Mailing Address: 900 Cottage Grove Rd.
Bloomfield, Connecticut 06002
Home Office: Bloomfield, Connecticut

Cigna Health and Life Insurance Company ("Cigna")

Cigna Dental 1500 Plan

If You Wish To Cancel Or If You Have Questions

If You are not satisfied, for any reason, with the terms of this Policy You may return it to Cigna within 10 days of receipt. Cigna 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 Cigna for this or any other reason, write:

Cigna
Individual Services
P. O. Box30365
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 IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare 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.

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

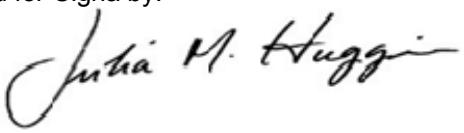
1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. If You have committed, any act or practice that constitutes fraud, or made an intentional misrepresentation of material fact in connection with this Policy or coverage.
3. When Cigna ceases to offer policies of this type to all individuals in Your class, Virginia 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 Cigna at the time of discontinuation; and (3) act uniformly without regard to any health status-related factor of an Insured Person of a covered individual who may become eligible for the coverage.
4. When Cigna ceases offering all dental plans in the individual market in Virginia in accordance with applicable law, Cigna will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.

Cigna Health and Life Insurance Company may change the premiums of this Policy after 60 day's written notice to the Insured Person. However, Cigna 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.

THIS POLICY DOES NOT PAY FOR ANY MEDICAL SERVICES.
IT PROVIDES FOR CERTAIN DENTAL SERVICES ONLY.

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:



Julia H. Huggins, President

Anna Krishtul, Corporate Secretary-

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Introduction

About This Policy

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

Under this Policy, "You" or "Your" refers to the policyholder whose application has been accepted by Cigna under the Policy issued. When Cigna uses the term "Insured Person" in this Policy, Cigna means 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 Cigna 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.

Cigna will provide the services and benefits listed in this Policy to You and Your Family Member(s) covered under the Policy.

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

Important Information Regarding Benefits

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

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

Cigna recommends that You familiarize Yourself with our grievance procedure, and make use of it before taking any other action.

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218-1157
1-800-552-7945 (toll free in Virginia) or 1-877-310-6560 (toll-free nationwide)

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your Policy number available.

NOTICE: This company is subject to regulation in the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.

PAYOR OF LAST RESORT– the Department of Medical Assistance Services, which administers Virginia's Medicaid Program, is the payor of last resort. Please note that Cigna will not exclude enrolling an individual or withhold payments for benefits to an Insured or on the Insured's behalf for dental care covered under the Policy because the Insured is eligible for medical assistance under Medicaid.

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 Cigna at the address shown on the first page of this Policy or by accessing myCigna.com. Notice should include the name of the Insured, and claimant if other than the Insured, and the Policy identification number.

Unpaid Premiums: At the time of payment of a claim under this Policy, any premiums then due and unpaid may be deducted from the payment.

Claim Forms: When Cigna receives the notice of claim, Cigna 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: Written proof of loss must be given to Cigna within 90 days after the end of each period for which the Company is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, the Company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

Assignment of Claim Payments:

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

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

Cigna assumes 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 Cigna will make payments to the Provider for any benefits payable under this Policy.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Cigna to do otherwise prior to Cigna's payment. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or the Insured's estate.

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 Cigna's payment to the Insured Person will be considered fulfillment of Cigna's obligation.

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 reasonably as Necessary during the pendency of a claim under this Policy.

Change of Beneficiary: The Insured can change the beneficiary at any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the Policy, unless the designation of the beneficiary is irrevocable.

Who Is Eligible For Coverage

Conditions Of Eligibility

This Policy is for residents of the state of Virginia. The Insured must notify Cigna 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 Cigna. Other Insured Persons may include the following Family Member(s):

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, or Your spouse's or domestic partner children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing intellectual or physical handicap and are chiefly dependent upon the Insured for support and maintenance. Cigna may require written proof of such disability 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 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 Newborn grandchild will be automatically covered for the first 31 days of life if this grandchild is Your dependent for Federal Income Tax purposes at the time of application. 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.
- An adopted child, including a child who is placed with You for adoption, is automatically covered for 31 days from the date of adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of adoption or initiation of a suit of adoption, 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, any direct or indirect affiliate of Cigna, and his or her enrollment was terminated for cause; or
- The individual has unpaid financial obligations to Cigna or any direct or indirect affiliate of Cigna; or
- The individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for misrepresentations or omitted information or health history; or
- The individual was previously enrolled under this Policy or another Cigna Individual Dental Policy and terminated his or her enrollment. The individual will be allowed to reenroll 12 months from the Effective Date of termination.

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

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

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person's eligibility under this Plan would terminate due to the Insured's death, 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.

BENEFIT SCHEDULE

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

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

CIGNA DENTAL PREFERRED PROVIDER INSURANCE ***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 Deductibles are expenses to be paid by You or Your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached You and Your family need not satisfy any further dental Deductible for the rest of that Calendar Year.
Participating Provider Payment Participating Provider services are paid based on the Contracted Fee agreed upon by the Provider and CHLIC.
Non-Participating Provider Payment Non-Participating Provider services are paid based on the Contracted Fee.
Simultaneous Accumulation of Amounts Expenses incurred for either Participating or Non-Participating Provider charges will be used to satisfy both the Participating and Non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and Non-Participating Provider services will be applied toward both the Participating and Non-Participating Provider maximum shown in the Schedule.

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

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

Waiting Periods

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

there is no waiting period for class I services;

after 6 consecutive months of coverage dental benefits will increase to include the list of class II procedures;

after 12 consecutive months of coverage dental benefits will increase to include the list of class III procedures.

after 12 consecutive months of coverage dental benefits will increase to include the list of class IV procedures.

Covered Dental Expense: What The Policy Pays For

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

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

the service is ordered or prescribed by a Dentist;

is essential for the Necessary care of teeth;

the service is within the scope of coverage limitations;

the Deductible amount in The Schedule has been met;

the maximum benefit in The Schedule has not been exceeded;

the charge does not exceed the amount allowed under the Alternate Benefit Provision;

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.

Class I Services - Diagnostic and Preventive Dental Services

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

Class II Services - Diagnostic Services

- Complete mouth survey or panoramic x-rays - only 1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.
- Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period.
- Intraoral occlusal x-rays - Limited to 2 films in any consecutive 12-month period.

Fillings

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

Oral Surgery, Routine Extractions

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

Miscellaneous Services

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

Class III Services - Diagnostic Procedures

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

Denture Adjustments, Rebasing and Relining

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

Repairs To Crowns and Inlays

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

Repairs To Dentures and Bridges

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

Inlays, Onlays and Crowns

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

Endodontic Procedures

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

Minor Periodontal Procedures

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

Major Periodontal Surgery

- Gingivectomy - Only one periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
- Gingival Flap Procedure Including Root Planing - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
- Clinical Crown Lengthening - Hard Tissue - No limitation.
- Mucogingival Surgery - Per Quadrant - only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
- Osseous Surgery - only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
- Bone Replacement Graft - First Site Quadrant.
- Bone Replacement Graft - Each Additional Site in Quadrant.
- Guided Tissue Regeneration - Resorbable Barrier - per Site, per Tooth - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery.
- Pedicle Soft Tissue Graft - No limitation.
- Free Soft Tissue Graft (including donor site surgery) - No limitation.

- Subepithelial Connective Tissue Graft Procedure (including donor site surgery) - No limitation.
- Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area) - No limitation.

Oral Surgery - Surgical Extractions

- Surgical Extraction – (except for the removal of impacted teeth) - Includes an allowance for local anesthesia and routine postoperative care.
- Surgical Removal of Residual Tooth Roots (Cutting Procedure) - Includes an allowance for local anesthesia and routine postoperative care.

Other Oral Surgery

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

Surgical Extraction of Impacted Teeth

- Surgical Removal of Impacted Tooth - Soft Tissue - The benefit includes an allowance for local anesthesia and routine postoperative care.
- Surgical Removal of Impacted Tooth - Partially Bony - The benefit includes an allowance for local anesthesia and routine postoperative care.
- Surgical Removal of Impacted Tooth - Completely Bony - The benefit includes an allowance for local anesthesia and routine postoperative care.

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

Prosthetics

- Full dentures — there are no additional benefits for personalized dentures or overdentures or associated procedures. Cigna will not pay for any denture until it is accepted by the patient. Limited to one time per arch per 84 consecutive months.
- Partial dentures — there are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Cigna will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 84 consecutive months unless there is a Necessary extraction of an additional Functioning Natural Tooth.
- Add tooth to existing partial denture to replace newly extracted Functional Natural Tooth — only if more than 12 consecutive months have elapsed since the insertion of the partial denture.
- Complete and partial overdentures — there are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Cigna will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 84 consecutive months unless there is a Necessary extraction of an additional Functioning Natural Tooth.
- Post and core (in conjunction with a fixed bridge) — Covered only for endodontically treated teeth with total loss of tooth structure.
- Fixed Partial Dentures (Nonprecious Metal Pontics, Retainer Crowns and Metallic Retainers) - Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.
- Replacement: Benefits for the replacement of an existing bridge are payable only if the existing bridge is at least 84 consecutive months old, is not serviceable, and cannot be repaired.
- Benefits for retainer crowns and pontics are based on the amount payable for nonprecious metal substrates.
- Cast Metal Retainer for Resin Bonded Fixed Bridge - Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.
- Replacement: Benefits are based on the amount payable for nonprecious metal substrates. Benefits for the replacement of an existing resin bonded bridge are payable only if the existing resin bonded bridge is at least 84 consecutive months old, is not serviceable, and cannot be repaired.

Anesthesia and IV Sedation

- General Anesthesia - Paid as a separate benefit only when Medically or Dentally Necessary and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- I. V. Sedation - Paid as a separate benefit only when Medically or Dentally Necessary and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- Each month of active treatment is a separate Dental Service.

Covered Orthodontic Treatment

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

Orthodontia Provision

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

Replacement Provisions For Orthodontic Coverage

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

Pre-Existing Condition Limitation

There is no payment for replacement of teeth for 12 months from the Effective Date of coverage that are missing when a person first becomes Insured.

Exclusions And Limitations: What Is Not Covered By This Policy

Expenses Not Covered

Covered Expenses do not include expenses incurred for:

- procedures which are not included in the list of Covered Dental Expenses.
- procedures which are not Medically and/or Dentally Necessary.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint. This exclusion does not apply to Orthodontic Treatment of jaw joint problems.
- the alteration or restoration of occlusion.
- the restoration of teeth which have been damaged by erosion, attrition or abrasion.
- bite registration or bite analysis.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic. Cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- the initial placement of a full denture or partial denture unless it includes the replacement of a functioning atural tooth extracted while the person is covered under this plan (the removal of only a permanent third molar will not qualify a full or partial denture for benefit under this provision).
- the initial placement of a fixed bridge, unless it includes the replacement of a Functioning Natural Tooth extracted while the person is covered under this plan. If a bridge replaces teeth that were missing prior to the date the person's coverage became effective and also teeth that are extracted after the person's Effective Date, benefits are payable only for the pontics replacing those teeth which are extracted while the person was Insured under this plan. The removal of only a permanent third molar will not qualify a fixed bridge for benefit under this provision.
- the initial placement of an implant unless it includes the replacement of a Functioning Natural Tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.
- core build-ups. . The term Core build ups refers to the building up of the coronal structure when there is insufficient structure to hold the prosthetic device over the tooth.

- replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
  (a) replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or
  (b) the partial denture is less than 84 consecutive months old, and the replacement is needed due to a Medically and/or Dentally Necessary extraction of an additional Functioning Natural Tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
  (c) replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional Medically and/or Dentally Necessary extraction of a Functioning Natural Tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting. Note: this exclusion does not apply to splinting that is secondary to tooth transplantation, as described in the Covered Expenses section of Your Policy.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminate).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- treatment of jaw fractures and orthognathic surgery.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.

- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years.
- diagnostic casts, diagnostic models, or study models.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

No payment will be made for expenses incurred for You or any one of Your Dependents:

- For services not specifically listed as Covered Services in this Policy.
- For services or supplies that are not Medically and/or Dentally Necessary.
- For services received before the Effective Date of coverage.
- For services received after coverage under this Policy ends.
- For Professional services or supplies received or purchased directly or on Your behalf by You, if You are a Dentist. 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 an Injury 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. Cigna will refund premiums as applicable on a pro-rate basis to a covered person for any charges related to a military-service condition if Cigna receives written notice of military service;
- 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;
- for charges incurred when You or any of Your Dependents no longer live in the Service Area;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for Medically or Dentally 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;
- that are a covered expense under any other dental plan which provides dental benefits, subject to the Insurance With Other Companies provision.;
- 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. 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.

THE FOLLOWING WILL APPLY TO RESIDENTS OF VIRGINIA
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.
Cigna wants 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
Cigna is here to listen and help. If You have a concern regarding a person, a service, the quality of care, or contractual benefits, You may call our toll-free number and explain Your concern to one of our Customer Service representatives. You may 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.
Cigna will do its best to resolve the matter on Your initial contact. If we need more time to review or investigate Your concern, we will get back to You as soon as possible, but in any case within 30 days.
If You are not satisfied with the results of a coverage decision, You can start the appeals procedure.

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

Level-One Appeal
Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a Dentist reviewer.
For all level-one appeals involving Medical Necessity or clinical appropriateness (also called reconsideration), we will respond with a written decision within 10 working days.
Cigna will respond to all other level-one appeals with a written decision within 30 calendar days after we receive an appeal. 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.
You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize Your life or health or would jeopardize Your ability to regain the dental functionality that existed prior to the onset of Your current condition.
A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.
If You are not satisfied with our level-one appeal decision, You may request a level-two appeal.

Level-Two Appeal
If You are dissatisfied with our level-one appeal decision, You may request a second review. To start a level-two appeal, follow the same process required for a level-one appeal.
Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Dentist reviewer. You may present Your situation to the Committee in person or by conference call.
For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. 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 by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 working days after the

Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.
You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize Your life or health or would jeopardize Your ability to regain the dental functionality that existed prior to the onset of Your current condition.
A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure
If You are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, You may request that Your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.
There is no charge for You to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.
In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.
To request a review, You must notify the Appeals Coordinator within 180 days of Your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.
The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to Your condition, as determined by Cigna's Dentist reviewer, the review shall be completed within three days.
The Independent Review Program is a voluntary program arranged by Cigna.

Appeal to the Commonwealth of Virginia
If You have any questions regarding an appeal concerning the health care services You have been provided, which have not been satisfactorily addressed, You may contact the Office of the Managed Care Ombudsman for assistance. The Virginia Bureau of Insurance, Office of the Managed Care Ombudsman may be contacted as follows:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll-Free: 1-877-310-6560
Richmond Metropolitan Area: 804-371-9032
E-mail:ombudsman@scc.virginia.gov
WebPage: Information regarding the Ombudsman
may be found by accessing State Corporation
Commission's Web Page at:
www.scc.virginia.gov

If You have quality of care or quality of service concerns, You may contact the Office of Licensure and Certification at any time, at the following:

Office of Licensure and Certification (OLC)
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233
Phone: 804-367-2104 – ask for MCHIP
Fax Line: 804-527-4503

No Insured who exercises the right to file a complaint or an appeal shall be subject to disenrollment or otherwise penalized due to the filing of a complaint or appeal.

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

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

Dispute Resolution
All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Cigna's 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 Cigna that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Cigna will be acknowledged in writing, along with a description of how Cigna proposes to resolve the grievance.

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, 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.

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, however, if we do not receive Your premium before the end of the grace period, Your coverage will be terminated on the last date of the Grace Period. Please see the following provisions for further information regarding cancellation and reinstatement.

Cancellation by Insured:

You may cancel this Policy at any time by written notice, delivered or mailed to Cigna effective upon receipt or on such later date as specified in the notice.

In the event of cancellation, Cigna shall return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata.

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, except in the case of termination for non-payment of premiums, in which case this Policy shall terminate immediately upon notice to the Insured Person.

Modification of Coverage: Cigna reserves 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. A modification that will reduce or eliminate benefits or coverages under Your Policy, or that will result in an increase in premium during the Policy term, will become effective only if Cigna receives Your signed acceptance of such changes. Cigna will file any changes made to this Policy's provisions, benefits and coverages consistent with state law.

Reinstatement: If the renewal premium is not paid before the grace period ends, the Policy will lapse. Later acceptance of the premium by Cigna or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the Policy. If Cigna or its agent requires an application for reinstatement, the Insured Person will be given a conditional receipt for the premium. If the application is approved the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless Cigna has previously written the Insured Person of its disapproval. The reinstated Policy will cover only loss that results from an Injury sustained after the date of reinstatement and sickness that starts more than 10 days after such date. In all other respects the rights of the Insured Person and Cigna will remain the same, subject to any provisions noted or attached to the reinstated Policy. Any premiums the Company accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement. There is a $50 fee for reinstatement.

Fraud: If the Insured Person has committed any fraud or deception in connection with this Policy, within 2 years from the date of this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: If the Insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age

Legal Actions: You cannot file a lawsuit before 60 days after Cigna has 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: Any provision of this Policy that on its Effective Date is in conflict with the laws of the state in which the Insured resides on that date is hereby amended to conform to the minimum requirements of the laws.

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 if such fraudulent use took place within 2 years from the date of this Policy.
- 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 Cigna 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 Cigna is liable under this Policy, Cigna has 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.
- Cigna 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, Cigna 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 Cigna receives 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.
- Cigna 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 Cigna will provide the Insured Person with one, or visit our Web site, www.myCigna.com.
- Insurance effective at any one time on the Insured under a like Policy or policies in this Company is limited to the one such Policy elected by the Insured, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

- Insurance With Other Companies. 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 coverage prior to the loss), 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. Cigna shall return promptly such portion of any premium paid as shall exceed the pro rata portion for the amount so determined.
- 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. .If You pay on a different frequency, the amount due is adjusted appropriately.

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

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

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

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

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

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.

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

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

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

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food.

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

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

Injury or injuries, for which benefits are provided, means accidental bodily Injury sustained by the Insured Person which are the direct result of an accident, independent of disease or bodily infirmity or any other cause, and which occur while the insurance is in force.

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

Medically Necessary and/or Dentally Necessary
Services provided by a Dentist or physician are Medically/Dentally Necessary if they are:
(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and
(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and
(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and
(4) the most fitting level or service which can safely be given to You or Your Dependent.

A: (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, 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 Contracted Fee which may be less than actual billed charges. Non-Participating Providers can bill You for amounts exceeding Covered Expenses.

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

Participating Provider - Cigna Dental Preferred Provider is a Dentist or a professional corporation, professional association, partnership, or any other entity that has a direct or indirect contractual arrangement with 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. The Insured may request continuation of health care services for a period of 90 days from the date of the Provider's notice of termination from the plan, except if a Provider is terminated for cause.

Policy is the set of benefits, conditions, exclusions, limitations, and premiums described in this document, including the Policy specification page, 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.

Report means information obtained by Cigna from the treating Dentist.

Service Area is any place that is within the state of Virginia.

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.