

Cigna Health and Life Insurance Company (“Cigna”)

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

Cigna Dental 1500

POLICY FORM NUMBER: HC-NOT46, et., al.

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Cigna Health and Life Insurance Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

A. Coverage is provided by Cigna Health and Life Insurance Company (referred to herein as “Cigna”), an insurance company that provides participating provider benefits.

B. To obtain additional information, including Provider information write to the following address or call the toll-free number:

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

C. A Participating Provider Plan enables the Insured to incur lower dental costs by using providers in the Cigna network.

A **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.

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

D. Covered Services and Benefits

Benefits covered by your Dental Plan include Preventive & Diagnostic Care such as Oral Exams, Cleanings and X-Rays. Your Plan also includes Basic Restorative Care such as fillings and simple extractions. Major Restorative Care is covered under your plan and includes Crowns, Dentures and Bridges. Coverage for Orthodontia is also included under your plan. For a complete listing of covered services, please read your plan documents.

The frequency of certain Covered Services, like cleanings, are limited. Refer to your Policy for specific limitations on frequency under your plan.

HC-NOT12.OOC

BENEFIT SCHEDULE

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-SOC188.OOC

CIGNA DENTAL PREFERRED PROVIDER INSURANCE <i>The Schedule</i>
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	\$50 per person Not Applicable to Class I	
Individual		
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	Cigna DPPO Advantage Participating Providers	Cigna DPPO Participating Providers** and 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.OOC

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 6 consecutive months of coverage dental benefits will increase to include the list of Class III procedures;
- after 6 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures.

HC-DBW8.OOC

E. Insured's Financial Responsibility

The Insured is responsible for paying the monthly or quarterly premium on a timely basis. The Insured is also responsible to pay Providers for charges that are applied to the Deductibles, Coinsurance, and any amounts charged by Non-Participating Providers in excess of the Maximum Reimbursable Charges. In addition, any charges for Dentally Necessary items that are excluded under the Policy are the responsibility of the Insured.

HC-POB59.OOC

F. 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 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 (laminare).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- treatment of jaw fractures and orthognathic surgery.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, 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.OOC

G. Predetermination of Benefits Program

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.

HC-DEN82.OOC

H. General Provisions

When You Have a Concern or Complaint

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 or contractual benefits, 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 appeals procedure.

Administrative Appeals Procedure

Cigna has a two 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 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 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.

Level Two Appeal

If You are dissatisfied with our level one appeal decision, You may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal, except that such a request must be submitted within 60 days from Your receipt of a Level One Appeal decision.

Requests for a second review will be acknowledged in writing that we have received Your request within 10 business days. Post-service requests will be completed within 30 calendar days, while most pre-service

requests will be completed within 15 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You will be notified in writing of the decision.

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 nonauthorization of an admission or continuing inpatient Hospital stay. 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.

Appeal to the State of New Jersey

For appeals regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy, or the contractual benefits, 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, 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 Medical Necessity Appeal process.

Medical Necessity Appeals Procedure

Cigna has a two step procedure for coverage decisions. To initiate a Medical Necessity 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 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.

Level Two Appeal

If You are dissatisfied with our level one appeal decision, You may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal, except that such a request must be submitted within 60 days from Your receipt of a Level One Appeal decision.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least one Dentist reviewer and two other Dentists/health care professionals. Anyone involved in the prior decision may not participate on the Appeal Committee. The committee will consult with at least one Dentist in the same or similar specialty as the care under consideration, as determined by Cigna's Dentist reviewer. You may request that the same or similar specialist be a participant on the committee. You may present Your situation to the committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received Your request within 10 business days and schedule a committee review. The committee review will be completed within 15 calendar days for pre-service appeals and 20 business days for post-service appeals. If more time or information is needed to make the determination, we will notify the Department of Banking and Insurance and You in writing to request an extension of up to 15 calendar days for pre-service appeals and 20 business days for post-service appeals and to specify any additional information needed by the Appeals Committee to complete the review. You will be notified in writing of the Appeals Committee's decision.

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. When an appeal is expedited, we will respond with a decision within 72 hours.

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 Provider, on Your behalf, should complete the State of New Jersey IURO forms provided by Cigna and mail the completed forms to:

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

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 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 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:

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

Notice of Benefit Determination on Appeal

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

Relevant Information

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

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.OOC

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.OOC

I. Participating Providers

Cigna will provide a current list of dentists currently participating with Cigna and their locations to each Insured upon request.

To verify if a dentist is currently participating with Cigna and is accepting new Cigna Insured's, the Insured should visit our website at mycigna.com.

HC-IMP102.OOC

J. Renewability, Eligibility, and Continuation

1. The Policy will renew except for the specific events stated in the Policy. Cigna may change the premiums of the Policy with 30 days written notice to the Insured. However, Cigna will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all insured's in the same class and covered under the same Policy as You.
2. The Individual Plan is designed for residents of New Jersey who are not enrolled under or covered by any other group or individual health coverage. You must notify Cigna of all changes that may affect any Insured Person's eligibility under the Policy.
3. You or Your Insured Family Member(s) will become ineligible for coverage:
 - 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 civil 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.

4. 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-ELG58.OOC

K. Premium

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 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.

HC-POL190.OOC

This document may include the following filed and approved form numbers

HC-NOT12.OOC
HC-SOC188.OOC
HC-SOC257.OOC
HC-DBW8.OOC
HC-DFS539.OOC
HC-POB59.OOC
HC-DEX24.OOC
HC-DEN82.OOC
HC-APL175.OOC
HC-APL140.OOC
HC-IMP102.OOC
HC-ELG58.OOC
HP-POL190.OOC