**Cigna Health and Life Insurance Company ("Cigna")**

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

# Cigna Dental 1500

**POLICY FORM NUMBER: HC-NOT11, et., al.**

# OUTLINE OF COVERAGE

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

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

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

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

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

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

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

- The following Class II services will be provided according to the dentist's contracted rate with Cigna for such services:
  Fillings
  Oral Surgery, Simple Extractions

- The following Class III services will be provided according to the dentist's contracted rate with Cigna for such services:
  Root Canal Therapy / Endodontics
  Minor Periodontics
  Major Periodontics
  Oral Surgery, All Except Simple Extractions
  Surgical Extraction of Impacted Teeth
  Relines, Rebases, and Adjustments
  Repairs - Bridges, Crowns, and Inlays
  Repairs – Dentures
  Anesthetics
  Crowns / Inlays / Onlays
  Prosthesis Over Implant
  Dentures
  Bridges

- The following Class IV services will be provided according to the dentist's contracted rate with Cigna for such services:
  Orthodontia

**If You Wish To Cancel Or If You Have Questions**

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

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

## D. Covered Services and Benefits

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

The frequency of certain Covered Services, like cleanings, are limited. Refer to your Policy for specific limitations on frequency under your plan.
HC-NOT31.OOC

### BENEFIT SCHEDULE

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.
HC-SOC188.OOC

## CIGNA DENTAL PREFERRED PROVIDER INSURANCE
### *The Schedule*

**For You and Your Dependents**

**The Schedule**

If you select a Participating Provider, your cost will be less than if you select a Non-Participating Provider.

**Emergency Services**
The Benefit Percentage payable for Emergency Services charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

**Deductibles**
Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

**Benefit Differential Limitation**
The difference between the member coinsurance amounts for a Participating Provider and a non-Participating Provider is no more than 20 percentage points, exclusive of any deductibles or copayments

**Participating Provider Payment**
Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and CHLIC.

**Non-Participating Provider Payment**
Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

**Simultaneous Accumulation of Amounts**
Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule.

Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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

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

HC-SOC248.OOC

## Waiting Periods

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

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

HC-DBW6.OOC

The **Maximum Reimbursable Charge** for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The percentile used to determine the Maximum Reimbursable Charge is listed in the Schedule.

The Maximum Reimbursable Charge is subject to other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS539.OOC

## E. Insured's Financial Responsibility

The Insured is responsible for paying the monthly or quarterly premium on a timely basis. The Insured is also responsible to pay Providers for charges that are applied to the Deductibles, Coinsurance, and any amounts charged by Non-Participating Providers in excess of the Maximum Reimbursable Charges. In addition, any charges for Dentally Necessary items that are excluded under the Policy are the responsibility of the Insured.
HC-POB50.OOC

## F. Exclusions And Limitations: What Is Not Covered By This Policy

**Expenses Not Covered**

Covered Expenses do not include expenses incurred for:

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

  (a) replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or

(b) the partial denture is less than 84 consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or

(c) replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional Necessary extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).

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

- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

### General Limitations

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

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

HC-DEX24.OOC

## G. Predetermination of Benefits Program

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

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

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

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

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.
HC-DEN82.OOC

## H. General Provisions

**THE FOLLOWING WILL APPLY TO RESIDENTS OF MASSACHUSETTS**
**WHEN YOU HAVE A CONCERN OR A COMPLAINT**

For the purposes of this section, any reference to "You," "Your" or "Yourself" also refers to a representative or provider designated by You to act on Your behalf, including, but not limited to Your guardian, conservator, holder of a power of attorney, health care agent, family member, or other person authorized by You in writing or by law, unless otherwise noted.

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

**Start with Member Services**

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

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

Cigna has an inquiry process during which Cigna may attempt to answer questions and/or resolve concerns communicated by You, to Your satisfaction within three working days. This process shall not be used for review of an adverse determination that must be reviewed through the internal appeals process. When this inquiry process fails to answer Your questions or resolve Your concerns to Your satisfaction within three working days, the inquiry will, at Your option be subject to the internal appeal process.

The inquiry process includes the following:

- provision in writing to You of a clear, concise and complete description of the inquiry process;
- protocol to receive and address an inquiry as expeditiously as possible, and to determine whether Your inquiry has been resolved to Your satisfaction;
- protocol to provide written notice to You when Your inquiry has not been explained or resolved to Your satisfaction within 3 working days of the inquiry, of the right to have the inquiry processed as an internal appeal at Your option, including reduction of an oral inquiry to writing by Cigna;
- written acknowledgment and written resolution of the inquiry; and
- a system for maintaining records of each inquiry communicated by You, and response thereto, for a period of 2 years, which records shall be subject to inspection by the Commissioner of Insurance and the Department.

We will do our best to resolve the matter on Your initial contact. If You are not satisfied with the results of a coverage decision, You can start the appeals procedure.

**Internal Appeals Process**

Cigna has an internal appeals process. 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 supporting information. We will acknowledge receipt of Your appeal within 5 working days.

If You are unable or choose not to write, You may ask to register Your appeal by calling the toll-free number on mycigna.com or claim form. You may also register Your appeal by electronic means provided that an oral appeal made by You shall be reduced to writing by Cigna and a copy forwarded to You within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of You and Cigna.

Any appeal that requires the review of dental records shall include Your or Your authorized representative's signature on a form provided promptly by Cigna authorizing the release of dental and treatment information relevant to Your appeal. You shall have access to any dental information and records relevant to Your appeal that is in the possession of Cigna and under its control. Cigna shall request authorization from You when necessary for requests reduced to writing by Cigna and for any written requests lacking authorization.

In the event that You do not provide the signed authorization within 30 days of the receipt of the appeal, Cigna may, in its discretion, issue a resolution of the appeal without review of some or all of the dental records.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. For appeals involving Medical Necessity or clinical appropriateness, the Dentist reviewer will consult with at least one Dentist actively practicing in the same or similar specialty who typically treats the dental condition, performs the procedure or provides the treatment as the care under consideration, as determined by Cigna's Dentist reviewer. For postservice claims, the review will be completed within 30 working days. You will be notified in writing of the appeal decision within 30 working days of receipt of the appeal. The 30-work-day time limit noted above may be waived or extended by mutual written agreement between You and Cigna.

A written resolution shall include a substantive clinical justification that is consistent with generally accepted principles of professional dental practice, and shall at a minimum:

- Identify the specific information upon which the adverse determination was based;
- Discuss Your presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such dental evidence fails to meet the relevant dental review criteria;
- Specify alternative treatment options covered by Cigna, if any;
- Reference and include applicable clinical practice guidelines and review criteria.

Please note that an appeal not properly acted upon by Cigna within the required time limits stated in this certificate shall be deemed resolved in Your favor. Time limits include any extensions made by mutual written agreement between You, or Your authorized representative, and Cigna.

If an appeal is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at Cigna's expense through completion of the internal appeal process regardless of the final internal appeal decision.

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

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

**Your Right to Contact the Commonwealth of Massachusetts**

You have the right to contact the Office of Patient Protection for assistance or for a copy of the grievance report at any time. The Office of Patient Protection may be contacted at the following:

Massachusetts Office of Patient Protection
800-436-7757 (telephone)
617-624-5046 (fax)

The following information is available from the Office of Patient Protection:

- a list of sources of independently published information assessing insured satisfaction and evaluating the quality of health care services offered by the carrier;
- the percentage of Dentists who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary Dentist disenrollment;
- the percentage of premium revenue expanded by the carrier for health care services provided to insureds for the most recent year for which information is available; and
- a report detailing, for the previous calendar year, the total number of: filed appeals, appeals that were approved internally, appeals that were denied internally, and appeals that were withdrawn before resolution; and external appeals pursued after exhausting the internal appeal process and the resolution of all such external appeals.

**Notice of Benefit Determination on Appeal**

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

**Relevant Information**

Relevant Information is any document, record, or other information which 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.
HC-APL183.OOC

**Dispute Resolution**

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our complaint and adverse determination appeal procedures. Complaints and adverse determination appeals may be reported by telephone or in writing. All complaints and adverse determination appeals received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

**Binding Arbitration**

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

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

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

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

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.
HC-APL140.OOC

## I. Participating Providers

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

To verify if a dentist is currently participating with Cigna and is accepting new Cigna Insured's, the Insured should visit our website at mycigna.com.
HC-IMP102.OOC

## J. Renewability, Eligibility, and Continuation

1. The Policy will renew except for the specific events stated in the Policy. Cigna may change the premiums of the Policy with 30 days written notice to the Insured. However, Cigna will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all insured's in the same class and covered under the same Policy as You.
2. The Individual Plan is designed for residents of Massachusetts who are not enrolled under or covered by any other group or individual health coverage. You must notify Cigna of all changes that may affect any Insured Person's eligibility under the Policy.
3. You or Your Insured Family Member(s) will become ineligible for coverage:
   - When premiums are not paid according to the due dates and grace periods described in the premium section.
   - With respect to Your spouse or domestic partner or partner to a civil union: when the spouse is no longer married to the Insured or when the civil union is dissolved.
   - With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
   - The date the Policy terminates.
   - When the Insured no longer lives in the Service Area.
4. If an Insured Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

HC-ELG58.OOC

## K. Premium

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

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

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

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

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

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

c. A change in residence

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

Cigna also reserves the right to change the premium on 30 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.
HP-POL190.OOC

This document may include the following filed and approved form numbers

HC-NOT31.OOC
HC-SOC188.OOC
HC-SOC248.OOC
HC-SOC185.OOC
HC-DBW6.OOC
HC-DFS539.OOC
HC-DFS540.OOC
HC-POB50.OOC
HC-DEX24.OOC
HC-DEN82.OOC
HC-APL183.OOC
HC-APL140.OOC
HC-IMP102.OOC
HC-ELG58.OOC
HP-POL190.OOC