Cigna Health and Life Insurance Company may change the premiums of this Policy after 60 day's written notice to the Covered Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Covered Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")

Home Office: 900 Cottage Grove Road, Bloomfield, CT 06002

Cigna Dental Vision 1000 Plan

THIS IS A LIMITED BENEFIT DENTAL AND VISION EXPENSE POLICY.
PLEASE READ IT CAREFULLY.

If You Wish To Cancel Or If You Have Questions

If You are not satisfied, for any reason, with the terms of this Policy You may return it to Us within 10 days of receipt. We will then cancel Your coverage as of the original Effective Date and promptly refund any premium You have paid. If We do not return any premiums paid within 30 days from the date of cancellation, We will pay interest on the proceeds. 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.

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.

DENTAL BENEFITS: This policy is a Preferred Provider plan design which utilizes both Participating and Non-Participating Dental Providers. If You select a Participating Dental Provider, Your cost will be less than if You select a Non-Participating Dental Provider. See the section entitled Dental PPO - Participating and Non-Participating Dental Providers for detail on payment of services.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Conditionally Renewable
This Policy is monthly or quarterly dental and vision coverage subject to continual payment by the Covered Person and market availability. Cigna will renew this Policy except for the specific events stated in the Policy's Cancellation provision. 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***

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Introduction

About This Policy

Your 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 "Covered Person" in this Policy, We mean You and any eligible Dependent(s) who are covered under this Policy. You and all Dependent(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 Medically Necessary as defined in this Policy and for which the Covered Person has benefits. The fact that a Provider prescribes or orders a service does not, in itself, mean that the service is Medically 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 "Medically 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 Dependent(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 Dependent(s) covered under the Policy.

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

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. If it was not reasonably possible to give written proof in the time required, the Company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

Assignment of Claim Payments:

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

1. It is duly executed on a claim form; 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 dental services provided by a Participating Dental Provider is automatically assigned to the Provider unless the Participating Dental Provider indicates that the Covered Person has paid the claim in full. The Participating Dental 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 Dental Provider are payable to the Covered Person unless assignment is made as above. If payment is made to the Covered Person for services provided by a Non-Participating Dental Provider, the Covered Person is responsible for paying the Non-Participating Dental Provider and Our payment to the Covered 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 for dental services will be paid directly to Participating Dental Providers unless You instruct Us to do otherwise prior to Our payment. For all other services, benefits will be paid directly to You, unless otherwise assigned. 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 care nor attempt to evaluate those services.

Physical Examination and Autopsy: Cigna, at its own expense, shall have the right and the opportunity to examine any Covered 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 and to make an autopsy in case of death if not forbidden by law.

Who is Eligible for Coverage

Conditions of Eligibility

This Policy is for residents of the state of Michigan. The Insured must notify Us of all changes that may affect any Covered 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 Covered Persons may include the following Dependent(s):

- Your lawful Spouse, Domestic Partner, or partner to a Civil Union.
- Your Dependent children who have not yet reached age 26.
- Your Dependent stepchildren who have not yet reached age 26.
- Your grandchildren who have not yet reached age 26 if they are Your Dependents for Federal Income Tax purposes at the time of application.
- Your own, Your Spouse's, 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 medically certified 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, Your Spouse's, 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 a Dependent, and pay any additional premium required.
- Your Newborn grandchild will be automatically covered for the first 31 days of life if this grandchild is Your dependent for Federal Income Tax purposes at the time of application. To continue coverage, You must notify Cigna within 31 days of the Newborn grandchild's date of birth that You wish to have the Newborn grandchild added as a Dependent, 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 the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as a Dependent by notifying Cigna within 31 days after the date of placement for adoption or initiation of a suit of adoption, and paying any additional premium.
- A foster child is automatically covered for 31 days from the date of placement in Your residence. To continue coverage, You must enroll the child as a Dependent by notifying Cigna in writing within 31 days after placement 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 a Dependent by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

Dependent Insurance

For Your Dependents to be insured under the Policy, You must elect the Dependent insurance for Yourself no later than 30 days after You become eligible. For Your Dependents to be insured, You will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Eligibility for Dependent Insurance

Your Dependent will become eligible for Dependent insurance on the later of:

- the day You meet the eligibility requirements noted above; or
- the day You acquire Your first Dependent.

Effective Date of Dependent Insurance

Insurance for Your Dependents will become effective on the date You elect it, by signing a written agreement with the Policyholder to make the required contribution, but no earlier than the day You become eligible for Dependent Insurance. All of Your Dependents as defined will be included.

Your Dependents will be insured only if You are insured.

Eligibility for Coverage for Adopted Children

Any child who is adopted by You, including a child who is placed with You for adoption, will be eligible for Dependent coverage, if otherwise eligible as a Dependent, upon the date of placement with You. A child will be considered placed for adoption when You become legally obligated to support that child, totally or partially prior to that child's adoption. If a child placed for adoption is not adopted, all dental coverage ceases when the placement ends, and will not be continued. The provisions in the Exception for Newborns provision that describe requirements for enrollment and Effective Date of insurance will also apply to an adopted child or a child placed with You for adoption.

Exception for Newborns

Any Dependent child born while You are insured will become insured on the date of the child's birth if You elect Dependent Insurance no later than 31 days after birth. If You do not elect to insure Your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as a Covered Person if:

- The individual was previously enrolled under a plan offered or administered by Cigna, any direct or indirect affiliate of Cigna, and their 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 their 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 their enrollment. The individual will be allowed to reenroll 12 months from the effective date of termination.

Except as described in the Continuation section, a Covered 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, 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 Dependent (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 Dependent(s) eligibility for benefits under this Policy.

Continuation

If a Covered Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Dependent(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 Covered Person's insurance will be continued if the Covered Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate.

Benefit Schedule

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

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

CIGNA DENTAL AND VISION INSURANCE
The Schedule

For You and Your Dependents

The Schedule – Dental Benefits

If You select a Participating Dental Provider, Your cost will be less than if You select a Non-Participating Dental Provider.

Emergency Services

The Benefit Percentage payable for Emergency Services charges made by a Non-Participating Dental Provider is the same Benefit Percentage as for Participating Dental 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.

Dental Deductibles

Dental Deductibles are expenses to be paid by You or Your Dependent. Dental Deductibles are in addition to any Coinsurance. Once the Dental 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 Dental Provider Payment

Participating Dental Provider services are paid based on the Contracted Fee agreed upon by the Provider and Cigna.

Non-Participating Dental Provider Payment

Non-Participating Dental Provider services are paid based on the Contracted Fee.

DENTAL BENEFIT HIGHLIGHTS	
Classes I, II **Calendar Year Maximum**	$1,000 per person
Calendar Year Dental Deductible Individual	$50 per person Not Applicable to Class I
Family Maximum	$150 per family Not Applicable to Class I
Class I	**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%
Class II	**The Percentage of Covered Expenses the Plan Pays**
Basic Restorative Fillings Oral Surgery, Simple Extractions Emergency Care to Relieve Pain Non-Routine X-rays	70% after dental deductible

The Schedule - Vision Benefits

VISION BENEFIT HIGHLIGHTS	
Eye Examinations, including refraction	The plan pays 30% of expenses, not to exceed a $50 calendar year maximum per person
Materials (corrective eyeglasses or contact lenses, including fittings and follow-up visits)	$100 calendar year maximum per person

Waiting Periods

There is no waiting period for Class I or II dental benefits or for vision benefits.

Covered Expense

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 Covered 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 Expense means that portion of a Provider's charge that is payable for a service delivered to a Covered Person provided:

- the service is ordered or prescribed by a Provider;
- the service is essential for the Necessary care of teeth or vision;
- the service is within the scope of coverage limitations;
- the Dental 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 Dental Benefit Provision;
- the services for Classes I, II, and vision started and completed while coverage is in effect.

Alternate Dental Benefit Provision

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

If the Covered Person requests or accepts a more costly covered dental service, they are responsible for expenses that exceed the amount covered for the least costly dental service. Therefore, Cigna recommends Predetermination of Dental Benefits before major treatment begins.

Predetermination of Dental 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 Dental 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 dental service the level of payment will be consistent with similar services that provide the least expensive professionally satisfactory result.

Participating and Non-Participating Dental Providers

Payment for a service delivered by a Participating Dental Provider is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in the Schedule.

The Covered Person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a Non-Participating Dental Provider is the Contracted Fee for that procedure as listed on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, times the benefit percentage that applies to the class of service, as specified in the Schedule. The Primary Schedule is the fee schedule with the lowest Contracted Fees currently being accepted by a Participating Dental Provider in the relevant 3-digit zip code.

The Covered Person is responsible for the balance of the Provider's actual charge.

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 1 per person per 6 consecutive months.

Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure is payable in any 6 consecutive month period.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 14 years old. Only 1 per person per 12 consecutive months.

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, fixed unilateral – Limited to 1 non-orthodontic treatment for a person less than 14 years old.

Bitewing x-rays – Only 1 set per person per 12 consecutive months, limited to 4 films per set.

Class II Services – Basic Restoration

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 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.

Emergency Care to Relieve Pain

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Covered Persons under this Policy for the purpose of promoting general health and well-being.

If You are a Cigna Covered Person You may be eligible for additional dental benefits during certain episodes of care. For example, if You have certain conditions including but not limited to pregnancy, diabetes or cardiac disease, You are eligible for additional dental benefits. Please review Your plan enrollment materials for details. You may contact Customer Service at 1-800-244-6224 for additional information.

These Additional Programs are not contractual benefits under Your Policy. These Additional Programs may be added or discontinued at any time and are not guaranteed renewable under this Policy.

Missing Teeth Limitation

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

Covered Vision Services

The following section lists vision Covered 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. Covered Expenses are limited to the calendar year maximums and coinsurance shown in The Schedule.

Examinations
One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses performed by a Provider.

Materials
Corrective spectacle lenses, frames, and contact lenses prescribed by a Provider.
Corrective contact lenses fittings and follow-up visits.

Exclusions and Limitations: What is Not Covered by This Policy

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- procedures which are not included in the list of Covered Dental Services or Covered Vision Services;
- cone beam imaging;
- instruction for plaque control, oral hygiene and diet;
- core build-ups;
- veneers;
- precious or semi-precious metals for crowns, bridges and abutments;
- restoration of teeth which have been damaged by erosion, attrition or abrasion;
- bite registrations; precision or semi-precision attachments; or splinting;
- implants or implant related services;
- orthodontic treatment, except for the treatment of cleft lip and cleft palate;
- general anesthesia or intravenous sedation, when used for the purposes of anxiety control or patient management is not covered; may be considered only when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- athletic mouth guards;
- services performed solely for cosmetic reasons;
- personalization or decoration of any dental device or dental work;
- replacement of an appliance per benefit guidelines;
- services that are medical in nature;
- services and supplies received from a hospital;
- prescription drugs;
- plano lenses;
- VDT (video display terminal)/computer eyeglass benefit;
- medical or surgical treatment of the eyes;
- any type of corrective vision surgery, including LASIK surgery, radial ketatonomy (RK), automated lamellar keratoplasty (ALK), or conductive keratoplasty (CK);
- Orthoptic or vision training and any associated supplemental testing;
- any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- safety eyewear;
- sub-normal vision aids or non-prescription lenses; or
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage.

General Limitations

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

- For services not specifically listed as Covered Services in this Policy;
- For services or supplies that are not Medically 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 insurance coverage;
- For Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Provider, from any of the following:
  - Yourself or Your employer;
  - a person who lives in the Covered Person's home, or that person's employer;
  - a person who is related to the Covered 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 condition which occurred while serving in the military or an associated auxiliary unit;
- services or supplies received due to an act of war, declared or undeclared while serving in the military or an associated auxiliary unit;
- 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 plan which provides dental or vision 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.

Third Party Liability

You agree to advise Us, in writing, within a reasonable time of Your claim against the third party and to take such action, provide such information and assistance, and execute such documents as We may reasonably require to facilitate enforcement of the claim. You also agree to take no action that may prejudice the rights or interests of Us under this Policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice Our rights or interests, may be considered to be a material breach by Us and may subject You to legal action.

We may have a right to a lien, to the extent of benefits advanced, upon any recovery that You receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Policy for the treatment of the Illness, disease, Injury or condition for which the third party is liable. We will be entitled to collect on Our lien even if the amount recovered by or for the Covered Person (or their estate, parent or legal guardian) from or for the account of such third party as compensation for the Injury, Illness or condition is less than the actual loss suffered by the Covered Person.

Right of Reimbursement

If a Covered Person incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Covered Person may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

WHEN YOU HAVE A GRIEVANCE OR AN APPEAL

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

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

Start with Member Services

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

Customer Services Toll-Free Number or address 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 or grievance, We will get back to You as soon as possible, but in any case within 30 days.

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

Appeals Procedure

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

Level One Appeal

Your appeal will be reviewed with a full investigation and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. The health care professional will have knowledge of the medical condition, procedure or treatment indicated in the appeal; they are licensed in the same profession and have a similar specialty; they were not involved in any part of the initial investigation of the complaint or grievance and were not involved until now in the appeal; and do not have a direct business relationship with You or the initial Provider that recommended the procedure, treatment or service in the appeal.

For level one appeals, We will respond in writing with a decision of the investigation within 30 calendar days after We receive an appeal for a post-service coverage determination.

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

Level Two Appeal

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

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

For level two appeals We will acknowledge in writing that We have received Your request and schedule a Committee review. For post-service claims, the Committee review will be completed within 30 calendar days. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Expedited Appeal

An expedited appeal applies if a grievance is submitted and a Provider, orally or in writing, attests that the time frame for a grievance under a normal Level One Appeal would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function. A determination will be made by Us not later than 72 hours after receipt of an expedited appeal. Within 10 days after receipt of a determination, the Covered Person may request a determination of the matter by the director under an external appeal process. If the determination by Us is made orally, We shall provide a written confirmation of the determination to the Covered Person not later than 2 business days after the oral determination.

Notice of Benefit Determination on Appeal

Every notice of an appeal decision of the investigation 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.

All records related to the grievance will be maintained by Cigna Health and Life Insurance Company for a minimum of two years following the year the grievance was filed.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; 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; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or 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.

External Appeal Process

Once the appeals and grievance process has been exhausted, You have the right to request an external appeal review within 127 days after receipt of our adverse decision or coverage denial with the Director of the Michigan Department of Insurance and Financial Services. The request for an external review must be in writing and should include all necessary information and documents pertaining to the adverse decision. As part of the request for an external review, You must provide written consent authorizing the Director to obtain all necessary medical records from both Us and any health care Provider used for review purposes regarding the decision to deny, limit, reduce or terminate coverage. All medical records used in the external review process will be held in confidence.

You may contact the Michigan's Department of Insurance and Financial Services at:

Department of Insurance and Financial Services

Office of General Counsel – Appeals Section (by mail)

P.O. Box 30220 Lansing, MI 48909-7720 (by courier/delivery)

530 W. Allegan Street, 7th Floor Lansing MI 48933

Online Portal:

https://difs.state.mi.us/Complaints/ExternalReview.aspx

E-mail: DIFS-HealthAppeal@michigan.gov

Phone: (877) 999-6442

Fax: (517) 284-8837

Non-Binding Arbitration

To the extent permitted by law, any controversy between Us and a Covered Person (including any legal representative acting on Your or the Covered Person's behalf), arising out of or in connection with this policy, must be submitted to non-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 thirty (30) days of the effective date of written notice of arbitration, each party shall choose one arbitrator within fifteen (15) working days after the expiration of such thirty (30) day period and the two (2) arbitrators so chosen shall choose a third (3rd) 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 fifteen (15) working-day-period, the arbitrator chosen shall choose a third (3rd) arbitrator in accordance with these requirements.

The arbitration hearing shall be held within thirty (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 thirty (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 (2) arbitrators if there are three (3) arbitrators, shall be non-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.

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. A claim for a loss incurred or disability, as defined in the Policy, beginning after two years from the date of issue of this Policy will not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the Effective Date of coverage of this Policy.

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 Covered 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 Covered Person notifies Us that the Covered Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 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 We will provide written notice to each Covered Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage.
6. When We cease offering all dental and vision plans in the individual market in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to the date of the discontinuation of the coverage.
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.

Termination Effective Date: Coverage under this Policy shall terminate at midnight of the date of termination provided in the written notice, except in the case of termination for non-payment of fees, in which case this Policy shall terminate immediately upon notice to the Covered Person.

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 Covered 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.

Change of Beneficiary: Unless the Covered Person makes an irrevocable designation of beneficiary, the Covered Person has the right to change the beneficiary under this Policy. Consent of a beneficiary is not required to surrender this Policy, for the assignment of the Policy, to change a beneficiary, or to make any other changes in the Policy.

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

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

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

Fraud: If the Covered 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 Covered Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Covered 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 Covered 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 Covered 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 Covered Person while receiving care from any Participating or Non-Participating Dental Provider. Such facilities and Providers act as Covered Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Covered Person at the billing address listed in Our records. It is the Covered Person's responsibility to notify Us of any address changes. The Covered Person will meet any Notice requirements by mailing the Notice to:

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

- 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 Covered Person unless prohibited by law. We will not request a refund of a claim payment more than 24 months after the claim is paid, except in cases of fraud or overpayment of the claim.
- In order for a Covered 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 Covered Person(s) receives a service or supply for which the charge is made.
- We will pay all dental benefits of this Agreement directly to Participating Dental Providers, whether the Covered Person has Authorized assignment of benefits or not, unless the Covered Person has paid the claim in full, in which case We will reimburse the Covered Person. In addition, We may pay any covered Provider of services directly when the Covered 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 Covered Person. The Covered Person is responsible for paying the Foreign Country Provider. These payments fulfill Our obligation to the Covered 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 Dental Provider's termination or breach of, or inability to perform under, any Provider contract, if You or Your Dependent(s) may be materially and adversely affected.
- We will provide the Covered Person with an updated list of local Participating Dental Providers when requested. If the Covered 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 Covered Person with one.

- If while covered under this Policy, the Covered Person(s) is also covered by another Cigna individual or group Policy, the Covered Person(s) will be entitled to the benefits of only one Policy. Covered Person(s) may choose this Policy or the Policy under which Covered 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. We will not request a refund of a claim payment more than 24 months after the claim is paid, except in cases of fraud or overpayment of the claim.
- 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 a Covered 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.
- If Covered Person(s) were covered by a prior Individual Cigna Policy that is replaced by this Policy with no lapse of coverage 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 Covered Person(s);
b. A change in age of any member which results in a higher premium;
c. A change in residence.

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

Cigna also reserves the right to change the premium on 60 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Covered Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

Definitions

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

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

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.

Civil Union means a state sanctioned or legally recognized union of two eligible individuals of the same or opposite sex.

Coinsurance means the percentage of charges for Covered Expenses that a Covered Person is required to pay under the Plan.

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

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Contracted Fee of the Participating Dental Provider. 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 Covered Person receives the service or supply.** Covered Expenses may be less than the amount that is actually billed.

Covered Person is a person who is insured for coverage under the terms of this Policy.

Covered Services means a service used to treat a Covered Person's dental or vision condition and which is:

- prescribed or performed by a Provider while the insurance provided under this Policy is in effect;
- Medically Necessary and/or Dentally Necessary to treat the Covered Person's condition; and
- described in The Schedule.

Deductible means expenses to be paid by You or Your Dependents before benefits are paid under the Policy.

Dental Emergency means a service 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.

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

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

Effective Date means the date that coverage for insurance begins under the Policy. See the Policy cover page for the Effective Date.

Dependent means:

- Your lawful Spouse; or
- Your Domestic Partner; or
- Your partner of a Civil Union; and
- Any child of Yours who is;
  - less than 26 years old.

The term child means a child born to You or a child legally adopted by You. It also includes a stepchild who lives with You, a grandchild who lives with You, a foster child, or a child for whom You are the legal guardian, or Collateral Dependent who lives with You, or a child supported pursuant to a court order imposed on You (including a Qualified Medical Child Support Order).

If Your Domestic Partner has a child who lives with You, that child will also be included as a Dependent.

Collateral Dependent, means when a court ordered guardianship or legal guardianship of niece, and/or nephew exists.

Benefits for a Dependent child will continue until the last day of the Calendar Year in which the limiting age is reached.

Domestic Partner means a person of the same or opposite sex who:

- shares Your permanent residence;
- has resided with You for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with You and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under Your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Us to be sufficient to establish financial interdependency under the circumstances of Your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with You, a notarized affidavit attesting to the above which can be made available to Us upon request.

In addition, You and Your Domestic Partner will be considered to have met the terms of this definition as long as neither You nor Your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, Spouse or Spouse equivalent of the same or opposite sex.

You and Your Domestic Partner must have registered as Domestic Partners, if You reside in a state that provides for such registration.

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.

The term 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).

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

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

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

Medically Necessary and/or Dentally Necessary is used to describe certain services. Services provided by a Provider are Medically/Dentally Necessary if they are:

1. required for the diagnosis and/or treatment of the particular condition or disease; and
2. consistent with the symptom or diagnosis and treatment of the condition or disease; and
3. commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed condition or disease; and
4. the most fitting level or service which can safely be given to You or Your Dependent.

A diagnosis, treatment and service with respect to a condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or Provider.

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the Covered Person's condition according to broadly accepted standards of care.

Non-Participating Dental Provider means a Dentist, or a professional corporation, professional association, partnership, or other entity that has not entered into a contract with Us to provide dental services. Services received from Non-Participating Dental Providers are considered Out-of-Network.

Ophthalmologist means a Provider duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of Your immediate family.

Optometrist means a Provider duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services are performed, other than a member of Your immediate family.

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

Participating Dental Provider is a Dentist or a professional corporation, professional association, partnership, or any other entity which is entered into a contract with Cigna to provide dental services at predetermined fees to a Covered Person. The Providers qualifying as Participating Dental Providers may change from time to time. Services received from Participating Dental Providers are considered In-Network.

Periodontist is a Dentist who specializes in the prevention, diagnosis, and treatment of periodontal disease (disease of the gums and bone that surround the teeth), and in the placement of dental implants.

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, riders or endorsements to this document.

Provider means a licensed practitioner or any other health care practitioner acting within the scope of the practitioner's license. Provider includes but is not limited to a licensed Dentist, Optometrist, Ophthalmologist or Periodontist.

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

Spouse means Your legally recognized Spouse, lawful Domestic Partner or Civil Union Partner in the state where You reside.

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.