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

Cigna Health and Life Insurance Company ("Cigna")

Cigna Dental 1500 Plan

If You Wish To Cancel Or If You Have Questions

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

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

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

If the policy is issued due to a direct response solicitation, then the Notice is the same except the Insured Person has 30 days in which to return the policy to get a refund of any premium paid.

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

Guaranteed Renewable

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

Signed for Cigna by:

Julia M. Huggins, President

Jill Stadelman, Corporate Secretary

HC-NOT46

Table of Contents

HC-TOC14

Introduction

About This Policy

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

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

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

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

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

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

How to File a Claim for Benefits

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

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

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

Proof of Loss: You must give Us written proof of loss within 12 months after the date of the loss, except in absence of legal capacity. Proof of loss is a claim form or letter as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period. Failure to furnish proof within the time allowed shall not cancel or reduce any claim if it can be shown that proof was furnished as soon as it was reasonably possible.

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: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. Any benefits due You which are unpaid at Your death will be paid to Your estate.
Cigna is entitled to receive from any Provider of service information about You which is necessary to administer claims on Your behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, You have authorized every Provider furnishing care to disclose all facts pertaining to Your care, treatment, and physical condition, upon Our request. You agree to assist in obtaining this information if needed.

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

Physical Examination : Cigna, at its own expense, shall have the right and the opportunity to examine any Insured Person for whom a claim is made, when and so often as We may reasonably require during the pendency of a claim under this Policy.
HC-CLM58

Who Is Eligible For Coverage

Conditions Of Eligibility

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

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

- Your lawful spouse or domestic partner or partner to a civil union.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, or Your spouse's or domestic partner or Your partner to a civil union's children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or domestic partner or Your partner to a civil union's Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of adoption or initiation of a suit of adoption, and paying any additional premium.
- If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

Specific Causes for Ineligibility

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

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

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

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

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

Continuation

If an Insured Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.
HC-ELG56

BENEFIT SCHEDULE

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

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

CIGNA DENTAL PREFERRED PROVIDER INSURANCE ***The Schedule***
For You and Your Dependents
The Schedule
If you select a Participating Provider, your cost will be less than if you select a Non-Participating Provider.
Emergency Services The Benefit Percentage payable for Emergency Services charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.
Deductibles Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.
Participating Provider Payment Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and CHLIC.
Non-Participating Provider Payment Non-Participating Provider services are paid based on the Contracted Fee.
Simultaneous Accumulation of Amounts Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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

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

HC-SOC257

Waiting Periods

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

- there is no waiting period for Class I, services;
- after 6 consecutive months of coverage dental benefits will increase to include the list of Class II procedures;
- after 12 consecutive months of coverage dental benefits will increase to include the list of Class III procedures;
- after 12 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures.

HC-DBW8

Covered Dental Expense: What The Policy Pays For

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

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

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is Medically Necessary and/or Dentally Necessary.

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

Predetermination of Benefits

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

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

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

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

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

Covered Services

The following section lists covered dental services. If a service is not listed there is no payment unless Cigna agrees to cover it. If Cigna agrees to cover the service the level of payment will be consistent with similar services that provide the least expensive professionally satisfactory result.
HC-DEN142

Dental PPO - Participating and Non-Participating Providers

Participating Providers

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

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

The Contracted Fee may vary based on geographical area.

Non-Participating Providers

Plan payment for a covered service delivered by a non-Participating Provider is the Maximum Allowable Charge (MAC) fee for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule.

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

New Jersey – MAC Fee Amounts

The MAC is the fee for that procedure aligned to the 3-digit zip code for the geographical area where the service is performed. This sample list of the 100 most utilized procedures contains the lowest amounts that Cigna will use as the basis for its payments in New Jersey. These amounts may be higher in your geographical area. To obtain the amount for a specific procedure or a complete list of procedure amounts for your geographical area, please call 1-800-Cigna24.

ADA Code	ADA Nomenclature *Procedures with an average charge $750 or greater.	MAC Fee
D0120	Periodic oral evaluation - established patient	$ 21
D0140	Limited oral evaluation - problem focused	$ 44
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$ 21
D0150	Comprehensive oral evaluation - new or established patient	$ 32
D0180	Comprehensive periodontal evaluation - new or established patient	$ 32
D0210	Intraoral - complete series (including bitewings)	$ 62
D0220	Intraoral - periapical first film	$ 11
D0230	Intraoral - periapical each additional film	$ 7
D0240	Intraoral - occlusal film	$ 16
D0270	Bitewing - single film	$ 11
D0272	Bitewings - two films	$ 18
D0274	Bitewings - four films	$ 27
D0277	Vertical bitewings - 7 to 8 films	$ 38
D0330	Panoramic film	$ 48
D0350	2-D Oral / facial photographic images obtained intraorally or extraorally	$ 22
D0470	Diagnostic casts	$ 47
D1110	Prophylaxis - adult	$ 40
D1120	Prophylaxis - child	$ 30
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$ 16
D1208	Topical application of fluoride - Excluding Varnish	$ 16
D1351	Sealant - per tooth	$ 25
D1510	Space maintainer - fixed - unilateral	$ 146
D2140	Amalgam - one surface, primary or permanent	$ 48
D2150	Amalgam - two surfaces, primary or permanent	$ 63
D2160	Amalgam - three surfaces, primary or permanent	$ 78
D2161	Amalgam - four or more surfaces, primary or permanent	$ 91

ADA Code	ADA Nomenclature *Procedures with an average charge $750 or greater.	MAC Fee
D2330	Resin-based composite - one surface, anterior	$ 63
D2331	Resin-based composite - two surfaces, anterior	$ 83
D2332	Resin-based composite - three surfaces, anterior	$ 111
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$ 113
D2391	Resin-based composite - one surface, posterior	$ 63
D2392	Resin-based composite - two surfaces, posterior	$ 82
D2393	Resin-based composite - three surfaces, posterior	$ 111
D2394	Resin-based composite - four or more surfaces, posterior	$ 116
D2740	Crown - porcelain/ceramic substrate*	$ 480
D2750	Crown - porcelain fused to high noble metal*	$ 482
D2751	Crown - porcelain fused to predominantly base metal*	$ 416
D2752	Crown - porcelain fused to noble metal*	$ 442
D2790	Crown - full cast high noble metal*	$ 454
D2920	Re-cement or re-bond crown	$ 43
D2930	Prefabricated stainless steel crown - primary tooth	$ 106
D2940	Sedative filling	$ 43
D2950	Core buildup, including any pins	$ 80
D2952	Post and core in addition to crown, indirectly fabricated*	$ 166
D2954	Prefabricated post and core in addition to crown	$ 138
D2962	Labial veneer (porcelain laminate) - laboratory*	$ 387
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$ 75
D3221	Pulpal debridement, primary and permanent teeth	$ 75
D3310	Endodontic therapy, anterior tooth (excluding final restoration)*	$ 326
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)*	$ 380
D3330	Endodontic therapy, molar (excluding final restoration)*	$ 513
D3348	Retreatment of previous root canal therapy - molar	$ 602
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$ 62
D4249	Clinical crown lengthening - hard tissue*	$ 385
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant*	$ 534
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant*	$ 267
D4263	Bone replacement graft - first site in quadrant	$ 187
D4266	Guided tissue regeneration - resorbable barrier, per site*	$ 272
D4273	Subepithelial connective tissue graft procedures, per tooth*	$ 427
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$ 104
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$ 52
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$ 62
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$ 46
D4910	Periodontal maintenance	$ 66
D5110	Complete denture - maxillary*	$ 631
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	$ 699
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)*	$ 699
D5650	Add tooth to existing partial denture	$ 82
D6058	Abutment supported porcelain/ceramic crown	$ 650
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$ 668

ADA Code	ADA Nomenclature *Procedures with an average charge $750 or greater.	MAC Fee
D6242	Pontic - porcelain fused to noble metal	$ 442
D6245	Pontic - porcelain/ceramic	$ 480
D6740	Crown - porcelain/ceramic	$ 480
D6750	Crown - porcelain fused to high noble metal	$ 482
D6751	Crown - porcelain fused to predominantly base metal	$ 416
D6752	Crown - porcelain fused to noble metal	$ 442
D6930	Recement fixed partial denture	$ 59
D7111	Extraction, coronal remnants - deciduous tooth	$ 58
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$ 58
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$ 118
D7220	Removal of impacted tooth - soft tissue	$ 143
D7230	Removal of impacted tooth - partially bony	$ 192
D7240	Removal of impacted tooth - completely bony	$ 218
D7250	Surgical removal of residual tooth roots (cutting procedure)	$ 118
D7953	Bone replacement graft for ridge preservation - per site	$ 182
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$ 3,338
D8090	Comprehensive orthodontic treatment of the adult dentition	$ 3,338
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$ 37
D9220	Deep sedation/general anesthesia - first 30 minutes	$ 185
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$ 67
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$ 168
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$ 52
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$ 48
D9610	Therapeutic parenteral drug, single administration	$ 24
D9910	Application of desensitizing medicament	$ 22
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$ 27
D9940	Occlusal guard, by report	$ 221
D9951	Occlusal adjustment - limited	$ 50

HC-DEN195

Class I Services - Diagnostic and Preventive Dental Services

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

HC-DEN76

Class II Services

Diagnostic Services

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

Fillings

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

Oral Surgery, Routine Extractions

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

Miscellaneous Services

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

HC-DEN77

Class III Services

Diagnostic Procedures

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

Denture Adjustments, Rebasing and Relining

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

Repairs To Crowns and Inlays

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

Repairs To Dentures and Bridges

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

Inlays, Onlays and Crowns

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

Endodontic Procedures

- Therapeutic Pulpotomy - Payable for deciduous teeth only.
- Root Canal Therapy, Primary Tooth (excluding final restoration) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Root Canal Therapy - Permanent Tooth - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Root Canal Therapy, Retreatment - by Report - Covered only if more than 24 consecutive months have passed since the original endodontic therapy and only if necessity is confirmed by professional review.

- Apexification - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. A maximum of 3 visits per tooth are payable.
- Apicoectomy - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Retrograde Filling (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Not separately payable on the same date and tooth as an Apicoectomy.
- Root Amputation (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.
- Hemisection - Fixed bridgework replacing the extracted portion of a hemisected tooth is not covered. Procedure includes local anesthesia and routine postoperative care.

Minor Periodontal Procedures

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

Major Periodontal Surgery

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

Oral Surgery - Surgical Extractions

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

Other Oral Surgery

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

Surgical Extraction of Impacted Teeth

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

Prosthetics

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

Anesthesia and IV Sedation

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

HC-DEN78

Each month of active treatment is a separate Dental Service.

Class IV - Covered Orthodontic Treatment

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

Orthodontia Provision

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

Replacement Provisions For Orthodontic Coverage

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

HC-DEN79

Miscellaneous

As a Cigna Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and wellbeing. Please visit our website at www.cigna.com for details.

If you are a Cigna Dental plan member, you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

HC-POB49

Missing Teeth Limitation

There is no payment for replacement of teeth that are missing when a person first becomes insured.
HC-MTL8

Exclusions And Limitations: What Is Not Covered By This Policy

Expenses Not Covered

Covered Expenses do not include expenses incurred for:

- procedures which are not included in the list of Covered Dental Expenses.
- procedures which are not included in the list of Covered Dental Expenses.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- the alteration or restoration of occlusion.
- the restoration of teeth which have been damaged by erosion, attrition or abrasion.
- bite registration or bite analysis.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of a full denture or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan (the removal of only a permanent third molar will not qualify a full or partial denture for benefit under this provision).
- the initial placement of a fixed bridge, unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. If a bridge replaces teeth that were missing prior to the date the person's coverage became effective and also teeth that are extracted after the person's effective date, benefits are payable only for the pontics replacing those teeth which are extracted while the person was insured under this plan. The removal of only a permanent third molar will not qualify a fixed bridge for benefit under this provision.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.
- core build-ups.
- replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
  - (a) replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or
  - (b) the partial denture is less than 84 consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
  - (c) replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional Necessary extraction of a functioning natural tooth while the person is covered under this

plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminate).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- treatment of jaw fractures and orthognathic surgery.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time or transportation costs.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- diagnostic casts, diagnostic models, or study models.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

HC-DEX24

When You Have a Concern or Complaint

Definitions

Administrative Appeals
Administrative appeals are issues raised by any person covered under a managed care plan about any aspect of the coverage under the managed care plan, the carrier's network, and the services provided by health care Providers in the carrier's network. They include denials based on a determination of member ineligibility, including rescission, or the application of a contract exclusion or limitation not relating to medical or dental necessity.

Adverse Benefit Determination Appeals
Adverse benefit determination appeals are appeals of denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including from application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because the item or service is experimental or investigational, cosmetic, excluded because the carrier has rescinded the coverage. They do not include denials based on a determination of member ineligibility, including rescission, or the application of a contract exclusion or limitation not relating to medical or dental necessity

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 and a “Dentist reviewer” is a licensed Dentist, depending on the care, treatment or service under review who is also a Medical Director or his or her designee who rendered the initial adverse determination.

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.

Complaints and Administrative Appeals Regarding Contractual Benefits, Quality of Care and Services

Start with Member Services

We are here to listen and help. If You have a specific concern or complaint regarding a person, a service, the quality of care, choice of or access to Providers, Provider network adequacy, contractual benefits or a determination of ineligibility, including rescission, You or Your designated representative (including Your treating Provider) can call our toll-free number and explain Your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

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

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

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

Administrative Appeals Procedure

Cigna has a one step appeals procedure for coverage decisions. To initiate an Administrative Appeal, You must submit a request for an appeal in writing within 180 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 calling the toll-free number on mycigna.com. If You choose to designate a representative to appeal on Your behalf, including Your treating Provider, all correspondence related to Your appeal will be sent to Your designated representative and You. If You do not want such representative to pursue the appeal on Your behalf, You must notify Cigna that You do not want this representative appealing this issue on Your behalf.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Expedited appeals will be considered by a health care professional.

For level one appeals, we will acknowledge in writing that we have received Your request within 10 business days and respond in writing with a decision within 30 calendar days after we receive an appeal for a post-service coverage determination or within 15 calendar days for a pre-service coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of Your Dentist would cause You severe pain which cannot be managed without the requested services; or (b) Your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Dentist reviewer, in consultation with Your treating Provider, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond with a decision within 72 hours.

Appeal to the State of New Jersey

For Administrative Appeals, if You remain dissatisfied after exhausting Cigna's Complaint and Appeal procedure, You may appeal to the State of New Jersey Department of Banking and Insurance at the following address and telephone number:

Consumer Protection Services
New Jersey Department of Banking and Insurance
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
(609) 292-5316

You may also wish to access an online New Jersey complaint form at: www.state.nj.us/dobi/enfcon.htm.

Appeals Regarding Required Medical Necessity and Utilization Review Determinations

Initial Determination

Cigna is responsible for making decisions about the appropriateness, medical necessity and efficiency of health care services provided to Members under this Certificate. All decisions to deny or limit coverage for an inpatient admission, a service, a procedure or an extension of inpatient stay, or because coverage has been rescinded, are made by a New Jersey-licensed Dentist.

The health care determinations made by Cigna are directly communicated to the treating or requesting provider (including a Provider acting on Your behalf with Your consent, if such provider is the requesting Provider) on a timely basis appropriate to the Member's medical needs. Cigna will not reverse its initial determination of medical necessity or appropriateness unless misrepresented or fraudulent information was submitted to Cigna as part of the request for health care services.

You or Your designated representative (including a Provider acting on Your behalf with Your consent) may request a written notice of an initial determination made by Cigna, including an explanation of the Adverse Benefit Determination Appeal process.

Adverse Benefit Determination Appeals Procedure

Cigna has a one step procedure for Adverse Benefit Determination Appeals. To initiate an Adverse Benefit Determination appeal, You must submit a request for an appeal in writing to the address that appears on mycigna.com, explanation of benefits or claim form within 180 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 calling the toll-free number on mycigna.com. If you choose to designate a representative to appeal on Your behalf, including Your treating Provider, all correspondence related to Your appeal will be sent to Your designated representative and You. If You do not want such representative to pursue the appeal on Your behalf, You must notify Cigna that You do not want this representative appealing this issue on Your behalf.

Level One Appeal

You have the opportunity to speak with, and may request appeal review by, Cigna's Dentist reviewer.

For level one appeals, we will respond in writing with a decision within five business days after we receive an appeal.

You may request that the appeal process be expedited if: (a) the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of Your Dentist would cause You severe pain which cannot be managed without the requested services; (b) Your appeal involves non-authorization of an admission or continuing inpatient Hospital stay; or (c) Your appeal addresses a determination regarding urgent or emergency care. Cigna's Dentist reviewer, in consultation with the treating Dentist will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond with a decision within 72 hours.

You or Your treating Provider, on Your behalf, may request review of Your appeal by the IURO without completing the internal review if:

- Cigna has missed any timeframes associated with the processing of Your medical necessity appeal. You must certify to the IURO that You or Your treating provider, on Your behalf, did not hinder Cigna from making a timely determination by failing to provide the information required for Cigna to make its decision, or
- Cigna waives its right to an internal review of your appeal, or
- You have applied for an expedited external review at the same time as applying for an expedited internal appeal.

External Appeals of Utilization Management Determinations

After exhausting Cigna's Medical Necessity Appeal procedure, if You remain dissatisfied with Cigna's health care determination, You may initiate a review by an independent utilization review organization (IURO) within 60 calendar days from the receipt of Cigna's final written decision. To initiate a review, You or Your treating provider, on Your behalf, should complete the State of New Jersey IURO forms provided by Cigna and mail the completed forms to:

Department of Banking and Insurance
Consumer Protection Services Office
of Managed Care
PO Box 329
Trenton, New Jersey 08625-0329
(888) 393-1062

along with a check or money order for $25 payable to the "New Jersey Department of Banking and Insurance" (this fee may be reduced to $2 in cases of financial hardship). If a Provider is appealing to the IURO on Your behalf, the Provider is responsible for paying Your portion of the cost of the IURO appeal (e.g. $25, or $2 if financial hardship). Cigna will bear the remaining costs of the review.

You or Your treating provider, on Your behalf, may also request review of Your appeal by the IURO if Cigna has missed any timeframes associated with the processing of Your medical necessity appeal. If this is the case, You must certify to the IURO that You or Your treating provider, on Your behalf, did not hinder Cigna from making a timely determination by failing to provide the information required for Cigna to make its decision.

Once the IURO communicates its decision, Cigna will respond within 10 business days to You (or the provider, on Your behalf) the IURO and the Department of Banking and Insurance with a written report describing how Cigna will implement the IURO's decision.

The External Appeals Program is a voluntary program. The decision of the IURO is binding on Cigna.

Appeal to the State of New Jersey

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

Department of Banking and Insurance
Consumer Protection Services Office
of Managed Care
PO Box 329
Trenton, New Jersey 08625-0329
(888) 393-1062

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an Adverse Benefit Determination, the notice will be provided in a culturally and linguistically appropriate manner and provide information sufficient to identify the claim, including:

- date of service;
- health care Provider;
- claim amount (if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- denial code and its corresponding meaning;
- a description of the standard, if any, used in denying the claim;
- a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer;
- reference to the specific Policy provisions on which the decision is based;
- 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;
- for a final Adverse Benefit Determination, the notice must include a discussion of the decision; and
- a description of available external review processes, including information about how to initiate an appeal;

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.

Legal Action Following Appeals

If Your plan is governed by ERISA, You have the right to bring a civil action in federal court under Section 502(a) of ERISA if You are not satisfied with the outcome of the Appeals Procedure. In most instances, You may not initiate a legal action against Cigna until You have completed the Level One and Level Two Appeal processes. If Your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action in federal court.

If Your plan is governed by New Jersey P.L.2001, c.187 (2A:53A-30 et seq), You have the right to bring action in state court accordance with that statute. You must exhaust the Independent Health Care Appeals Program procedures created pursuant to section 11 of P.L.1997, c.192 (C26:2S-11), before filing an action in state court, unless serious or significant harm to the covered person has occurred or will imminently occur, before filing an action in state court for economic and non-economic loss that occurs as a result of Cigna's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of a covered person's: (1) death; (2) serious and protracted or permanent

impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition resulting in chronic and significant pain; or (7) substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care.
HC-APL175

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.
HC-APL140

Terms of the Policy

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

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

Grace Period: There is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period 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, by written notice, only in the event of any of the following:

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, New Jersey law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in New Jersey in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area.

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

Rescissions: Your coverage may not be rescinded (retroactively terminated) by Cigna unless: you (or a person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; or makes an intentional misrepresentation of material fact. If a rescission occurs, Cigna will provide 30 days advance notice.

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

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

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

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

Fraud: 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 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 33630-3365

- When the amount paid by Cigna exceeds the amount for which We are liable under this Policy, We have the right to recover the excess amount from the Insured Person unless prohibited by law.

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

Premiums

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

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

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

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

a. Deletion or addition of a new eligible Insured Person(s);

b. A change in age of any member which results in a higher premium;

c. A change in residence.

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

Cigna also reserves the right to change the premium on 30-90 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.
HP-POL234

Definitions

The following definitions contain the meanings of key terms used in this Policy. Throughout this Policy, the terms defined appear with the first letter of each word in capital letters.
HC-DFS556

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

Cigna. We, Our, and Us mean Cigna (Cigna Health and Life Insurance Company), or an affiliate. Cigna is a licensed and regulated insurance company operating throughout the United States.
HC-DFS521

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

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

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Contracted Fee. In addition, Covered Expenses may be limited by other specific maximums described in this Policy. Covered Expenses are subject to applicable Deductibles and other benefit limits. **An expense is incurred on the date the Insured Person receives the service or supply.** Covered Expenses may be less than the amount that is actually billed.
HC-DFS525

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.
HC-DFS526

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.
HC-DFS527

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

Dentist. The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the dental services described in the policy.
HC-DFS530

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

Family Member means Your spouse, Domestic Partner, partner to a civil union, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"
HC-DFS631

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the covered person's upper or lower arch and which is opposed in the covered person's other arch by another natural tooth or prosthetic (i.e., artificial) replacement.
HC-DFS535

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

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

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

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

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

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.
HC-DFS542

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development for the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).
HC-DFS544

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.
HC-DFS545

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

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.
HC-DFS548

Orthodontic Treatment means the corrective movement of the teeth through the alveolar bone by means of an active appliance to correct a handicapping malocclusion of the mouth.
HC-DFS547

Participating Provider - Cigna Dental Preferred Provider is a Dentist or a professional corporation, professional association, partnership, or any other entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services at predetermined fees with regard to a particular Policy under which an Insured Person is covered. The providers qualifying as Participating Providers may change from time to time.
HC-DFS549

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

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

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

You, Your, and Yourself is the Policyholder who has applied for, and been accepted for coverage, as an Insured under the Policy and is named on the specification page.
HC-DFS555

This document may include the following filed and approved form numbers

HC-NOT46
HC-TOC14
HC-SPP14
HC-CLM58
HC-ELG56
HC-SOC186
HC-SOC257
HC-DBW8
HC-DEN142
HC-DEN140
HC-DEN76
HC-DEN77
HC-DEN78
HC-DEN79
HC-DEN80
HC-DEN141
HC-DEN195
HC-POB49
HC-MTL8
HC-DEX24
HC-SUB40
HC-BEX43
HC-APL175
HC-APL140
HP-POL234
HC-DFS556
HC-DFS519
HC-DFS521
HC-DFS522
HC-DFS523
HC-DFS525
HC-DFS526
HC-DFS527
HC-DFS528
HC-DFS530
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