Cigna Health and Life Insurance Company may change the premiums of this Policy after 45 day's written notice to the Insured Person. No such change will be made until 12 months after the Effective Date. We will not change premium rates more frequently than once every 12 months. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company
Cigna Dental Pediatric

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.

This is a Legal Contract between the Insured and Cigna, Please Read Your Policy Carefully.

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 30 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
1-866-484-5967

Include Your Cigna identification number with any correspondence. This number can be found by calling 1.800.Cigna24 (1.800.244.6224).

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

Conditionally Renewable

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

IMPORTANT CANCELLATION INFORMATION – Please Read The Provision Entitled, "Cancellation", Found on Page 28.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY OR CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

Signed for Cigna by:

Julia M. Huggins, President ***Jill Stadelman, Corporate Secretary***

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Introduction

About This Policy

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

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine insurer and insured payment obligations.

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of North Carolina. 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 children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life, waiting periods do not apply. If additional premium is required you must submit an enrollment/change form within 31 days of acquiring the new Dependent child. If no additional premium is required, the child will be covered even if not formally enrolled in the plan. However, for ease of administration, you are encouraged to enroll the new Dependent child when coverage begins.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the child's adoption or the date of the adopted child's placement for adoption, as applicable waiting periods do not apply. If additional premium is required you must submit an enrollment/change form within 31 days of acquiring the new Dependent child. If no additional premium is required, the child will be covered even if not formally enrolled in the plan. However, for ease of administration, you are encouraged to enroll the new Dependent child when coverage begins.
- A foster child is automatically covered for 31 days from the date of placement in Your residence, as applicable waiting periods do not apply If additional premium is required you must submit an enrollment/change form within 31 days of acquiring the new Dependent child. If no additional premium is required, the child will be covered even if not formally enrolled in the plan. However, for ease of administration, you are encouraged to enroll the new Dependent child when coverage begins.
- If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic following the date on which the court order is issued. The child may not be disenrolled while you remain a subscriber unless the order is no longer valid or the child is enrolled in another plan with comparable coverage.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) 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 Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the Month following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; 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 state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange 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 Exchange 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 exchange 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;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange 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 coverage effective dates determined as follows:

- 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.
- With respect to Your spouse: when the spouse is no longer married to the Insured.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area. Coverage will not be denied for dependent children that move out of the Service Area, as long as the Insured remains covered.

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

Continuation

If an Insured Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

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.

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage amount because actual provider charges may not be used to determine our and your payment obligations.

Benefit	Participating Provider	Non–Participating Provider
Emergency Services	The Benefit for Emergency Services incurred for charges made by a Non-Participating Provider is the same Benefit as for Participating Provider Charges. The Insured may not be balance billed by a Non-Participating provider for Emergency Services.	
Calendar Year Maximum: Class A/I, B/II, C/III & D/IV	None	
Lifetime Maximum: Class D/IV	None	
Calendar Year Deductible: Class A/I	None	
Calendar Year Deductible: Class B/II, C/III & D/IV	$150 per person	
	$300 per family	
Separate Lifetime Deductible for Class D/IV	None	
Out of Pocket Maximum: Class A/I, B/II, C/III & D/IV	$375 per person	
	$750 per family	

Benefit	Percentage of Covered Expenses the Plan Pays	
	In-Network Participating Provider	**Out-of-Network Non –Participating Provider**
Class A/I - Preventive/Diagnostic Services	100%	95%
Class B/II - Basic Restorative Services	50% after Deductible	45% after Deductible
Class C/III - Major Restorative Services	50% after Deductible	45% after Deductible
Class D/IV – Medically Necessary Orthodontia	50% after Deductible	45% after Deductible

Waiting Periods

- There are no waiting periods for Class A/I, B/II, C/III or D/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;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- For Class A/I, B/II or C/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 Plan – 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 only responsible for the balance of the provider's Contracted Fee. We will pay our portion of the contracted fee and the covered person may be responsible for the balance remaining, but only up to the contracted fee amount. Our providers are precluded from balance billing beyond the contracted fee amount for covered services.

Payment for a service delivered by a non-Participating Provider is the Contracted Fee for that procedure as listed on the fee 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 Dental Schedule. The fee schedule usually has the lowest Contracted Fees available for acceptance by a Participating Provider in the relevant 3 digit zip code.

The covered person is responsible for the balance of the provider's actual charge***

Please see illustration below of a sample payment obligation:

COST EXAMPLE

PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	***actual charge = $150
*Contracted Fee = $95	**fee schedule = $90
benefit percentage = 50%	benefit percentage = 45%
Plan pays: Contracted Fee times benefit percentage:	**Plan pays:** fee schedule amount times benefit percentage:
$95 X 50% = **$47.50**	$90 X 45% = **$40.50**
You pay: Contracted Fee minus what plan pays:	**You pay:** actual charge minus what plan pays:
$95 - $47.50 = $47.50	$150 - $40.50=**$100.50**

Payment of any benefits will be subject to any applicable deductibles and maximum benefits shown in The Dental Schedule.

See definition section for further explanation of Contracted Fee.

Covered Dental Expenses

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

Class A/I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	

DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).
D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	2 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1510	Space maintainer - fixed - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth
D1516, D1517	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1526, D1627	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1551, D1552	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class B/II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5511, D5512	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5611, D5612	Repair resin denture base	
D5621, D5622	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 REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class C/III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3355, D3356	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	

D4273	Subepithelial connective tissue graft procedures, per tooth	
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period unless there is a necessary extraction of an additional functioning natural tooth.
D5282, D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6110, D6111	Implant/abutment supported removable denture for completely edentulous arch	
D6112, D6113	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,
D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,

D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D3114, D6115	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6116, D6117	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,
D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,

PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9222, D9223	Deep sedation/general anesthesia - first 30 minutes	
D9222, D9223	Deep sedation/general anesthesia - each additional 15 minutes	
D9239, D9243	Intravenous conscious sedation/analgesia - first 30 minutes	
D9239, D9243	Intravenous conscious sedation/analgesia - each additional 15 minutes	
CONSULTATIONS		
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	
MEDICATIONS		
D9610	Therapeutic drug injection, by report	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9944, D9945, D9946	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class D/IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

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.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). However, for dependent children, benefits will include coverage of an injury or sickness including the Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including cleft lip and cleft palate. Benefits are the same for congenital defects or anomalies, including individuals born with cleft lip or cleft palate, as are provided for other dental conditions that are covered by the plan.
- 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.
- Replacement of lost or stolen appliances.
- Replacement of teeth beyond the normal complement of 32.
- Prescription drugs.
- Any procedure, service, supply or appliance used primarily for the purpose of splinting.
- Orthodontic treatment, except 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.
- 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 Dentally Necessary.
- For services received before the Effective Date of coverage.
- For services received after coverage under this Policy ends.
- For services for which You have no legal obligation to pay or for which no charge would be made if You did not have dental insurance coverage.
- For Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Dentist, from any of the following:
    - Yourself or Your employer;
    - a person who lives in the Insured Person's home, or that person’s employer;
    - a person who is related to the Insured Person by blood, marriage or adoption, or that person’s employer.
- Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers'

Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

- 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, that is, the expenses were incurred in connection with an unlawful, fraudulent act;
- For charges which the person is not legally required to pay;
- For charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan;
- To the extent that billed charges exceed the rate of reimbursement as described in the Schedule, except in the case of Emergency Services;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Any services covered under both a medical plan and this dental plan and reimbursed under the medical plan will not be reimbursed under this Plan.

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.

Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

You should be aware and understand that you may be giving up certain rights to have your dispute settled in and by a court of law, unless the law in your state provides for judicial review of arbitration proceedings.

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 or under its reinstatement, if applicable, no 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 10 day grace period for the receipt of monthly premium policies at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 10 day grace period for monthly premium policies and the end of the 31 day grace period for the receipt of all other premium policies.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage (see provisions listed under "Specific Causes for Ineligibility").
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. This policy is renewable at the option of the policyholder unless sufficient written notice of nonrenewal is given to each Insured Person. When We cease to offer policies of this type to all individuals in Your class, North Carolina law requires that we give notice. During the first year of any policy or during the first year following any lapse and reinstatement we will provide written notice to each Insured Person of the discontinuation before the 30th day preceding the premium due date. After one year of continuous coverage, written notice shall be the number of full months most nearly equivalent to one fourth the number of months of continuous coverage from policy inception to the date of mailing of the notice, provided no period of required notice shall exceed two years. We will also offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When the Insured no longer lives in the Service Area, (coverage will not be cancelled for dependent children that move out of the Service Area, as long as the Insured remains covered).

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

Modification of Coverage: We may modify this policy, including Policy provisions, benefits and coverages, by providing written notice to the Insured Person affected by such modification. Failure of an Insured Person to object in writing to any such proposed modification within 45 days following receipt of notice shall constitute the Insured Person's acceptance of such modification. Modification will be effective on a uniform basis among all individuals with coverage under this same Policy form. We will only modify this Policy for all Insured Persons in the same class and covered under the same Policy form, and not just on an individual basis. We will send written notice and the change will become effective, subject to the 45-day notice period described in the Premiums provision, on the date shown in the notice or on the next scheduled premium due date thereafter. Payment of the premiums will indicate acceptance of the change.

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

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

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

Renewal: This Policy renews on a Calendar Year basis.

Fraud: Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which "MAY" subject the person to criminal and civil penalties. If the Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made within 60 days of discovery so that We will be paid the premium rate appropriate for the true age of the Insured Person.

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

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

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

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

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

- When the amount paid by Cigna exceeds the amount for which We are liable under this Policy, We have the right to recover the excess amount from the Insured Person unless prohibited by law.
- In order for an Insured Person to be entitled to benefits under this Policy, coverage under this Policy must be in effect on the date the expense giving rise to a claim for benefits is incurred. Under this Policy, an expense is incurred on the date the Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured Person assigns benefits in writing no later than the time of filing proof of loss (claim), except for Foreign Country Provider claims. If We receive a claim from a Foreign Country Provider for Emergency Services, any eligible payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured Person for those services.
- Any payment of benefits in reimbursement for Covered Expenses paid by an eligible child, or the eligible child's custodial parent or legal guardian, will be made to the eligible child, the eligible child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the eligible child.

- Cigna will provide written notice to You within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- 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.

Network Providers 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.

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

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

Premiums

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

You will be responsible for an additional $25 charge for any check or electronic funds transfer that is returned to Us unpaid.

Rates will be guaranteed for no less than 12 months.

There is a 10 day grace period for the receipt of monthly premium policies and 31 days for the receipt of all other premium policies at Our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums.

We will refund unearned premium in the event of Your death or if you wish to discontinue coverage.

Your premium may change from time to time due to (but not limited to):

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium with 45 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 and no more frequently than once in any 12 consecutive month period. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

How to File a Claim for Benefits

Notice of Claim: Written notice of claim or valid receipt with information sufficient to identify the insured must be given within 180 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Us at the address shown on the first page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224) or to any authorized agent of the insurer. Notice should include the name of the Insured, and claimant if other than the Insured, and the Policy identification number.

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

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

Proof of Loss: You must give Us written proof of loss within 180 days after the date of the loss and in the case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 180 days after the termination of the period for which the insurer is liable,, except in absence of legal capacity. Proof of loss is a claim form or letter as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time proof is otherwise required.

Assignment of Claim Payments:

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

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

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

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

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

Payment of Claims: Cigna shall within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:

- Payment of the claim.
- Notice of denial of the claim.
- Notice that the proof of loss is inadequate or incomplete.
- Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.
- Notice that the claim is pending based on nonpayment of fees or premiums.
- If we request additional information and we do not receive the additional information within 90 days after the request is made, we will deny the claim and send the notice of denial to You.

Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. Any benefits due You which are unpaid at Your death will be paid to Your estate.

Cigna is entitled to receive from any Provider of service information about You which is necessary to administer claims on Your behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, You have authorized every Provider furnishing care to disclose all facts pertaining to Your care, treatment, and physical condition, upon Our request. You agree to assist in obtaining this information if needed.

Payments of benefits under this Plan neither regulate the amounts charged by Providers of dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured Person for whom a claim is made, when and so often as We may reasonably require during the pendency of a claim under this Policy.

When you Have a Complaint or an Appeal

THE FOLLOWING WILL APPLY TO RESIDENTS OF NORTH CAROLINA

Quality of Clinical Care Complaints

For complaints concerning the quality of clinical care delivered by Your provider, we shall acknowledge the complaint within 10 working days. The acknowledgment shall advise You that: (1) Cigna will refer the complaint to its quality assurance committee for review and consideration or any appropriate action against Your provider and (2) the North Carolina law does not allow for a second-level complaint review for complaints concerning quality of care.

When You Have a Complaint or An Appeal

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

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

Start with Member Services

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

Customer Services Toll-Free Number 1.800.Cigna24 (1.800.244.6224)

or address that appears on explanation of benefits or claim form

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

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

Appeals Procedure

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

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional who is licensed to practice medicine in North Carolina.

For level one appeals we will provide You, within three working days after receiving Your request for review, with the name, address and telephone number of the Appeal Coordinator and information on how to submit written material. We will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. Cigna will remain liable for charges during a concurrent review until You are notified of Cigna's decision. You will receive a detailed response in writing for the coverage determination decision in clear terms describing the contractual basis or medical rationale.

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

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

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

Level Two Appeal

If You are dissatisfied with our level one appeal decision, You may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration and who is licensed to practice medicine in North Carolina, as determined by Cigna's Dentist reviewer. You may present Your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing within 10 working days after we received Your request and schedule a Committee review. The acknowledgement will include the name, address, and telephone number of the Appeal Coordinator. The acknowledgement will also include a description of Your appeal rights, including the right to: (a) request and receive all information relevant to the review; (b) attend the Committee meeting; (c) present Your case to the Committee and submit supporting materials before and at the Committee meeting; (d) ask questions of any Committee member; and (e) be assisted by a representative of Your choice such as a Physician, family member, Employer representative, or attorney. An attorney representing Cigna may also attend. For postservice claims, the Committee review will be completed within 30 calendar days. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

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

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.

Notice of Benefit Determination on Appeal

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

Essential Health Benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

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

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

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

In-Network Covered Services means covered health care services that are received according to the rules of the health benefit plan from providers employed by, under contract with, or approved in advance by Cigna; and means emergency health care services regardless of the status or affiliation of the provider of such services.

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

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

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

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

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

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

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

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

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

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

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

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the fee 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.

Out-of-Network Covered Services means non-emergency, medically necessary covered health care services that are not received according to the rules of the health benefit plan, including services from affiliated providers that are received without the approval of Cigna.

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

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

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

Service Area is any place that is within the state of North Carolina.

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.