar year (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	2 per calendar year
D1208	Topical application of fluoride (prophylaxis not included)	2 per calendar year
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	Unrestored permanent molar teeth only (occlusal surfaces must be intact, no caries and/or with no restorations)

SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1510	Space maintainer - fixed - unilateral	Nonorthodontic treatment for premature loss of deciduous posterior teeth
D1515	Space maintainer - fixed - bilateral	Nonorthodontic treatment for premature loss of deciduous posterior teeth
D1520	Space maintainer - removable - unilateral	Nonorthodontic treatment for premature loss of deciduous posterior teeth
D1525	Space maintainer - removable - bilateral	Nonorthodontic treatment for premature loss of deciduous posterior teeth
D1550	Re-cementation of space maintainer	Nonorthodontic treatment for premature loss of deciduous posterior teeth
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	1 per 24 consecutive month period.
D2331	Resin-based composite - two surfaces, anterior	1 per 24 consecutive month period.
D2332	Resin-based composite - three surfaces, anterior	1 per 24 consecutive month period.
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	1 per 24 consecutive month period.
D2391	Resin-based composite - one surface, posterior	1 per 24 consecutive month period.
D2392	Resin-based composite - two surfaces, posterior	1 per 24 consecutive month period.
D2393	Resin-based composite - three surfaces, posterior	1 per 24 consecutive month period.
D2394	Resin-based composite - four or more surfaces, posterior	1 per 24 consecutive month period.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**

D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	
D2931	Prefabricated stainless steel crown - permanent tooth	
D2932	Prefabricated resin crown	
D2933	Prefabricated stainless steel crown with resin window	
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7111	Extraction, coronal remnants - deciduous tooth	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	2 per calendar year
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	

D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

Waiting Periods

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

- there is no waiting period for Class I, II, III services.

Limitations/Exclusions (What is Not Covered)

Excluded Services

Covered Expenses do not include expenses incurred for:

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

General Limitations

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

- For services or supplies that are not Dentally Necessary.
- For services received before the Effective Date of coverage.
- For services received after coverage under this Policy ends.
- For services for which You have no legal obligation to pay or for which no charge would be made if You did not have dental insurance coverage.

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

Member Payment Responsibility

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

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

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

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 60 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.

Claims Procedure (How To File A Claim)

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

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

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

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

Assignment of Claim Payments:

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

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

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

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

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss. Clean claims will be paid, denied, or settled within thirty calendar days after We receive them, if submitted electronically and within forty-five calendar days after We receive them, if submitted by any other means. Absent fraud, all other claims will be paid, denied, or settled within ninety calendar days after We receive them.

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.

General Policy Provisions

Third Party Liability

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

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

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. Circumstances where the injured party has not been fully compensated is void against public policy.

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.

Termination/NonRenewal, Continuation

Specific Causes for Ineligibility

Except as described in the Continuation sub-section below, 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 "Member Payment Responsibility" section.
- With respect to Your spouse or domestic partner: 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 "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.

Appeals and Complaints

THE FOLLOWING WILL APPLY TO RESIDENTS OF COLORADO WHEN YOU HAVE A COMPLAINT OR AN APPEAL

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

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

Start with Member Services

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

Customer Services Toll-Free Number 1.800.Cigna24 (1.800.244.6224)
or address that appears on the 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 calendar days.

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

Appeals Procedure

To initiate an appeal, You must submit a request for an appeal in writing within 180 calendar days of receipt of a denial notice. You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call or write to us at the toll-free number or address on Your Benefit Identification card, explanation of benefits or claim form. You may also register Your appeal by an arranged appointment or walk-in interview.

You have the following rights: (1) to attend the Committee review in person, or via teleconference or video conference; (2) to present their situation to the Committee in person or in writing; (3) to submit supporting material both before and at the Committee review; (4) to ask questions of any Cigna representative prior to the review; and (5) to question any reviewer at the review; and (6) to be assisted or represented by a person of their choice.

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 who will consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. This extension does not apply to postservice appeals involving Medical Necessity.

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.

Standard External Review Process for Medical Necessity Adverse Decisions

If You remain dissatisfied with the decision of Cigna, You may submit a written request for External Independent Review (EIR). You have 4 months after the date of receipt of Cigna's final adverse determination to submit a written request for EIR. All requests for external review must be in writing to Cigna and must include a completed external review request form. All requests must also include a signed consent, authorizing Cigna to disclose protected health information, including medical records, pertinent to the external review.

Within two working days of receipt of Your request for EIR, Cigna will deliver a copy of Your request to the Commissioner. If we decide to reverse our final adverse determination before sending Your request to the Commissioner, we will inform You within one working day of our decision by facsimile, telephone or other electronic means, followed up in writing.

Within two working days of receiving Your request for EIR from Cigna, the Commissioner will assign an independent external review entity to conduct the external review. Upon assignment, the Commissioner will notify Cigna, electronically, by facsimile, or by telephone, followed up in writing, of the name and address of the independent external review entity to which Your appeal should be sent. Within one working day of receiving the notice from the Commissioner, we will provide You either electronically, by facsimile, or by telephone, followed up in writing, with a description of the independent external review entity and how to provide the Commissioner with documentation regarding any potential conflict of interest with the independent external review entity. Within two working days of receipt of notice from Cigna concerning the independent external review entity, You may provide the Commissioner with documentation regarding a potential conflict of interest of the independent external review entity, electronically, by facsimile, or by telephone, followed up in writing. If the Commissioner determines that the independent external review entity presents a conflict of interest, the Commissioner shall assign, within one working day, another independent external review entity to conduct the external review. Upon this reassignment, the Commissioner will notify Cigna, electronically, by facsimile, or by telephone, followed up in writing, of the name and address of the new independent external review entity to which the appeal should be sent. The Commissioner will also notify You in writing of the Commissioner's determination regarding the potential conflict of interest and the name and address of the new independent external review entity.

Within five working days from the date Cigna receives notice from the Commissioner regarding the selection of the independent external review entity, we will deliver the following to the assigned independent external review entity: (1) all relevant medical records; (2) a copy of any and all denial letters; (3) a copy of the signed consent form; (4) all documentation provided to Cigna by You and/or a health care professional in support of Your request for coverage; (5) criteria used and clinical reasons for the adverse decision; and (6) an index of all submitted documents. Within two working days of receipt of the material from Cigna, the independent external review entity will deliver to You the index of all materials that Cigna has submitted to the independent external review entity. We will provide You, upon request, all relevant information supplied to the independent external review entity that is not confidential or privileged under state or federal law.

The independent external review entity will notify, You or Your health care professional and Cigna of any additional medical information required to conduct the review. Within five working days of such a request, You or Your health care professional will submit the additional information, or an explanation of why the additional information is not being submitted to the independent external review entity and Cigna. If You or Your health care professional fails to provide the additional information or the explanation of why additional information is not being submitted within five working days, the independent external review entity will make a decision based on the information submitted by Cigna. If Cigna fails to provide the required documents and information within five working days, the independent external review entity may terminate the external review and make a decision to reverse Cigna's final adverse determination. Immediately upon the reversal, the independent external review entity will notify You, Cigna and the Commissioner.

Upon receipt of any new information from You, Cigna may reconsider its final adverse determination that is the subject of the external review. The external review may only be terminated if Cigna decides to reverse its final adverse determination and provide coverage or payment for the health care service that was denied. Within one working day of Cigna making the decision to reverse its final adverse determination, Cigna will notify You, the independent external review, and the Commissioner of its decision, electronically, by facsimile, or by telephone, followed up in writing. The independent external review entity will terminate the external review upon receipt of the notice from Cigna.

Within 45 calendar days after the date of receipt of the request of the external review by Cigna, the independent external review entity will provide written notice of its decision to uphold or reverse Cigna's final adverse determination to You, if applicable, to Your designated representative, to Cigna, to Your Dentist and to the Commissioner. The independent external review entity may request that the Commissioner extend the deadline for the written notice of the decision for up to 10 working days. The independent external review entity's final decision will be binding for both You and Cigna.

Upon our receipt of the independent external review entity's notice of the decision reversing our final adverse determination, we will approve the coverage that was the subject of the final adverse determination. For postservice review, we will approve the coverage within five working days. We will provide written notice of the

approval to You within one working day of our approval of coverage. The coverage will be provided subject to the terms and conditions applicable to benefits under the plan.

Appeal to the State of Colorado

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

Colorado Division of Insurance
Department of Regulatory Affairs
1560 Broadway, Suite 850
Denver, CO 80202
1-800-930-3745

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.

Information on Policy and Rate Changes

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

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

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Policy Provisions", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums by the end of the grace period applicable to you. Please see “Grace Period” provision for further information regarding grace periods.
2. On the first of the month following Our receipt of Your written notice to cancel. If You purchased Your plan on a state exchange, We will cancel this Policy in accordance with Your written notice to cancel provided You provide notice at least fourteen days before the requested effective date of termination. If You provide Your written notice to cancel less than fourteen days before the requested date of termination, the effective date of termination will be no later than fourteen days after You provided the written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception, or intentional misrepresentation of a material fact in connection with this Policy or coverage with 30 days prior notice.
5. When We cease to offer policies of this type to all individuals in Your class, Colorado law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation, and (3) act uniformly without regard to any health status related factors of an Insured Person of a covered individual who may become eligible for the coverage.
6. When We cease offering all dental plans in the individual market in Colorado in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation. Your coverage will be continued through Your first renewal period but not more than 12 months after We send you the notice.
7. When the Insured no longer lives in the Service Area.

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

Modification of Coverage: We reserve the right to modify this policy, including Policy provisions, benefits and coverages, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same Policy form. We will only modify this Policy for all Insured Persons in the same class and covered under the same Policy form, and not just on an individual basis. We will send 60 days written notice and the change will become effective on the date shown in the notice or on the next scheduled premium due date thereafter. Payment of the premiums will indicate acceptance of the change.

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

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

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

Exception for Insured Persons deployed or called to Active Duty in the United States military: Upon application for reinstatement, We will provide the Policyholder deployed by or called to active duty in the military the same benefits in effect before the policy lapsed. Premium will not be increased unless rate increases are applicable to all Policyholders.

Renewal: This Policy renews on a Calendar Year basis.

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

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

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

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

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

- The Insured Person(s) are the only persons entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.
- The Effective Date of this Policy is printed on the Policy specification page.
- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

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

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

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

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

Definitions

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

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

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

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

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

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

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

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

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

Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the dental services described in the policy.

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

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

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

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the "Schedule of Benefits (Who Pays What)" section of this Policy.

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

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

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the "Schedule of Benefits (Who Pays What)" section of this Policy.

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

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

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

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

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

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

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

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

Newborn is an infant within 31 days of birth.

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

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

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

Policy is the set of benefits, conditions, exclusions, limitations, and premiums described in this document, including the Policy specification page, the completed and accepted application for coverage , 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 Colorado.

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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