Cigna Health and Life Insurance Company (“Cigna”)

Home office: 900 Cottage Grove Road Bloomfield, CT 06002

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

Cigna Dental Vision 1000 Plan

POLICY FORM NUMBER: INDDVPOLMD1021.1000

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!**

This Policy is NOT A MEDICARE SUPPLEMENT policy. It is not designed to fill the ‘gaps’ of Medicare. If You are eligible for Medicare review the Medicare Supplement Buyer’s Guide available from the company.

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 – Maryland
P. O. Box 30365
Tampa, FL 33630
1-877-484-5967

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

A **Participating Dental 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 a Covered Person is covered. The Providers qualifying as Participating Dental Providers may change from time to time.

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

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.

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 incurred 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.

Missing Teeth Limitation

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

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 Dental Providers in excess of the Contracted Fee. In addition, any charges for Medically Necessary and/or Dentally Necessary items that are excluded under the Policy are the responsibility of the Insured.

F. 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, subject to the Extension of Benefits provision.

- 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, This exclusion will not apply to the treatment of any illness covered under this policy if it is received in a hospital or other institution of the State or of a county or municipal corporation of the State, whether or not the hospital or other institution is deemed charitable. This exclusion does not apply to Medicaid.
- 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 (if coverage is suspended for an Insured during military service, upon receipt of written request, We will provide a refund of unearned premium on a pro rata basis);
- 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; This exclusion will not apply to the treatment of any illness covered under this policy if it is received in a hospital or other institution of the State or of a county or municipal corporation of the State, whether or not the hospital or other institution is deemed charitable; This exclusion does not apply to Medicaid.
- for charges which would not have been made if the person had no insurance; This exclusion will not apply to the treatment of any illness covered under this policy if it is received in a hospital or other institution of the State or of a county or municipal corporation of the State, whether or not the hospital or other institution is deemed charitable This exclusion does not apply to Medicaid. to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- to the extent that You or any of Your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- Procedures that are a covered expense under any other plan which provides dental or vision benefits on an expense incurred basis;
- We are not obligated to pay any claim, bill, or other demand or request for payment for Covered Services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

G. Predetermination of Dental 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.

H. General Provisions

When You Have a Complaint an Appeal or a Grievance

Definitions

Adverse Decision
An Adverse Decision is a utilization review determination by Cigna or a Private Review Agent that: (a) a proposed or delivered Health Care Service covered under the insured's contract is or was not Medically Necessary, appropriate, or efficient; and (b) may result in noncoverage of the Health Care Service.

Appeal
An Appeal is a protest filed by an Insured, an Insured Person's representative or a health care provider with Cigna under its internal Appeal process regarding a Coverage Decision concerning an insured.

Appeal Decision
An Appeal Decision is a final determination by Cigna that arises from an Appeal filed with Cigna under its Appeal process regarding a Coverage Decision concerning an insured.

Compelling Reason
A compelling reason includes showing that the potential delay in receipt of a health care service until after the insured or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the insured remaining seriously mentally ill with symptoms that cause the insured to be in danger to self or others.

Complaint
A Complaint is (1) a protest filed with the Maryland Insurance Commissioner involving an Adverse Decision or Grievance Decision concerning the insured; or (2) a protest filed with the Commissioner involving a Coverage Decision.

Emergency Case
An Emergency Case is a case involving an Adverse Decision for which an expedited review is required. An expedited review may be requested if: (1) an Adverse Decision is rendered for services that are proposed, but have not yet been rendered; and (2) the time frames under this process would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function or would cause You to be a danger to self or others.

Grievance
A Grievance is a protest by an insured, an Insured Person's representative or a health care provider on behalf of the insured filed with Cigna through its internal grievance process regarding an Adverse Decision concerning the insured.

Grievance Decision
A Grievance Decision by Cigna is a final determination that arises from a Grievance regarding an Adverse Decision concerning the insured, which was filed with Cigna under its internal grievance process.

Health Care Provider
A Health Care Provider means: (a) an individual who is licensed under the Maryland Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession, and is a treating provider of the insured; or (b) a hospital, as defined by Maryland law. The term Health Care Provider includes a nonphysician specialist who is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of his license or certification.

Health Care Service
A Health Care Service is a health or medical care procedure or service rendered by a health care provider that:
(a) provides testing, diagnosis, or treatment of a human disease or dysfunction; or (b) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

Medically Necessary/Medical Necessity

Medically Necessary/Medical Necessity refer to Health Care Services and supplies which are determined by Cigna to be: (a) medically required to meet the basic health needs of the insured; (b) consistent with the diagnosis of the condition; (c) consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; (d) required for purposes other than the comfort and convenience of the patient or his Physician; and (e) of demonstrated medical value.

Any services precertified by the Review Organization will be deemed Medically Necessary.

Private review agent

Private review agent means: (1) a nonhospital-affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of: (i) a Maryland business entity; or (ii) a third party that pays for, provides, or administers health care services to citizens of this State; or (2) any person or entity including a hospital-affiliated person performing utilization review for the purpose of making claims or payment decisions for health care services on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees employed by: (i) the hospital; or (ii) a business wholly owned by the hospital

When You Have a Complaint, an Appeal or a Grievance

For the purposes of this section, any reference to "You," "Your" or "Yourself" also refers to a representative or Your treating provider designated by You to act on Your behalf; and licensed Dentists depending on the care, treatment or service under review.

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

Start With Member Services

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

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

Quality of Care Issues

Quality of care issues include the following: (a) malpractice allegation; (b) negative patient outcomes related to poor care; (c) failure to follow up on diagnostic procedures; (d) failure to provide treatment for presenting complaints consistent with standard of care; (e) failure to appropriately document medical records; (f) confidentiality and privacy issues related to medical records or care; (g) dissatisfaction of providers; (h) qualifications of providers; (i) misdiagnosis; (j) inappropriate referrals; (k) environmental issues related to infection control and hazardous medical waste; (l) failure of a provider to perform adequate medical screening, assessments, or emergency care; (m) failure to provide an adequate internal insured Complaint process concerning quality of care issues; (n) failure to comply with policies and procedures concerning delivery of care;
(o) inadequate credentialing and performance appraisal for Physician or Dentists; and (p) denial of Health Care Service benefits by Cigna.

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

If You are not satisfied with the results of a Coverage Decision, such as a Claim denial or other adverse determination You can start the Administrative Appeals Procedure or Medical Necessity Grievance Procedure.

Internal Appeals and Grievance Procedure

Cigna has a one-step Appeals and Grievance Procedure for Coverage Decisions and decisions involving Medical Necessity. To initiate an Administrative Appeal or Medical Necessity Grievance, You must submit a written request for an Appeal or Grievance to the address that appears on mycigna.com, explanation of benefits or claim form within 365 days of receipt of a denial notice. For decisions involving Medical Necessity, a denial notice is the same as an Adverse Decision. Notice of an Adverse Decision must be sent by us within five working days after the decision is made. You should state the reason why You feel Your Appeal or Grievance should be approved and include any information supporting Your Appeal or Grievance. If You are unable or choose not to write, You may ask to register Your Appeal or Grievance by calling the toll-free number on mycigna.com, explanation of benefits or claim form. If we determine that we do not have sufficient information to complete our review, You will be notified within 5 working days after the Filing Date of Your Grievance and will be assisted by us in gathering the necessary information.

Filing Date means the earlier of (a) 5 days after the date of mailing or (b) the date of receipt.

Medical Necessity Grievance Procedure

Your request to reconsider an Adverse Decision will be reviewed and the decision made by someone not involved in the initial decision. Grievances involving Medical Necessity will be considered by a Dentist reviewer who is board certified or eligible in the same specialty as the treatment under review. The Dental Director who has responsibility for oversight of grievance decisions is:

Clay Hedland, DDS
Cigna HealthCare
1640 Dallas Parkway
Plano, TX 75093
(972) 863-5021

We will make a decision and will notify You verbally prior to notification in writing of our decision, both within 30 working days of the Filing Date of Your Grievance request, unless You agree in writing to an extension for a period of no longer than 15 calendar days. In no case will written notice of the Grievance decision be sent later than five working days after the Grievance decision has been made.

Decisions involving a Grievance request in connection with a retrospective denial will be made within 45 working days after the date on which the Grievance is filed. The decision will be communicated to You in writing and the notice will be sent within 5 working days after the decision has been made.

In the case of an expedited review for an Emergency Case, we will respond verbally with a decision within 24 hours of the date the grievance was filed, followed up in writing within 1 calendar day of the verbal response. The written notice will state the specific factual bases for Cigna's decision.

Administrative Appeal Procedure

Your request to reconsider a Coverage Decision will be reviewed and the decision made by someone not involved in the initial decision. We will make a final Appeal Decision and will notify You in writing of our decision, both within 30 calendar days of Your request. 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.

APPEALS TO THE STATE OF MARYLAND

MEDICAL NECESSITY GRIEVANCE

If You are not fully satisfied with the final decision of Cigna's Grievance review regarding Your Medical Necessity issue, You have the right within 4 months after receipt of Cigna's grievance decision, to file a Complaint with the Maryland Insurance Commissioner. The Complaint may be filed without first filing a Grievance if (1) Cigna waives the requirement that the internal process be exhausted; or (2) Cigna failed to comply with ANY of the internal grievance process requirements described on the form (3) You can demonstrate to the Commissioner a compelling reason to do so. You may also file a Complaint with the Commissioner if we fail to make a decision on a Medical Necessity Grievance within the required time frames, The Commissioner may be contacted at the following address, telephone number, and fax number:

Maryland Insurance Administration
Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone Number: 410-468-2000 or 1-800-492-6116
Fax Number: 410-468-2270

The Health Advocacy Unit is available to assist You in both mediating and filing a Grievance under our internal Grievance process. You may contact the Health Advocacy Unit of Maryland's Consumer Protection at:

Office of the Attorney General
Consumer Protection Division
200 St. Paul Place, 16th Floor
Baltimore, MD 21202

The Unit can also be reached by calling 410-528-1840 or 1-877-261-8807 (phone) or 410-576-6571 (fax) or by e-mail heau@oag.state.md.us .

Administrative or Other Appeals

If You are not satisfied with the final Appeal Decision, You have the right within 4 months to file a complaint with the Maryland Insurance Commissioner. The Administration may be contacted at the following address and telephone number:

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone Number: 410-468-2000

Fax Number: 410-468-2270

The Complaint may be filed with the Commissioner without first filing an Appeal, and receiving a final decision if:

the complaint is the subject of an initial Coverage Decision that involves care which has not yet been rendered, and You give sufficient information and supporting documentation in the complaint that demonstrates an Urgent Medical Condition exists.

If a case involves a retrospective denial, an Urgent Medical Condition that would allow You to file a complaint is not deemed to exist unless You have first exhausted Cigna's internal appeal process.

Coverage Decision means (1) an initial determination by us that results in noncoverage of a Health Care Service. (2) a determination by us that an individual is not eligible for coverage under Cigna's health benefit plan; or (3) any determination by us that results in the recission of an individual's coverage under a health benefit plan.

This includes nonpayment of all or any part of a claim. Coverage Decision does not include decisions based on Medical Necessity.

Urgent Medical Condition means a condition that satisfies either of the following:

a. medical condition, including a physical condition, mental condition, or a dental condition where the absence of medical attention within 72 hours could reasonably be expected, by a prudent layperson who possesses an average knowledge of health and medicine, to result in:
   (1) serious jeopardy to Your life or health;
   (2) Your inability to regain maximum function;
   (3) serious impairment to bodily functions;
   (4) serious dysfunction of any bodily organ or part; or
   (5) You remaining seriously mentally ill with symptoms that cause You to be a danger to self or others; or
b. medical condition, including a physical condition, mental condition, or a dental condition where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without care or treatment that is the subject of the Coverage Decision.

The Health Advocacy Unit is available to assist You in both mediating and filing an Appeal under our internal Appeal process. You may contact the Health Advocacy Unit of Maryland's Consumer Protection at:

Office of the Attorney General
Consumer Protection Division
200 St. Paul Place, 16th Floor
Baltimore, MD 21202

The Unit can also be reached by calling 410-528-1840 or 1-877-261-8807 (phone) or 410-576-6571 (fax) or by e-mail at heau@oag.state.md.us .

Adverse Decision Notice

We will provide oral communication of an adverse decision to the Insured, the Insured's representative or the health care provider, acting on behalf of the Insured. Notice of an adverse decision will be provided in writing or electronically within 5 business days after the adverse decision is made.

It will state in detail in clear, understandable language the specific factual basis for the decision, including:

(1) the specific criteria and standards, including interpretive guidelines on which the decision is based;
(2) the name, business address, and business telephone number of the Dental Director who has responsibility for oversight of the internal grievance decisions;
(3) details of Our grievance process and procedures;
(4) notice of the right of the Insured, Person or the Insured Person's representative or a health care provider on behalf of the Insured to submit a complaint with the Commissioner within 4 months after receipt of a grievance decision;
(5) notice of the right of the Insured Person, the Insured Person's representative or a health care provider to submit a complaint with the Commissioner without first filing a grievance;

(6) the Commissioner's address, telephone number and fax number;

(7) a statement that the Health Advocacy Unit is available to assist the Insured Person or the Insured Person's representative in mediating and filing a grievance under Our internal grievance process;

(8) the address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit

(9) 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;

(10) 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.

Grievance Decision Notice. We will provide oral communication of a grievance decision to the Insured, the Insured's representative, or the health care provider acting on behalf of the Insured. Notice of a grievance decision will be provided in writing or electronically within 5 business days after the grievance decision is made,

It will state in clear, understandable language the specific factual bases for the decision;

(1) the specific criteria and standards, including interpretive guidelines on which the grievance decision is based;

(2) the name, business address, and business telephone number of the Dental Director who has responsibility for oversight of the internal grievance process

(3) notice of the right of the Insured Person or the Insured Person's representative to submit a complaint with the Commissioner within 4 months after receipt of a grievance decision;

(4) the Commissioner's address, telephone number and fax number;

(5) a statement that the Health Advocacy Unit is available to assist the Insured Person or the Insured Person's representative filing a complaint with the Commissioner;

(6) the address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit

(7) 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;

(8) 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.

When filing a complaint with the Commissioner, the Insured Person or the Insured Person's representative will be required to authorize the release of any medical records of the Insured Person that may be required to be reviewed for the purpose of reaching a decision on the complaint.

I. Participating Dental Providers

Cigna will provide a current list of Dentists currently participating with Cigna and their locations to each Covered Person upon request.

To verify if a Dentist is currently participating with Cigna and is accepting new Cigna Insureds, the Covered Person should visit Our website at mycigna.com.

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 60 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 Insureds in the same class and covered under the same Policy as You.

2. The individual plan is designed for residents of Maryland 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 Covered Person's eligibility under the Policy.

3. You or Your Dependent(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, Domestic Partner, or partner to a Civil Union: when the Spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member(s): when You no longer meet the requirements listed in the Conditions of Eligibility section.
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

4. If a Covered Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Dependents 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.

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 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.