Cigna Health and Life Insurance Company may change the premiums of this Policy after 40 days 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")

900 Cottage Grove Road, Bloomfield, CT 06002

myCigna Dental 1500 Plan

If You Wish To Cancel Or If You Have Questions

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

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

Include Your Cigna identification number with any correspondence. This number can be found by accessing myCigna.com.

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health and Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. If You know of any misstatement in Your application You should advise the Company immediately regarding the incorrect or omitted information; otherwise, Your Policy may not be a valid contract.

This policy is not a Medicare supplement policy. It is not designed to fill the 'gaps' of Medicare. If you are eligible for Medicare, review the Medicare supplement buyer's guide available from the company.

Conditionally Renewable

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

Signed for Cigna by:

Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

HC-NOT34

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Introduction

About This Policy

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

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

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

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

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

Choice of Dentist: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Dentist of their choice. You may pay more for Covered Services, however, if the Insured Person receives them from a Dentist that is a Non-Participating Provider.
HC-SPP14

PLEASE READ THE FOLLOWING IMPORTANT NOTICE:

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

Important Information Regarding Benefits

Referral For Services by a Non-Participating Specialist or Nonphysician Specialist

You may receive a referral to a non-participating specialist or nonphysician specialist if (a) You are diagnosed with a condition or disease that requires specialized health care services or medical care; (b) we do not have a participating specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or (c) we cannot provide reasonable access to a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. Any deductible, copayment or coinsurance applicable to the services for which the referral is requested will be calculated as if the services were received from a Participating Provider. The term "nonphysician specialist" means a health care provider who is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of his license or certification.

HC-IMP134

How to File a Claim for Benefits

Notice of Claim: Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Us at the address shown on the first page of this Policy or by accessing myCigna.com or to an insurance producer authorized by Cigna.. Notice should include the name of the Insured, and claimant if other than the Insured, and the Policy identification number.

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

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

Proof of Loss: If this policy provides periodic payments for a continuing treatment, You must give Us written proof of loss within 90 days of the end of the period of treatment. For all other claims, written proof of loss is due within 90 days after the date of the loss. Proof of loss is a claim form or letter as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period. Failure to furnish proof within the time allowed shall not cancel or reduce any claim if it can be shown that proof was furnished as soon as it was reasonably possible, and in no event, except in the absence of legal capacity, less than one year from the time proof is otherwise required.

Assignment of Claim Payments:

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

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

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

Payment for services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating Provider is responsible for filing the claim and We will make payments to the Provider for any benefits payable under this Policy. Payment for services provided by a Non-Participating Provider are payable to the Insured Person unless assignment is made as above. We may refuse to directly reimburse a Non-Participating Provider under an assignment of benefits if:

1. We receive notice of the assignment of benefits after the time We have paid the benefits to the Insured Person;
2. if, due to an inadvertent administrative error, We have previously paid the Insured Person;
3. the Insured Person withdraws the assignment of benefits before We pay the benefits to the Non-Participating Provider; or
4. the Insured Person paid the Non-Participating Provider the full amount due at the time of service.

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: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

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.
HC-CLM69

Who Is Eligible For Coverage

Conditions Of Eligibility

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

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

- Your lawful spouse or domestic partner or partner to a civil union.
- Your own or your domestic partner's children who have not yet reached age 26.
- Your own or your domestic partner's stepchildren who have not yet reached age 26.
- Your own, or Your spouse's or domestic partner's or Your partner to a civil union's children, regardless of age, enrolled prior to age 26, who are incapable of self support due to mental or physical incapacity and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such condition and dependency within 31 days after the child's 26th birthday. 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 or Your partner to a civil union's Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- Your own or your domestic partner's Newborn grandchild will be automatically covered for the first 31 days of life if this grandchild is in your court-ordered custody and resides with you. To continue coverage, You must notify Cigna within 31 days of the Newborn grandchild's date of birth that You wish to have the Newborn grandchild added as an Insured Family Member, and pay any additional premium required.
- Your own or your domestic partner's adopted child or grandchild, 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 31 days after the date of placement for adoption or initiation of a suit of adoption, and paying any additional premium.
- A child who is who is under Your or your domestic partner's testamentary or court-ordered guardianship (other than temporary guardianship of less than 12 months duration) is automatically covered for 31 days from the date of appointment. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of court or testamentary appointment, 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 31 days after the date of the court order and paying any additional premium.

Specific Causes for Ineligibility

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

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

Except as described in the Continuation section, an Insured Person **will become ineligible for coverage** under the Policy:

- When premiums are not paid according to the due dates and grace periods described in the premium section.
- With respect to Your spouse or domestic partner or partner to a civil union: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates, subject to the Dental Benefits Extension provision.
- 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.

HC-ELG84

BENEFIT SCHEDULE

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

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.
HC-SOC186

CIGNA DENTAL PREFERRED PROVIDER INSURANCE ***The Schedule***
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 Expenses each Insured Person must incur before becoming eligible for Covered Services available under the Policy.
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	CONTRACTING PROVIDER	NON-CONTRACTING PROVIDER
Classes I, II, III Calendar Year Maximum	$1,500 per person	
Class IV Lifetime Maximum	$1,000 per person	
Calendar Year Deductible Individual	$50 per person Not Applicable to Class I	
Family Maximum	$150 per family Not Applicable to Class I	
Lifetime Class IV Deductible	$50 per person	
Class I	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Preventive Care Oral Exams Routine Cleanings Routine X-rays Non-Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic) Emergency Care to Relieve Pain	100% no deductible	100% no deductible
Class II	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Basic Restorative Fillings Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, Simple Extractions Surgical Extraction of Impacted Teeth Anesthetics	80% after plan deductible	80% after plan deductible

BENEFIT HIGHLIGHTS	CONTRACTING PROVIDER	NON-CONTRACTING PROVIDER
Class III	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Major Restorative Crowns / Inlays / Onlays Oral Surgery, All Except Simple Extractions Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures 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

HC-SOC245

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-DBW13

Covered Dental Expense: What The Policy Pays For

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

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

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

Alternate Benefit Provision

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

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

Predetermination of Benefits

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

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

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

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

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

Covered Services

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

Dental PPO – Participating and Non-Participating Providers

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

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

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

The covered person is responsible for the balance of the provider's actual charge. . As an exception, for charges made by an on-call dentist who has accepted and assignment of benefits, the covered person is responsible for the balance of the Contracted Fee.
HC-DEN144

Class I Services – Diagnostic And Preventive

- Clinical oral examination – Only 1 per person per calendar year.
- Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)
- X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 60 consecutive months**.**
- Bitewing x-rays – Only 2 charges per person per 12 consecutive months.
- Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 1 per person per calendar year.
- Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 14 years old. Only 1 per person per calendar year.
- Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old – Only 1 treatment per tooth in any 3 consecutive years.
- Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN126

Class II Services – Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance And Oral Surgery

- Amalgam Filling
- Composite/Resin Filling
- Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.
- Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.
- Periodontal Scaling and Root Planing – Entire Mouth
- Adjustments – Complete Denture
- Any adjustment of or repair to a denture within 12 months of its installation is not a separate Dental Service.
- Recement Bridge
- Routine Extractions

- Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth
- Removal of Impacted Tooth, Soft Tissue
- Removal of Impacted Tooth, Partially Bony
- Removal of Impacted Tooth, Completely Bony
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- I. V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

HC-DEN127

Class III Services - Major Restorations, Dentures and Bridgework

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

- Porcelain Fused to High Noble Metal
- Full Cast, High Noble Metal
- Three-Fourths Cast, Metallic
- Removable Appliances
- Complete (Full) Dentures, Upper or Lower

Partial Dentures

- Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
- Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

- Bridge Pontics - Cast High Noble Metal
- Bridge Pontics - Porcelain Fused to High Noble Metal
- Bridge Pontics - Resin with High Noble Metal
- Retainer Crowns - Resin with High Noble Metal
- Retainer Crowns - Porcelain Fused to High Noble Metal
- Retainer Crowns - Full Cast High Noble Metal

HC-DEN128

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

- Covered Expenses include:
- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.

- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.
- The total amount payable for all expenses incurred for Orthodontics during a person's lifetime will not be more than the Orthodontia Maximum shown in the Schedule.
- Payments for comprehensive full-banded Orthodontic treatment are made in monthly installments, subject to due written proof of loss. Any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. Payments are only made for services provided while a person is insured.

HC-DEN129

Missing Teeth Limitation

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

This payment limitation no longer applies after 12 months of continuous coverage.

HC-MTL14

Exclusions And Limitations: What Is Not Covered By This Policy

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- Services performed solely for cosmetic reasons.
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- for healthcare services determined to be furnished as a result of a referral prohibited by Maryland statutes;
- 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, subject to the Dental Benefits Extension provision.
- 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. This exclusion will not apply to the treatment of any illness covered under this policy if it is received in a hospital or other institution of the State or of a county or municipal corporation of the State, whether or not the hospital or other institution is deemed charitable.
- 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 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;
- 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.

HC-DEX31

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, reduced by a pro rata share of the court costs and legal fees incurred by the insured which are applicable to the portion of the settlement returned to the insurance company. 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. Any amount refunded to the insurance company will be reduced by a pro rata share of the court costs and legal fees incurred by the insured which are applicable to the portion of the settlement returned to the insurance company.
HC-SUB53

Dental Benefits Extension

Benefits for Covered Expenses incurred in connection with a Dental Service, except orthodontia, will be extended for 90 days after the date a person's coverage terminates. Covered Expenses will be deemed to be incurred while he or she is insured if the treatment:

- begins before the date coverage terminates; and
- requires two or more visits on separate days to a Dentist’s office.

If the plan covers orthodontia, benefits will be extended until the later of 60 days after the date coverage terminates or the end of the quarter in progress.
HC-BEX45

When You Have a Complaint an Appeal or a Grievance

Definitions

Adverse Decision
An Adverse Decision is a utilization review determination by Cigna or a Private review agent that: (a) a proposed or delivered Health Care Service covered under the insured's contract is or was not Medically Necessary, appropriate, or efficient; and (b) may result in noncoverage of the Health Care Service.

Appeal
An Appeal is a protest filed by an Insured, an Insured Person's representative or a health care provider with Cigna under its internal Appeal process regarding a Coverage Decision concerning an insured.

Appeal Decision
An Appeal Decision is a final determination by Cigna that arises from an Appeal filed with Cigna under its Appeal process regarding a Coverage Decision concerning an insured.

Compelling Reason
A compelling reason includes showing that the potential delay in receipt of a health care service until after the insured or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the insured remaining seriously mentally ill with symptoms that cause the insured to be in danger to self or others.

Complaint
A Complaint is (1) a protest filed with the Maryland Insurance Commissioner involving an Adverse Decision or Grievance Decision concerning the insured; or (2) a protest filed with the Commissioner involving a Coverage Decision.

Emergency Case
An Emergency Case is a case involving an Adverse Decision for which an expedited review is required. An expedited review may be requested if: (1) an Adverse Decision is rendered for services that are proposed, but have not yet been rendered; and (2) the time frames under this process would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function or would cause You to be a danger to self or others.

Grievance
A Grievance is a protest by an insured, an Insured Person's representative or a health care provider on behalf of the insured filed with Cigna through its internal grievance process regarding an Adverse Decision concerning the insured.

Grievance Decision
A Grievance Decision by Cigna is a final determination that arises from a Grievance regarding an Adverse Decision concerning the insured, which was filed with Cigna under its internal grievance process.

Health Care Provider
A Health Care Provider means: (a) an individual who is licensed under the Maryland Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession, and is a treating provider of the insured; or (b) a hospital, as defined by Maryland law. The term Health Care Provider includes a nonphysician specialist who is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of his license or certification.

Health Care Service
A Health Care Service is a health or medical care procedure or service rendered by a health care provider that: (a) provides testing, diagnosis, or treatment of a human disease or dysfunction; or (b) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

Medically Necessary/Medical Necessity
Medically Necessary/Medical Necessity refer to Health Care Services and supplies which are determined by Cigna to be: (a) medically required to meet the basic health needs of the insured; (b) consistent with the diagnosis of the condition; (c) consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; (d) required for purposes other than the comfort and convenience of the patient or his Physician; and (e) of demonstrated medical value.

Any services precertified by the Review Organization will be deemed Medically Necessary.

Private review agent
Private review agent means: (1) a nonhospital-affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of: (i) a Maryland business entity; or (ii) a third party that pays for, provides, or administers health care services to citizens of this State; or (2) any person or entity including a hospital-affiliated person performing utilization review for the purpose of making claims or payment decisions for health care services on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees employed by: (i) the hospital; or (ii) a business wholly owned by the hospital.

When You Have a Complaint, an Appeal or a Grievance

For the purposes of this section, any reference to "You," "Your" or "Yourself" also refers to a representative or Your treating provider designated by You to act on Your behalf; and licensed Dentists depending on the care, treatment or service under review.

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

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

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

Quality of Care Issues
Quality of care issues include the following: (a) malpractice allegation; (b) negative patient outcomes related to poor care; (c) failure to follow up on diagnostic procedures; (d) failure to provide treatment for presenting complaints consistent with standard of care; (e) failure to appropriately document medical records; (f) confidentiality and privacy issues related to medical records or care; (g) dissatisfaction of providers; (h) qualifications of providers; (i) misdiagnosis; (j) inappropriate referrals; (k) environmental issues related to infection control and hazardous medical waste; (l) failure of a provider to perform adequate medical screening, assessments, or emergency care; (m) failure to provide an adequate internal insured Complaint process concerning quality of care issues; (n) failure to comply with policies and procedures concerning delivery of care; (o) inadequate credentialing and performance appraisal for Physician or Dentists; and (p) denial of Health Care Service benefits by Cigna.

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, such as a Claim denial or other adverse determination You can start the Administrative Appeals Procedure or Medical Necessity Grievance Procedure.

Internal Appeals and Grievance Procedure
Cigna has a one-step Appeals and Grievance Procedure for Coverage Decisions and decisions involving Medical Necessity. To initiate an Administrative Appeal or Medical Necessity Grievance, You must submit a written request for an Appeal or Grievance to the address that appears on mycigna.com, explanation of benefits or claim form within 365 days of receipt of a denial notice. For decisions involving Medical Necessity, a denial notice is the same as an Adverse Decision. Notice of an Adverse Decision must be sent by us within five working days after the decision is made. You should state the reason why You feel Your Appeal or Grievance should be approved and include any information supporting Your Appeal or Grievance. If You are unable or choose not to write, You may ask to register Your Appeal or Grievance by calling the toll-free number on mycigna.com, explanation of benefits or claim form. If we determine that we do not have sufficient information to complete our review, You will be notified within 5 working days after the Filing Date of Your Grievance and will be assisted by us in gathering the necessary information.

Filing Date means the earlier of (a) 5 days after the date of mailing or (b) the date of receipt.

Medical Necessity Grievance Procedure
Your request to reconsider an Adverse Decision will be reviewed and the decision made by someone not involved in the initial decision. Grievances involving Medical Necessity will be considered by a Dentist reviewer who is board certified or eligible in the same specialty as the treatment under review. The Dental Director who has responsibility for oversight of grievance decisions is:

Clay Hedland, DDS
Cigna HealthCare
1640 Dallas Parkway
Plano, TX 75093
(972) 863-5021

We will make a decision and will notify You verbally prior to notification in writing of our decision, both within 30 working days of the Filing Date of Your Grievance request, unless You agree in writing to an extension for a period of no longer than 15 calendar days. In no case will written notice of the Grievance decision be sent later than five working days after the Grievance decision has been made.

Decisions involving a Grievance request in connection with a retrospective denial will be made within 45 working days after the date on which the Grievance is filed. The decision will be communicated to You in writing and the notice will be sent within 5 working days after the decision has been made.

In the case of an expedited review for an Emergency Case, we will respond verbally with a decision within 24 hours of the date the grievance was filed, followed up in writing within 1 calendar day of the verbal response. The written notice will state the specific factual bases for Cigna's decision.

Administrative Appeal Procedure
Your request to reconsider a Coverage Decision will be reviewed and the decision made by someone not involved in the initial decision. We will make a final Appeal Decision and will notify You in writing of our decision, both within 30 calendar days of Your request. 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.

APPEALS TO THE STATE OF MARYLAND
MEDICAL NECESSITY GRIEVANCE
If You are not fully satisfied with the final decision of Cigna's Grievance review regarding Your Medical Necessity issue, You have the right within 4 months after receipt of Cigna's grievance decision, to file a Complaint with the Maryland Insurance Commissioner. The Complaint may be filed without first filing a Grievance if (1) Cigna waives the requirement that the internal process be exhausted; or (2) Cigna failed to comply with ANY of the internal grievance process requirements described on the form (3) You can demonstrate to the Commissioner a compelling reason to do so. You may also file a Complaint with the Commissioner if we fail to make a decision on a Medical Necessity Grievance within the required time frames, including if a Grievance decision is not received within 24 hours for an Expedited Medical Necessity Grievance. The Commissioner may be contacted at the following address, telephone number, and fax number:

Maryland Insurance Administration
Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone Number:
410-468-2000 or 1-800-492-6116
Fax Number: 410-468-2270

The Health Advocacy Unit is available to assist You in both mediating and filing a Grievance under our internal Grievance process. You may contact the Health Advocacy Unit of Maryland's Consumer Protection at:

Office of the Attorney General
Consumer Protection Division
200 St. Paul Place, 16th Floor
Baltimore, MD 21202

The Unit can also be reached by calling 410-528-1840 or 1-877-261-8807 (phone) or 410-576-6571 (fax) or by e-mail heau@oag.state.md.us .

Administrative or Other Appeals
If You are not satisfied with the final Appeal Decision, You have the right within 4 months to file a complaint with the Maryland Insurance Commissioner. The Administration may be contacted at the following address and telephone number:

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone Number: 410-468-2000

The Complaint may be filed with the Commissioner without first filing an Appeal, and receiving a final decision if: the complaint is the subject of an initial Coverage Decision that involves care which has not yet been rendered, and You give sufficient information and supporting documentation in the complaint that demonstrates an Urgent Medical Condition exists.

If a case involves a retrospective denial, an Urgent Medical Condition that would allow You to file a complaint is not deemed to exist unless You have first exhausted Cigna's internal appeal process.

Coverage Decision means (1) an initial determination by us that results in noncoverage of a Health Care Service. (2) a determination by us that an individual is not eligible for coverage under Cigna's health benefit plan; or (3) any determination by us that results in the recission of an individual's coverage under a health benefit plan.

This includes nonpayment of all or any part of a claim. Coverage Decision does not include decisions based on Medical Necessity.

Urgent Medical Condition means a condition that satisfies either of the following:

a. medical condition, including a physical condition, mental condition, or a dental condition where the absence of medical attention within 72 hours could reasonably be expected, by a prudent layperson who possesses an average knowledge of health and medicine, to result in:
   (1) serious jeopardy to Your life or health;
   (2) Your inability to regain maximum function;
   (3) serious impairment to bodily functions;
   (4) serious dysfunction of any bodily organ or part; or
   (5) You remaining seriously mentally ill with symptoms that cause You to be a danger to self or others; or

b. medical condition, including a physical condition, mental condition, or a dental condition where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without care or treatment that is the subject of the Coverage Decision.

The Health Advocacy Unit is available to assist You in both mediating and filing an Appeal under our internal Appeal process. You may contact the Health Advocacy Unit of Maryland's Consumer Protection at:

Office of the Attorney General
Consumer Protection Division
200 St. Paul Place, 16th Floor
Baltimore, MD 21202

The Unit can also be reached by calling 410-528-1840 or 1-877-261-8807 (phone) or 410-576-6571 (fax) or by e-mail at heau@oag.state.md.us .

Adverse Decision Notice
We will provide oral communication of an adverse decision to the Insured, the Insured's representative or the health care provider, acting on behalf of the Insured. Notice of an adverse decision will be provided in writing or electronically within 5 business days after the adverse decision is made.

It will state in detail in clear, understandable language the specific factual basis for the decision, including:

(1) the specific criteria and standards, including interpretive guidelines on which the decision is based;

(2) the name, business address, and business telephone number of the Dental Director who has responsibility for oversight of the internal grievance decisions;

(3) details of Our grievance process and procedures;

(4) notice of the right of the Insured, Person or the Insured Person's representative or a health care provider on behalf of the Insured to submit a complaint with the Commissioner within 4 months after receipt of a grievance decision;

(5) notice of the right of the Insured Person, the Insured Person's representative or a health care provider to submit a complaint with the Commissioner without first filing a grievance;

(6) the Commissioner's address, telephone number and fax number;

(7) a statement that the Health Advocacy Unit is available to assist the Insured Person or the Insured Person's representative in mediating and filing a grievance under Our internal grievance process;

(8) the address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit

(9) 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;

(10) 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.

Grievance Decision Notice. We will provide oral communication of a grievance decision to the Insured, the Insured's representative, or the health care provider acting on behalf of the Insured. Notice of a grievance decision will be provided in writing or electronically within 5 business days after the grievance decision is made,

It will state in clear, understandable language the specific factual bases for the decision;

(1) the specific criteria and standards, including interpretive guidelines on which the grievance decision is based;

(2) the name, business address, and business telephone number of the Dental Director who has responsibility for oversight of the internal grievance process

(3) notice of the right of the Insured Person or the Insured Person's representative to submit a complaint with the Commissioner within 4 months after receipt of a grievance decision;

(4) the Commissioner's address, telephone number and fax number;

(5) a statement that the Health Advocacy Unit is available to assist the Insured Person or the Insured Person's representative filing a complaint with the Commissioner;

(6) the address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit

(7) 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;

(8) 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.

When filing a complaint with the Commissioner, the Insured Person or the Insured Person's representative will be required to authorize the release of any medical records of the Insured Person that may be required to be reviewed for the purpose of reaching a decision on the complaint.
HC-APL190

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an Officer of Cigna and unless such approval is endorsed on or 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.
- no claim for loss incurred will be reduced or denied on the grounds that a disease or physical condition had existed prior to the effective date of coverage under this policy, unless such disease or physical condition was excluded from coverage by name or specific description on the date of loss.

Grace Period: There is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. If You fail to pay Your premium by the end of the 31 day grace period, termination will occur on the last day of the grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have knowingly or willfully committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Maryland 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; and (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.
6. When We cease offering all dental plans in the individual market in Maryland in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area.

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

Termination Effective Date: Coverage under this Policy shall terminate at midnight of the date of termination provided in the written notice.

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

Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by Cigna or by any insurance producer duly authorized by Cigna to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if Cigna or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by Cigna or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless Cigna has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Fraud: If the Insured Person has knowingly or willfully committed, or allowed someone else to commit, any fraud or deception in connection with the application for coverage under this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect as of the date the fraudulent act was committed.

Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

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.

Change of Beneficiary: The right to change a beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

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

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

- The Insured Person(s) are the only persons entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.
- The Effective Date of this Policy is printed on the Policy specification page.
- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna

Individual Services

P. O. Box 30365

Tampa, FL 33630-3365

- When the amount paid by Cigna exceeds the amount for which We are liable under this Policy, We have the right to recover the excess amount from the Insured Person unless prohibited by law.
- In order for an Insured Person to be entitled to benefits under this Policy, coverage under this Policy must be in effect on the date the expense giving rise to a claim for benefits is incurred, subject to the Dental Benefits Extension Provision. Under this Policy, an expense is incurred on the date the Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured Person assigns benefits in writing no later than the time of filing proof of loss (claim), except for Foreign Country Provider claims. If We receive a claim from a Foreign Country Provider for Emergency Services, any eligible payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured Person for those services.
- Any payment of benefits in reimbursement for Covered Expenses paid by an eligible child, or the eligible child's custodial parent or legal guardian, will be made to the eligible child, the eligible child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the eligible child.
- Cigna will provide written notice to You within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at the number on myCigna.com and We will provide the Insured Person with one, or visit our Web site, www. Cigna.com.
- Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.
- If an insured person has coverage that provides the same benefits under this policy with another carrier (of which Cigna has not received written notice of the loss prior to the occurrence), the only liability Cigna shall be responsible for is the amount which otherwise would have been payable under this policy. Payment will never exceed the total of the incurred expenses or the maximums shown in the schedule.
- Failure by Cigna to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.
- If Insured Person(s) were covered by a prior Individual Cigna Policy that is replaced by this Policy with no lapse of coverage:
    - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Premiums:

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals who pay monthly. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

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

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

Written notice of any increase in premium will be sent to You at least 40 days prior to the increase. These changes will be effective on the date stated on Your premium notice.

Cigna also reserves the right to change the premium on 40 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-POL250

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.
HC-DFS556

Calendar Year is a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time.
HC-DFS519

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.
HC-DFS521

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.
HC-DFS522

Contracted Fee. The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Insured Person, according to the Insured Person's dental benefit plan.
HC-DFS523

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.
HC-DFS525

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.
HC-DFS526

Deductible means the expenses each Insured Person must incur before becoming eligible for Covered Services available under the Policy.
HC-DFS661

Dental Prostheses are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.
HC-DFS528

Dentist. The term 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.
HC-DFS530

Effective Date is the date on which coverage under this Policy begins for You and any of Your Family Member(s).
HC-DFS531

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"
HC-DFS533

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.
HC-DFS535

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.
HC-DFS536

Insured Means the applicant who has applied for, been accepted for coverage, and who is named as the Insured on the specification page.
HC-DFS537

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.
HC-DFS538

Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.
HC-DFS541

Medically Necessary and/or Dentally Necessary
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.
HC-DFS542

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).
HC-DFS544

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.
HC-DFS545

Newborn is an infant within 31 days of birth.
HC-DFS546

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.
HC-DFS548

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.
HC-DFS547

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.
HC-DFS549

Policy is the set of benefits, conditions, exclusions, limitations, and premiums described in this document, including the Policy specification page, the completed and accepted application for coverage attached to this Policy, and any amendments or endorsements to this document.
HC-DFS550

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.
HC-DFS552

Service Area is any place that is within the state of Maryland.
HC-DFS553

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.
HC-DFS555