Cigna Health and Life Insurance Company may change the premiums of this Policy after 75 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You. We will only change premiums on an Annual basis.

Cigna Health and Life Insurance Company ("Cigna")

Cigna Dental Pediatric

900 Cottage Grove Road
Bloomfield CT 06002

NOTICE: THIS IS A LIMITED BENEFIT POLICY. IT DOES NOT PROVIDE COVERAGE FOR ANY MEDICAL BENEFITS AND SERVICES. THIS IS AN EXCHANGE CERTIFIED STAND ALONE DENTAL POLICY THAT PROVIDES COVERAGE FOR CERTAIN DENTAL BENEFITS AND SERVICES ONLY.

If You Wish To Cancel Or If You Have Questions

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

Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630
1.800.Cigna24 (1.800.244.6224)

Include Your Cigna identification number with any correspondence. This number can be found on Your Cigna identification card.

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. Pediatric coverage and benefits are only available to Insured Persons up to the age of 19. Please note that benefits will apply until the end of the calendar year in which this limiting age is reached. If You know of any misstatement in Your application, You should advise the company immediately regarding the incorrect information; otherwise, Your Policy may not be a valid contract.

Conditionally Renewable

This Policy is dental pediatric coverage subject to continual monthly or quarterly 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. Coverage will end at 12:00 a.m. **Eastern time.**

Renewal: This Policy renews on a Calendar Year basis.

Cancellation by Cigna: We 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 of the grace period.

2. When You become ineligible for this coverage.

3. If You have committed, any act, practice, or omission that constitutes fraud or the Insured Person makes an intentional misrepresentation of a material fact in connection with the application for this Policy or coverage within 2 years from the date of this Policy.

4. When We cease to offer policies of this type to all individuals in Your class. In this event, 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 pediatric dental insurance coverage offered by Us at the time of discontinuation; and (3) act uniformly without regard to any health status related factors of an Insured Person.

5. When We cease offering any plans in the individual market in Virginia, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.

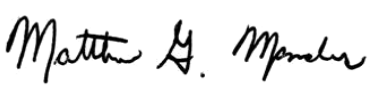
6. When the Insured no longer resides, lives, or works in the Coverage Area.

7. When Cigna determines that any premium payment for this Policy is being paid directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor; however, if You, Your Family Members or an Acceptable Third Party Payor make all premium payments for this Policy that are due after the date of Cigna's determination, the Policy shall remain in effect, subject to all other terms and conditions contained herein.

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

Cigna Health and Life Insurance Company may change the premiums of this Policy after 75 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 and only upon Renewal.

Signed for Cigna by:



Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

Important Information Regarding Your Insurance

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, Florida 33630-3365
1.800.Cigna24 (1.800.244.6224)

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:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-800-552-7945, in state calls
1-877-310-6560, national toll free number

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.

Your policy 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 32.1.

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.

Please Read The Following Important Notice

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

Table of Contents

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 **1.800.Cigna24 (1.800.244.6224)** if You have any questions regarding whether services are covered.

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

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

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

Who Is Eligible For Coverage?

Conditions of Eligibility

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

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

- Your lawful spouse.
- Your children.
- Your stepchildren.
- Your own, or Your spouse's unmarried children, regardless of age, enrolled prior to age 19, who are incapable of self-support due to medically certified continuing intellectual or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 19th 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 Newborn children are automatically covered for the first 31 days of life. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of birth, and pay any additional premium. Coverage for a newborn dependent child enrolled within 61 days of birth will be retroactive to the date of the child's birth. This also applies to a newborn child with respect to whom:
  - a decree of adoption by You has been entered within thirty-one days after the date of the child's birth; or
  - adoption proceedings have been instituted by You within 31 days after the date of the child's birth and You have temporary custody; or
  - the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.
  - An adopted child is eligible for coverage from the date of adoption or parental placement with an Insured Person, and if the adoption occurred within 31 days of birth, the child shall be considered a newborn child of the Insured Person as of the date of placement. This shall continue unless the placement is disrupted prior to final decree of adoption or the child is removed from placement.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of adoption, and pay any additional premium. Coverage for an adopted dependent child enrolled within 61 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption.
- A child who is placed with You for foster care is automatically covered for 31 days from the date of the foster child's placement. To continue coverage past that time You must enroll the foster child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date the child is placed with You for foster care, and pay any additional premium. Coverage for a foster child enrolled within 61 days of placement for foster care will be retroactive to the date of the child's placement for foster care.
- 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 past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the court order date, and paying any additional premium. Court-ordered coverage for a dependent child enrolled within 61 days of the court order will be retroactive to the date of the court order. If a court has ordered an Insured to obtain coverage for a child, and that parent fails to obtain coverage as ordered, the child's other parent or the Virginia Department of Social Services may enroll the child for coverage as a dependent of the Insured.

When Can I Apply?

Application to Enroll or Change Coverage

The Patient Protection and Affordable Care Act of 2010 (PPACA) specifies that an eligible person must enroll for coverage or change plans during the annual Open Enrollment Period. Persons who fail to enroll or change plans during the Open Enrollment Period must wait until the next Open Enrollment Period to enroll in a plan or to change plans. However, if a person experiences a triggering event as described below, the triggering event starts a 60-day Special Enrollment Period during which an eligible person can enroll and an Insured Person can add dependents and change coverage.

The Open Enrollment Period and Special Enrollment Period are explained below.

Annual Open Enrollment Period

The Annual Open Enrollment Period is a specified period of time each Year during which individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another.

To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependent(s), and We must receive that application during the Annual Open Enrollment Period.

Your coverage under this Policy will then become effective upon the earliest day allowable under federal rules for that Year's open enrollment period. **Note: If You do not apply to obtain or change coverage during the Annual Open Enrollment Period, You will not be able to apply again until the following Year's Annual Open Enrollment Period** unless You qualify for a special enrollment period as described below.

Special Enrollment Periods

A special enrollment period occurs when a person experiences a triggering event.

If You experience one of the triggering events listed below, You can enroll for coverage and enroll Your eligible Dependent(s) during a special enrollment period instead of waiting for the next Annual Open Enrollment Period.

Triggering events for a special enrollment period are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage, birth adoption or placement for adoption or placement in foster care; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the federally facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already

enrolled in a qualified health plan. The Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or

- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month; or
- An eligible individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the Marketplace may provide

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

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will have coverage effective dates determined as follows):

- In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care;
- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective for a qualified individual or enrollee on the first day of the following month.

For all other triggering events the effective dates are:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

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.
- For the spouse - when the spouse is no longer married to the Insured.
- For You and Your Family Member(s) when you no longer meet the requirements listed in the Eligibility Requirements section;
- The date the Policy terminates.
    - When the Policyholder no longer resides, lives or works in the Coverage 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, that Family Member has the right to continuation of his or her insurance. Coverage will be continued under that Member's name if the Family Member exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. In such a case, coverage will continue without evidence of insurability.

Benefit Schedule

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to the age of 19. Benefits will apply until the end of the calendar year in which this limiting age is reached.

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured 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.

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

Benefit	Cigna DPPO Advantage Participating Providers	Cigna DPPO Participating Providers** and Non-Participating Providers
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I	None	
Calendar Year Deductible: Class II, III & IV	$150 per person	
	$300 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$350 per person	
	$700 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Cigna DPPO Advantage Participating Providers	**Cigna DPPO Participating Providers** and Non-Participating Providers**
Class I - Preventive/Diagnostic Services	100%*	100%*
Class II - Basic Restorative Services	50% after Deductible*	50% after Deductible*
Class III - Major Restorative Services	50% after Deductible*	50% after Deductible*
Class IV –Medically Necessary Orthodontia	50% after Deductible*	50% after Deductible*

*For explanation of any additional payment responsibility to the covered person, see section entitled **Dental PPO – Participating and Non-Participating Providers.**

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

Waiting Periods

There are no waiting periods for Class I, II, III or IV.

What the Policy Pays For

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

The benefits described 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;
- For Class I, II or III; the service is started and completed while coverage is in effect.

Alternate Benefit Provision

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

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

Predetermination of Benefits

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

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

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

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

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

Dental PPO – Participating and Non-Participating Providers

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.

Covered Dental Expenses

Please note: The Pediatric Dental benefits described within the following pages apply to Insured Persons up to the age of 19. Benefits will apply until the end of the calendar year in which this limiting age is reached.

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation- established patient	One of (D0120) per 6 Month(s) Per Provider OR Location. One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.
D0140	Limited oral evaluation - problem focused	Two of (D0140) per 12 Month(s) Per Provider OR Location. Limited examinations D0140 are not reimbursable on the same day as codes D0120, D0145, D0150 and D9310.
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	Age 0-2 One of (D0145) per 6 Month(s) Per Provider OR Location. One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.
D0150	Comprehensive oral evaluation - new or established patient	One of (D0150) per 6 Month(s) Per Provider AND Location. One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	intraoral - complete series of radiographic images	Age 6 – 19 One of (D0210, D0330) per 60 Month(s) Per Provider OR Location. Frequency of service or age deviation must be supported by Medical Necessity
D0220	intraoral - periapical first radiographic image	
D0230	intraoral - periapical each additional radiographic image	
D0240	intraoral - occlusal radiographic image	Two of (D0240) per 12 Month(s) Per patient.
D0250	extraoral - first radiographic image	
D0260	extraoral - each additional radiographic image	
D0270	Bitewing - single film	
D0272	Bitewings - two films	One of (D0272, D0273, D0274) per 12 Month(s) Per Provider OR Location.
D0273	Bitewings - three films	One of (D0272, D0273, D0274) per 12 Month(s) Per Provider OR Location.
D0274	Bitewings - four films	One of (D0272, D0273, D0274) per 12 Month(s) Per Provider OR Location.
D0330	Panoramic film	Age 6 – 19 One of (D0210, D0330) per 60 Month(s) Per Provider OR Location. Frequency of service or age deviation must be supported by Medical Necessity.
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	Non-orthodontic procedures.
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	Age 13-19 One of (D1110, D1120) per 6 Month(s) Per Provider OR Location. Includes minor scaling procedures.
D1120	Prophylaxis - child	Age 0-12 One of (D1110, D1120) per 6 Month(s) Per Provider OR Location.

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	One of (D1203, D1204, D1206, D1208) per 6 Month(s) Per Provider OR Location.
D1208	topical application of fluoride - excluding varnish	One of (D1203, D1204, D1206, D1208) per 6 Month(s) Per Provider OR Location.
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	Age 5-19 One of (D1351, D1352) per 1 Lifetime Per patient per tooth. Sealants will not be covered when placed over restorations. Teeth must be caries free. Includes buccal surfaces of mandibular molars and lingual surfaces of maxillary molars.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1510	Space maintainer - fixed - unilateral	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.
D1515	Space maintainer - fixed - bilateral	One of (D1515, D1525) per 24 Month(s) Per patient per arch.
D1520	Space maintainer - removable - unilateral	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.
D1525	Space maintainer - removable - bilateral	One of (D1515, D1525) per 24 Month(s) Per patient per arch.
D1550	Re-cementation of space maintainer	
D1555	Removal of fixed space maintainer	Not allowed by dentist or dental office that placed space maintainers
GUM (PERIODONTAL) THERAPY		
Claim Code	**Description**	**Frequency**
D4910	periodontal maintenance procedures	Four of (D4910) per 12 Month(s) Per patient. Any combination of D1110, D1120 and D4910 up to four (4) per 12 months. Covered following active treatment only (D4210, D4211, D4260, D4261, D4341, D4342).
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	Not allowed with any other services other than radiographs and emergency exam.
D9920	behavior management, by report	Patient record must indicate the additional staffing required to complete the treatment. Patient record must indicate the type and/or types of behavior management techniques used.
D9999	unspecified adjunctive procedure, by report	For hospital operating room cases. Includes all workups, same day surgery visit, and discharge summary, etc. Cannot be billed with D9420. Requires prior approval.

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2150	Amalgam - two surfaces, primary or permanent	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2160	Amalgam - three surfaces, primary or permanent	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2161	Amalgam - four or more surfaces, primary or permanent	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2331	Resin-based composite - two surfaces, anterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2332	Resin-based composite - three surfaces, anterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2390	resin-based composite crown, anterior	
D2391	resin-based composite - one surface, posterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2392	resin-based composite - two surfaces, posterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2393	resin-based composite - three surfaces, posterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
D2394	resin-based composite - four or more surfaces, posterior	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	
D2920	re-cement or re-bond crown	
D2940	protective restoration	Not allowed in conjunction with root canal therapy, pulpotomy, pulpectomy, or on the same date of service as a restoration.
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3110	pulp cap - direct (exluding final restoration)	
D3120	pulp cap - indirect (excluding final restoration)	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	Cannot be billed in conjunction with root canals (D3310, D3320, D3330).
D3221	pulpal debridement, primary and permanent teeth	

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	
CROWNS, TOOTH CAPS		
Claim Code	**Description**	**Frequency**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	One of (D3310) per 1 Lifetime Per patient per tooth.
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	One of (D3320) per 1 Lifetime Per patient per tooth.
D3330	endodontic therapy, molar (excluding final restoration)	One of (D3330) per 1 Lifetime Per patient per tooth.
D3346	retreatment of previous root canal therapy-anterior	One of (D3346) per 1 Lifetime Per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.
D3347	retreatment of previous root canal therapy-bicuspid	One of (D3347) per 1 Lifetime Per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.
D3348	retreatment of previous root canal therapy-molar	One of (D3348) per 1 Lifetime Per Provider per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	
D3352	apexification/recalcification - interim medication replacement	Limited three (3) treatments.
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	One of (D3353) per 1 Lifetime Per Provider per tooth.
D3410	apicoectomy - anterior	One of (D3410) per 1 Lifetime Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D3421	apicoectomy - bicuspid (first root)	One of (D3421) per 1 Lifetime Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D3425	apicoectomy - molar (first root)	One of (D3425) per 1 Lifetime Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D3426	apicoectomy (each additional root)	Pre-operative radiographs with claim for pre-payment review.
D3430	retrograde filling - per root	One of (D3430) per 1 Lifetime Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
GUM (PERIODONTAL) THERAPY		
Claim Code	**Description**	**Frequency**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	One of (D4210) per 24 Month(s) Per patient per quadrant. One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. A min of 4 affected teeth in the quadrant. Gingivectomies for the removal of hyperplasic tissue to reduce pocket depth. Request only when non-surgical treatment has not been effective or when the patient is taking medications that cause such conditions.
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	One of (D4211) per 24 Month(s) Per patient per quadrant. One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. 1 to 3 affected teeth in the quadrant. For removal of hyperplastic tissue. Should be only requested when non-surgical treatment does not achieve the desired results or when the patient is being treated with medications that result in such conditions.
D4249	clinical crown lengthening - hard tissue	One of (D4249) per 1 Lifetime Per patient per tooth. Periodontal charting and preoperative radiographs with claim for pre-payment review.
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	One of (D4260) per 60 Month(s) Per patient per quadrant. One of (D4260, D4261) per 60 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant. Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	One of (D4261) per 60 Month(s) Per patient per quadrant. One of (D4260, D4261) per 60 Month(s) Per patient per quadrant. One (1) to three (3) affected teeth in the quadrant. Periodontal charting and pre-operative radiographs with claim for pre-payment review.

D4263	bone replacement graft - first site in quadrant	Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4264	bone replacement graft - each additional site in quadrant	Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4270	pedicle soft tissue graft procedure	
D4273	subepithelial connective tissue graft procedure	
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	One of (D4277) per 1 Lifetime Per patient per quadrant.
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	One of (D4278) per 1 Lifetime Per patient per quadrant.
D4320	provision splinting - intracoronal	
D4321	provision splinting - extracoronal	
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	periodontal scaling and root planing - four or more teeth per quadrant	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Either D4341 or D4342. A minimum of four (4) affected teeth in the quadrant. Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4342	periodontal scaling and root planing - one to three teeth per quadrant	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Either D4341 or D4342. One (1) to three (3) affected teeth in the quadrant. Check service limit. Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	One of (D4355) per 12 Month(s) Per patient. Only covered when there is substantial gingival inflammation (gingivitis) in all four quadrants. Cannot be billed on same day with D1110 or D1120.
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	adjust complete denture - maxillary	Not covered within 6 months of placement.
D5411	adjust complete denture - mandibular	Not covered within 6 months of placement.
D5421	adjust partial denture-maxillary	Not covered within 6 months of placement.
D5422	adjust partial denture - mandibular	Not covered within 6 months of placement.
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	repair broken complete denture base	
D5520	replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	repair resin denture base	
D5620	repair cast framework	
D5630	repair or replace broken clasp	
D5640	replace broken teeth-per tooth	
D5650	add tooth to existing partial denture	
D5660	add clasp to existing partial denture	
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	reline complete maxillary denture	One of (D5730) per 24 Month(s) Per patient. Not covered within 6 months of placement.
D5731	reline complete mandibular denture (chairside)	One of (D5731) per 24 Month(s) Per patient. Not covered within 6 months of placement.
D5740	reline maxillary partial denture	One of (D5740) per 24 Month(s) Per patient. Not covered within 6 months of placement.

D5741	reline mandibular partial denture	One of (D5741) per 24 Month(s) Per patient. Not covered within 6 months of placement.
D5750	reline complete maxillary denture	One of (D5750) per 24 Month(s) Per patient. Not covered within 6 months of placement.
D5751	reline complete mandibular denture (laboratory)	One of (D5751) per 24 Month(s) Per patient. Not covered within 6 months of placement.
D5760	reline maxillary partial denture	One of (D5760) per 24 Month(s) Per patient. Not covered within 6 months of placement.
D5761	reline mandibular partial denture	One of (D5761) per 24 Month(s) Per patient. Not covered within 6 months of placement.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	tissue conditioning, maxillary	
D5851	tissue conditioning, mandibular	Narrative of medical necessity with claim for prepayment review.
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	re-cement or re-bond fixed partial denture	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7111	extraction, coronal remnants - deciduous tooth	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.
D7220	removal of impacted tooth-soft tissue	Removal of asymptomatic tooth not covered.
D7230	removal of impacted tooth-partially bony	Removal of asymptomatic tooth not covered.
D7240	removal of impacted tooth-completely bony	Removal of asymptomatic tooth not covered.
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, aberrant tooth position, or unusual depth of impaction. Pre-operative radiographs with claim for pre-payment review.
D7250	surgical removal of residual tooth roots (cutting procedure)	Will not be paid to the dentist or dental group that removed the tooth. Removal of asymptomatic tooth not covered.
OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7260	oroantral fistula closure	
D7261	primary closure of a sinus perforation	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Narrative with claim for prepayment review.
D7280	Surgical access of an unerupted tooth	Pre-operative radiographs and narrative with claim for pre-payment review.
D7282	mobilization of erupted or malpositioned tooth to aid eruption	
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	
D7286	incisional biopsy of oral tissue-soft	
D7288	brush biopsy - transepithelial sample collection	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	One of (D7310) per 1 Lifetime Per patient per quadrant. One of (D7310, D7311) per 1 Day(s) Per patient per quadrant. Either D7310 or D7311. Minimum of three (3) extractions per quadrant. Not allowed with a surgical extraction in same quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.

D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	One of (D7311) per 1 Lifetime Per patient per quadrant. One of (D7310, D7311) per 1 Day(s) Per patient per quadrant. Either D7310 or D7311. Minimum of three (3) extractions per quadrant. Not allowed with a surgical extraction in same quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	One of (D7320) per 1 Lifetime Per patient per quadrant. One of (D7320, D7321) per 1 Day(s) Per patient per quadrant. No extractions performed in edentulous area.
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	One of (D7321) per 1 Lifetime Per patient per quadrant. One of (D7320, D7321) per 1 Day(s) Per patient per quadrant. No extractions performed on edentulous area.
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
D7472	removal of torus palatinus	
D7473	removal of torus mandibularis	
D7485	surgical reduction of osseous tuberosity	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	incision and drainage of abscess - intraoral soft tissue	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Either D7510 or D7511.
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	One of (D7510, D7511) per 1 Day(s) Per patient. Either D7510 or D7511.
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	One of (D7960, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility, for large diastemas between teeth, or when frenum interferes with a prosthetic appliance, or when it is the etiology of periodontal tissue disease. Midsagittal removal only.
D7963	frenuloplasty	One of (D7960, D7963) per 1 Lifetime Per patient. Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure.
D7970	excision of hyperplastic tissue - per arch	
D7971	excision of pericoronal gingiva	
D7972	surgical reduction of fibrous tuberosity	
ADJUNCTIVE GENERAL SERVICES		
Claim Code	**Description**	**Frequency**
D9220	deep sedation/general anesthesia-first 30 minutes	
D9221	deep sedation/general anesthesia-each additional 15 minutes	Maximum of 150 minutes (10 units).
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment.
D9241	intravenous moderate (conscious) sedation/analgesia - first 30 minutes	Maximum of 150 minutes (10 units).
D9242	intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes	Maximum of 150 minutes (10 units).
D9248	non-intravenous moderate (conscious sedation)	Must be documented as a medically necessity in the patient records.
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	One of (D9310) per 1 Day(s) Per Provider OR Location. Not to be billed on the same day or within 6 months of another exam code. Oral evaluations and any consulting services are inclusive in the code. Not to be billed with any other treatment codes, except may be billed with diagnostic codes. Must be a consult request from a health care provider, excludes placement from DentaQuest.

D9420	hospital or ambulatory surgical center call	Maximum of three (3) for the same day. Cannot be billed with D9999 for hospital care on the same date of service.
D9440	office visit - after regularly scheduled hours	
D9610	therapeutic drug injection, by report	Either D9610 or D9612.
D9612	therapeutic drug injection - 2 or more medications by report	Either D9610 or D9612.
D9630	other drugs and/or medicaments, by report	Not to be used for Nitrous Oxide or conscious sedation.
D9910	application of desensitizing medicament	
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	

Class III - Major Restorative Services

RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2644	onlay-porcelain/ceramic-4+ surfaces	One of (D2644) per 60 Month(s) Per patient per tooth.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2710	crown - resin-based composite (indirect)	One of (D2710) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2720	crown-resin with high noble metal	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2721	crown - resin with predominantly base metal	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2722	crown - resin with noble metal	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2740	crown - porcelain/ceramic substrate	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2750	crown - porcelain fused to high noble metal	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2751	crown - porcelain fused to predominantly base metal	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2752	crown - porcelain fused to noble metal	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2790	crown - full cast high noble metal	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.

D2791	crown - full cast predominantly base metal	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2792	crown - full cast noble metal	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2794	crown - titanium	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.
D2929	Prefabricated porcelain/ceramic crown – primary tooth	
D2930	prefabricated stainless steel crown-primary tooth	
D2931	prefabricated stainless steel crown-permanent tooth	
D2932	prefabricated resin crown	
D2933	prefabricated stainless steel crown with resin window	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	core buildup, including any pins when required	One of (D2950, D2952, D2954) per 1 Day(s) Per patient per tooth.
D2952	cast post and core in addition to crown	One of (D2950, D2952, D2954) per 1 Day(s) Per patient per tooth. One of (D2952, D2954) per 60 Month(s) Per patient per tooth.
D2954	prefabricated post and core in addition to crown	One of (D2950, D2952, D2954) per 1 Day(s) Per patient per tooth. One of (D2952, D2954) per 60 Month(s) Per patient per tooth.
D2962	labial veneer (porc laminate) - laboratory	One of (D2962) per 60 Month(s) Per patient per tooth. Will be considered as an alternative to a full restoration for an endodontically treated tooth. Pre-operative radiographs with claim for pre-payment review.
D2970	temporary crown (fractured tooth)	Limited to a fractured tooth. Not to be used as temporary crown during crown fabrication. Pre-operative radiographs and narrative with claim for pre-payment review.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	complete denture - maxillary	One of (D5110) per 60 Month(s) Per patient.
D5120	complete denture - mandibular	One of (D5120) per 60 Month(s) Per patient.
D5130	immediate denture - maxillary	One of (D5130) per 1 Lifetime Per patient.
D5140	immediate denture - mandibular	One of (D5140) per 1 Lifetime Per patient.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	One of (D5211, D5213, D5225) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	One of (D5212, D5214, D5226) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	One of (D5211, D5213, D5225) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.

D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	One of (D5212, D5214, D5226) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5225	maxillary partial denture-flexible base	One of (D5211, D5213, D5225) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5226	mandibular partial denture-flexible base	One of (D5212, D5214, D5226) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5281	removable unilateral partial denture - one piece cast metal	One of (D5281) per 60 Month(s) Per patient per quadrant. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
5951	feeding aid	
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6205	pontic - indirect resin based composite	One of (D6205) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6211	pontic-cast base metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6212	pontic - cast noble metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6214	pontic - titanium	One of (D6214) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6240	pontic-porcelain fused-high noble	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6241	pontic-porcelain fused metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6242	pontic-porcelain fused-noble metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6245	prosthodontics fixed, pontic - porcelain/ceramic	One of (D6245) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6250	pontic-resin with high noble metal	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6251	pontic-resin with base metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6252	pontic-resin with noble metal	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6545	retainer - cast metal fixed	One of (D6545) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	One of (D6548) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.

FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6710	crown - indirect resin based composite	One of (D6710) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6720	crown-resin with high noble metal	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6721	crown-resin with base metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6722	crown-resin with noble metal	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6740	prosthodontics fixed, crown - porcelain/ceramic	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6750	crown-porcelain fused high noble	One of (D6750) per 60 Month(s) Per patient per tooth. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6751	crown-porcelain fused to metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6752	crown-porcelain fused noble metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6790	crown-full cast high noble	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6791	crown - full cast base metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6792	crown - full cast noble metal	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6794	crown - titanium	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D7880	Occlusal orthotic device, bv report	Covered only for temporomandbular pain, dysfunction or assoc. musculature.
D9940	occlusal guard, by report	

Class IV – Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D0340	cephalometric radiographic image	
D7283	placement of device to facilitate eruption of impacted tooth	Will not be payable unless orthodontic treatment has been proposed or is in progress. Orthodontic approval is not required. Pre-operative radiographs and narrative with claim for pre-payment review.
D8020	limited orthodontic treatment of the transitional dentition	
D8030	limited orthodontic treatment of the adolescent dentition	Narrative of medical need with claim for prepayment review.
D8040	limited orthodontic treatment of the adult dentition	Narrative of medical need with claim for prepayment review.
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8080	comprehensive orthodontic treatment of the adolescent dentition	One of (D8080) per 1 Lifetime Per patient. Panoramic or periapical radiogprahs. Cephalogram and/or photos or OrthoCad equivalent. PRIOR AUTHORIZATION IS REQUIRED.
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	One of (D8220) per 1 Lifetime Per patient.
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	pre-orthodontic treatment examination to monitor growth and development	For denied cases only An internal authorization will be issued for the payment of the pre-orthodontic visit (code D8660)
D8670	periodic orthodontic treatment visit	One of (D8670) per 90 Day(s) Per patient. Maximum of three (3) quarterly payments.
D8692	replacement of lost or broken retainer	One of (D8692) per 1 Day(s) Per Provider OR Location per arch. Narrative of medical necessity with claim for prepayment review.
D8999	unspecified orthodontic procedure, by report	Debanding by dentist other than dentist who initially banded case is one example. Narrative of medical need with claim for prepayment review.

Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic. Services incidental to or following 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 are not considered cosmetic.
- 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. Except in cases where it is Dentally Necessary.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary.
- Payment for up to one set of lost/unrepairable retainers may be considered on a medically necessary basis.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting, other than procedures listed in the Covered Dental Expenses section.
- orthodontic treatment, except in cases where it is Dentally Necessary.
- 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, other than procedures listed in the Covered Dental Expenses section.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

- For services or supplies that are not Medically or Dentally Necessary.
- For services received before the Effective Date of coverage.
- For services received after coverage under this Policy ends.
- For services for which You have no legal obligation to pay or for which no charge would be made if You did not have dental insurance coverage.
- Services performed by a member of the Insured Persons Immediate Family.
- 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;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- 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.

General Provisions

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our complaint and adverse determination appeal procedures. Complaints and adverse determination appeals may be reported by telephone or in writing. All complaints and adverse determination appeals received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Insurance with Other Companies

If there is other valid coverage, not with this Company, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this Company has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this Policy shall be for such proportion of the loss as the amount which would otherwise have been payable under this Policy plus the total of the like amounts under all such other valid coverages for the same loss of which this Company had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

Terms of the Policy

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

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

Grace Period: 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.

Cancellation by Cigna: We 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 of the grace period.
2. When You become ineligible for this coverage.
3. If You have committed, any act, practice, or omission that constitutes fraud or the Insured Person makes an intentional misrepresentation of a material fact in connection with the application for this Policy or coverage within 2 years from the date of this Policy.
4. When We cease to offer policies of this type to all individuals in Your class. In this event, 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 hospital medical or surgical insurance coverage offered by Us at the time of discontinuation; and (3) act uniformly without regard to any health status related factors of an Insured Person.
5. When We cease offering any plans in the individual market in Virginia, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
6. When the Insured no longer resides, lives or works in the Coverage Area.
7. When Cigna determines that any premium payment for this Policy is being paid directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor; however, if You, Your Family Members or an Acceptable Third Party Payor make all premium payments for this Policy that are due

after the date of Cigna's determination, the Policy shall remain in effect, subject to all other terms and conditions contained herein.

Cancellation by You: You may cancel this Policy:

1. On the earlier of Our receipt of Your written notice to cancel or the date on which Your written request for cancellation requests cancellation to be effective. In the event of cancellation, Cigna will return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
2. If You become an active-duty member of the military, upon receipt of a written notice of military service We will cancel Your Policy and refund premium on a pro rata basis.

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

Modification of Coverage: We reserve the right to modify this policy, including Policy provisions, benefits and coverages, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same Policy form. We will only modify this Policy at Renewal, 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 of intent to increase the annual premium or any deductible 75 days prior to the renewal of coverage. This Individual Plan renews on January 1 of each Year.

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

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

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

Renewal: This Policy renews on a Calendar Year basis.

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

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

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Insured Person resides, 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.

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.

Additional Provisions:

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

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

- When the amount paid by Cigna exceeds the amount for which We are liable under this Policy, We have the right to recover the excess amount from the Insured Person unless prohibited by law.
- In order for an Insured Person to be entitled to benefits under this Policy, coverage under this Policy must be in effect on the date the expense giving rise to a claim for benefits is incurred. Under this Policy, an expense is incurred on the date the Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Hospitals, Participating Physicians, and all other 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. However, We may, at Our option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the provider and Our payment to You will be considered fulfillment of Our obligation.
- Any payment of benefits in reimbursement for Covered Expenses paid by an eligible child, or the eligible child's custodial parent or legal guardian, will be made to the eligible child, the eligible child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the eligible child.
- Cigna will provide written notice to You within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at **1.800.Cigna24 (1.800.244.6224)** and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- Failure by Cigna to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.
- If Insured Person(s) were covered by a prior Individual Cigna Policy that is replaced by this Policy with no lapse of coverage:
  - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
  - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: Insurance effective at any one time on the Insured Person under a like Cigna Policy or Policies is limited to the one such Policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and Cigna will return all premiums paid for all other such Policies.

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 whose monthly payment is deducted directly from their checking account. 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 on 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 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 75 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.

Cigna will not accept the direct or indirect payment of premiums by any person or entity other than You, Your Family Members or an Acceptable Third Party Payor, except as expressly permitted by Cigna in writing. If Cigna receives any payment of premium in respect of this Agreement directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor, such payment will be considered a basis for the cancellation of this Policy.

How to File a Claim for Benefits

Notice of Claim: Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Cigna at P. O. Box 30365 Tampa, FL 33630. Notice should include the name of the Insured Person, and Claimant if other than the Insured Person, and the Member ID 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 Cigna.com or by calling **1.800.Cigna24 (1.800.244.6224)**.

Proof of Loss: If the Policy provides for periodic payment for a continuing loss, written proof of loss must be given to Cigna within 90 days after the end of each period for which Cigna 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, Cigna 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:

Dental benefits are assignable to the provider; when you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

We will recognize and consider any assignment made under the Policy, only 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 may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to the You or Your Dependents, You or Your Dependents are responsible for paying the Non-Participating Provider and Our payment to You will be considered fulfillment of Our obligation.

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

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

Payment of Claims: Benefits will be paid to the Insured Person. Any benefits unpaid at death may be paid, at Cigna's option, either to the Insured Person's beneficiary or the Insured Person's estate. If benefits are payable to the Insured Person's estate or a beneficiary who cannot execute a valid release, Cigna can pay benefits up to $2000, to someone related to the Insured Person or beneficiary by blood or by marriage whom Cigna considers to be entitled to the benefits. Cigna will be discharged to the extent of any payment made in good faith. Cigna may pay all or a portion of any indemnities provided for health care services to the health care services provider, unless the Insured Person directs otherwise in writing by the time proofs of loss are filed. Cigna cannot require that the services be rendered by a particular health care services provider.

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.

When you Have a Complaint or an Appeal

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

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

Start with Member Services.

We are here to listen and help. If You have a concern regarding a person, a service, the quality of care, contractual benefits, an initial eligibility denial or a rescission of coverage, You can call Our toll-free number and explain Your concern to one of Our Customer Service representatives. Please call Us at the Customer Service Toll-Free Number that appears on Your benefit identification card, explanation of benefits or claim form.

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

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

Appeals Procedure
To initiate an appeal, You must submit a request for an appeal in writing, within 180 days of receipt of a denial notice, to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

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 Us at the toll-free number on Your benefit identification card, explanation of benefits or claim form.

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 Physician or Dentist reviewer.

We will respond in writing or by electronic means to You or Your representative and the provider of record with a decision within 15 calendar days after We receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after We receive an appeal for a postservice coverage determination.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, We will provide this information to You as soon as possible and sufficiently in advance of the decision, so that You will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, We will provide the rationale to You as soon as possible and sufficiently in advance of the decision so that You will have an opportunity to respond.

Expedited Appeals
You may request that the appeal process be expedited if: (a) the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of Your Physician would cause You severe pain which cannot be managed without the requested services; or (b) Your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If You request that Your appeal be expedited based on (a) above, You may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited Cigna appeal would be detrimental to Your medical condition.

Cigna's Physician reviewer, or Your treating Physician, will decide if the expedited appeal criteria apply. When an appeal is expedited, We will respond orally with a decision to You and Your representative or provider as soon as possible, not to exceed 72 hours, taking into account medical exigencies. We will respond orally to expedited appeals related to prescriptions for the alleviation of cancer pain within 24 hours of the receipt of all necessary information. We will follow up in writing within 24 hours of the oral response to an expedited appeal.

For any concurrent review of an urgent care request, coverage for the treatment shall be continued without additional liability to You until you are notified of the review decision.

Complaint/Appeals Assistance from the Commonwealth of Virginia

If you have any questions regarding an appeal or grievance 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 (BOI), Office of the Managed Care Ombudsman may be contacted as follows:

Office of the Managed Care Ombudsman
Bureau of Insurance (BOI)
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.

Retrospective adverse determinations are not eligible for an expedited review.
If Your request is approved for an Expedited Appeal, the IRO assigned by the BOI will make a decision, as expeditiously as Your medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt, to uphold or reverse the adverse determination. You, Cigna and the BOI will be provided written notice within 48 hours after the date of providing the initial determination.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, Cigna shall promptly approve coverage of the recommended or requested health care service or treatment.

Please note that review and response requirements imposed on the IRO may be different than those shown above if the adverse determination is related to Experimental or Investigational Treatment. Should You wish to request an External Appeal for an adverse determination based in Experimental or Investigational Treatment, please contact Customer Service at the number on the back of Your member ID card, or You can contact the Virginia Bureau of Insurance at the contact information shown above.

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 professional qualifications and licensure of the person or persons reviewing the appeal; (2) a statement of the reviewers' understanding of the reason for Your appeal; (3) (1) information sufficient to identify the claim; (2) the specific reason or reasons for the denial decision, including the reviewers' decision in clear terms and the medical rationale in sufficient detail for You to respond further to Cigna's position; (3) reference to the specific Policy provisions on which the decision is based; (4) 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; (5) 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; and (6) information about, and contact information for, the Managed Care Patient Assistance Program. A final notice of adverse determination will include a discussion of the decision.

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

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.

Acceptable Third Party Payor means one or more of the following:

1. the Ryan White HIV/AIDS Program established under Title XXXVI of the Public Health Service Act;
2. an Indian tribe, tribal organization, or urban Indian organization;
3. a State or Federal government program; or
4. an independent private entity that (i) is organized as a not-for-profit organization under State law, (ii) has received a determination from the Internal Revenue Service that the entity qualifies for an exemption from federal income tax under 26 U.S.C. § 501(c)(3), and (iii) makes payments on Your behalf solely on the basis of Your financial need and does not in any way consider the health status of any Insured Person in determining whether to make such payments on Your behalf.

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

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

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

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

Coverage Area is any place that is within the counties, cities and/or zip code areas in the state of Virginia that Cigna has designated as the area where this Plan is available for enrollment. The Coverage Area includes the following counties; Amelia, Charles City, Chesterfield, Dinwiddie, Hanover, Henrico, Prince George, Sussex, Colonial Heights City, Hopewell City, Petersburg City, Richmond City, Alexandria City, Arlington, Clarke, Fairfax City, Fairfax, Falls Church City, Loudoun, Manassas City, Manassas Park City, Prince William, Stafford, and Warren.

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

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

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

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

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

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

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

Family Deductible applies if You have a Family plan and You and one or more of Your Family Member(s) are Insured under this Policy. Each Insured Person can contribute up to the Individual Deductible amount toward the Family Deductible. The Individual Deductible paid by each Family Member counts towards satisfying the Family Deductible. Once the Family Deductible amount is satisfied, the remaining Individual Deductibles will be waived for the remainder of the Year. The amount of the Family Deductible is described in the Benefit Schedule section of this Policy.

Family Member means Your spouse, children or other persons enrolled for coverage under this Policy. 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?”

Family Out-of-Pocket Maximum: The Family Out-of-Pocket Maximum is an accumulation of Covered Expenses that applies if You cover other Family Member(s). The Individual Out-of-Pocket paid by each Family Member counts toward satisfying the Family Out-of-Pocket Maximum. Each Insured Person can contribute up to the Individual Out-of-Pocket amount toward the Family Out-of-Pocket maximum. Once the Family Out of Pocket Maximum has been met for the Year, You and Your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family Out of Pocket Maximum and will always be paid by You. The amount of the Family Out-of-Pocket Maximum is described in the Benefit Schedule section of this Policy.

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

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

Immediate Family means all Family Members covered by this Policy.

Individual Out-of-Pocket Maximum: Once the Individual Out-of-Pocket Maximum has been met for the Year, for Covered Services, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year. Non-compliance penalty charges do not apply to the Individual Out-of-Pocket Maximum and will always be paid by You. The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for Covered dental Services. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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

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

Medically Necessary or Dentally Necessary
Covered Services and supplies are those determined by the Cigna Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Medically Necessary Orthodontic Care exists when there is a severe, dysfunctional, handicapping malocclusion.

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

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

Newborn is an infant within 31 days of birth.

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

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

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

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

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

Service Area means the area where in which Cigna has a Participating Provider network for use by this Plan. To locate a Provider who is Participating in the Network used by this Plan, call the toll-free number on the back of Your ID card, or check Cigna.com/ifp-providers or log onto www.mycigna.com and click on "find a Doctor, Dentist or Facility".

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

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