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 Hearing 2000 Plan

THIS IS A LIMITED BENEFIT DENTAL, VISION, AND HEARING 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 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 Cigna.

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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Conditionally Renewable

This Policy is monthly or quarterly dental, vision, and hearing 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***

Table of Contents

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 dental, vision, or hearing Provider of their choice. For dental benefits, 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.

PLEASE READ THE FOLLOWING IMPORTANT NOTICE:

WHILE THIS DENTAL PLAN OFFERS A FULL RANGE OF DENTAL BENEFITS, IT IS NOT BEING OFFERED AS AN ESSENTIAL HEALTH BENEFIT PEDIATRIC ORAL CARE PLAN INTENDED TO SATISFY THE REQUIREMENTS UNDER THE AFFORDABLE CARE ACT.

Important Information Regarding Benefits

Referral For Services by a Non-Participating Specialist or Nonphysician Specialist

You may receive a referral to a non-participating specialist or nonphysician specialist if (a) You are diagnosed with a condition or disease that requires specialized health care services or medical care; (b) we do not have a participating specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or (c) we cannot provide reasonable access to a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. Any deductible, copayment or coinsurance applicable to the services for which the referral is requested will be calculated as if the services were received from a Participating Provider. The term "nonphysician specialist" means a health care provider 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.

Continuity of Care Notice

You have special rights in Maryland when You are a new Insured Person and may be moving from Maryland Medical Assistance or another company's dental plan to Cigna coverage and if You currently are receiving treatment.

Right to use Non-Participating Providers. If You have been receiving services from a health care provider, and that provider is a Non-Participating Provider under your new health plan with Us, you may be able to continue to see your Provider as though the Provider were a Participating Provider. You or Your parent, guardian, designee, or health care provider may also contact Us on Your behalf at the number shown on myCigna.com to request the right to continue to see the Non-Participating Provider as if the Provider were an Participating Provider with Us.

This right applies only if You are being treated by the Non-Participating Provider for Covered Services for one or more of the following types of conditions:

- Acute dental conditions;
- Serious chronic dental conditions;
- Any other condition upon which We and the Non-Participating Provider agree.

There is a time limit for how long You can continue to see a Non-Participating Provider and only need to pay cost-sharing as though the Provider were a Participating Provider. For all conditions the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90 day limit is measured from the date Your coverage starts under the new plan.

You or Your representative need to contact Cigna so that Cigna can pay Your claim as if You are still receiving care from a Participating Provider. If the Non-Participating Provider accepts Cigna's rate of payment, the Provider is only permitted to bill You for the Participating Provider cost-sharing amounts that apply to the service, such as copayments, coinsurance and deductible.

If the Non-Participating Provider will not accept Cigna's rate of payment, the Provider may decide not to provide services to You, or may continue to provide services to You and bill You not only for any copayment, coinsurance or deductible that applies, but also bill You for the difference between the Provider's fee and the allowable charge determined by Cigna.

If you have any questions please contact Us at the number shown on myCigna.com.

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.

Failure to submit a claim within one year after the date of loss does not invalidate or reduce the amount of the claim if:

a. it was not reasonably possible to submit the claim within one year after the date of loss; and
b. the claim is submitted within two years after the date of loss.

In the event of Your incapacity, time to submit a claim shall be suspended. The suspension period will end when legal capacity is regained.

We will permit the Provider a minimum of 180 days from the date a Covered Service is rendered to submit a claim for reimbursement for the service.

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.

We may refuse to directly reimburse a Non-Participating Dental Provider under an assignment if:

a. We receive notice of the assignment after the time We have paid the benefits to You;
b. We have previously paid benefits to You due to an inadvertent administrative error;
c. You withdraw the assignment before We have paid the benefits to the Non-Participating Provider; or
d. You paid the Non-Participating Provider the full amount due at the time of service.

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: 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.

Who Is Eligible For Coverage

Conditions Of Eligibility

This Policy is for residents of the state of Maryland. 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 and are court-ordered into Your custody at the time of application.
- Your Dependent child who is under testamentary or court appointed guardianship with You, other than temporary guardianship of less than 12 months duration.
- 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 incapacity 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 only if additional premium is required, 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 and have been court-ordered into Your custody 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 or grandchild, 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, only if additional premium is required, You must enroll the child or grandchild 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 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. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

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, VISION, AND HEARING 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 incurred7 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, III **Calendar Year Maximum**	$1,500 per person
Calendar Year Dental Deductible Individual	$100 per person Not Applicable to Class I
Class I	**The Percentage of Covered Expenses the Plan Pays**
Preventive Care Oral Exams Routine Cleanings Routine X-rays Non-Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic) Emergency Care to Relieve Pain	100%
Class II	**The Percentage of Covered Expenses the Plan Pays**
Basic Restorative Fillings Surgical Extraction of Impacted Teeth Oral Surgery, Simple Extractions Relines, Rebases, and Adjustments Minor Periodontics Repairs - Bridges, Crowns, and Inlays Repairs – Dentures	70% after dental deductible
Class III	**The Percentage of Covered Expenses the Plan Pays**
Major Restorative Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Major Periodontics Oral Surgery, All Except Simple Extractions Prosthesis Over Implant Anesthetics Dentures Bridges	50% after dental deductible

The Schedule - Vision Benefits	
VISION BENEFIT HIGHLIGHTS	
Eye Examinations, including refraction	The plan pays 50% of expenses, not to exceed a $75 calendar year maximum per person
Materials (corrective eyeglasses or contact lenses, including fittings and follow-up visits)	$200 calendar year maximum per person

The Schedule - Hearing Benefits	
HEARING BENEFIT HIGHLIGHTS	
Hearing Examinations	$50 calendar year maximum per person
Materials (Hearing Aids, including fittings and repairs)	$500 calendar year maximum per person

Waiting Periods

A Covered Person may access their dental, vision, and hearing benefit insurance once he or she has satisfied the following waiting periods.

- there is no waiting period for Class I or II dental benefits or for vision and hearing benefits.
- after 12 consecutive months of coverage dental benefits will increase to include the list of Class III procedures.

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, vision, or hearing;
- 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, III, vision and hearing 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 any remaining balance after the payment 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 Non-Participating Dental Provider's actual charge.

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 1 per person per year.

Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure is payable per year.

Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. This procedure includes an allowance for an exam and scaling and root planing. 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.

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.

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.)

Class II Services – Basic Restoration

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.

Surgical Extraction of Impacted Teeth

Surgical Removal of Impacted Tooth - Soft Tissue - The benefit includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Impacted Tooth - Partially Bony - The benefit includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Impacted Tooth - Completely Bony - The benefit includes an allowance for local anesthesia and routine postoperative care.

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

Denture Adjustments, Rebasing and Relining

Denture Adjustments - Only covered 1 time in any consecutive 12-month period and only if performed more than 12 consecutive months after the insertion of the denture.

Relining Dentures, Rebasing Dentures - Limited to relining or rebasing done more than a consecutive 12-month period after the initial insertion, and then not more than one time in any consecutive 36-month period.

Tissue Conditioning - maxillary or mandibular - Payable only if at least 12 consecutive months have elapsed since the insertion of a full or partial denture and only once in any consecutive 36-month period.

Repairs To Crowns and Inlays

Recement Inlays - No limitation.

Recement Crowns - No limitation.

Repairs to Crowns - Limited to repairs performed more than 12 consecutive months after initial insertion.

Repairs To Dentures and Bridges

Repairs to Full and Partial Dentures - Limited to repairs performed more than 12 consecutive months after initial insertion.

Recement Fixed Partial Denture - Limited to repairs performed more than 12 consecutive months after initial insertion.

Fixed Partial Denture Repair, by Report - Limited to repairs performed more than 12 consecutive months after initial insertion.

Minor Periodontal Procedures

Periodontal Scaling and Root Planing (if not related to periodontal surgery) - Per Quadrant - Limited to 1 time per quadrant of the mouth in any consecutive 36-month period. Not separately payable if performed on the same treatment plan as prophylaxis.

Class III Services - Major Restoration

Diagnostic Procedures

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

Inlays, Onlays and Crowns

Inlays and Onlays - Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 84 consecutive months have elapsed since the last placement.

Crowns - Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 84 consecutive months have elapsed since the last placement. For persons under 16 years of age, benefits for crowns on vital teeth are limited to Resin or Stainless Steel Crowns.

Benefits for crowns are based on the amount payable for nonprecious metal substrate.

Stainless Steel Crowns, Resin Crowns - Covered only when the tooth cannot be restored by filling and then only 1 time in a consecutive 36-month period. Limited to persons under the age of 16.

Post and Core (in conjunction with a crown or inlay) - Covered only for endodontically treated teeth with total loss of tooth structure.

Endodontic Procedures

Therapeutic Pulpotomy - Payable for deciduous teeth only.

Root Canal Therapy, Primary Tooth (excluding final restoration) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Root Canal Therapy - Permanent Tooth - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Root Canal Therapy, Retreatment - by Report - Covered only if more than 24 consecutive months have passed since the original endodontic therapy and only if necessity is confirmed by professional review.

Apexification - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. A maximum of 3 visits per tooth are payable.

Apicoectomy - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Retrograde Filling (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Not separately payable on the same date and tooth as an Apicoectomy.

Root Amputation (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Hemisection - Fixed bridgework replacing the extracted portion of a hemisected tooth is not covered. Procedure includes local anesthesia and routine postoperative care.

Major Periodontal Surgery

Gingivectomy - Only one periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.

Gingival Flap Procedure Including Root Planing - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.

Clinical Crown Lengthening - Hard Tissue - No limitation.

Mucogingival Surgery - Per Quadrant - only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.

Osseous Surgery - only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.

Bone Replacement Graft - First Site Quadrant.

Bone Replacement Graft - Each Additional Site in Quadrant.

Guided Tissue Regeneration - Resorbable Barrier - per Site, per Tooth - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery.

Pedicle Soft Tissue Graft - No limitation.

Free Soft Tissue Graft (including donor site surgery) - No limitation.

Subepithelial Connective Tissue Graft Procedure (including donor site surgery) - No limitation.

Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area) - No limitation.

Oral Surgery - Surgical Extractions

Surgical Extraction – (except for the removal of impacted teeth) - Includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Residual Tooth Roots (Cutting Procedure) - Includes an allowance for local anesthesia and routine postoperative care.

Other Oral Surgery

Tooth Transplantation (includes reimplantation from one site to another and splinting and/or stabilization) - Includes an allowance for local anesthesia and routine postoperative care.

Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption - Includes an allowance for local anesthesia and routine postoperative care.

Biopsy of Oral Tissue, including brush biopsy technique - Includes an allowance for local anesthesia and routine postoperative care.

Alveoloplasty - Includes an allowance for local anesthesia and routine postoperative care.

Vestibuloplasty - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Radical Excision of Reactive Inflammatory Lesions (Scar Tissue or Localized Congenital Lesions) - Includes an allowance for local anesthesia and routine postoperative care.

Removal of Odontogenic Cyst or Tumor - Includes an allowance for local anesthesia and routine postoperative care.

Removal of Exostosis - Maxilla or Mandible - Includes an allowance for local anesthesia and routine postoperative care.

Incision and Drainage - Includes an allowance for local anesthesia and routine postoperative care.

Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Facial bones - Autogenous or Nonautogenous, by Report - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Frenectomy (Frenulectomy, Frenotomy), Separate Procedure - Includes an allowance for local anesthesia and routine postoperative care.

Excision of Hyperplastic Tissue - Per Arch - Includes an allowance for local anesthesia and routine postoperative care.

Excision of Pericoronal Gingiva - Includes an allowance for local anesthesia and routine postoperative care.

Synthetic Graft - Mandible or Facial Bones, by Report - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Prosthetics

Full dentures — There are no additional benefits for personalized dentures or overdentures or associated procedures. Cigna will not pay for any denture until it is accepted by the patient. Limited to one time per arch per 84 consecutive months.

Partial dentures — There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Cigna will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 84 consecutive months unless there is a necessary extraction of an additional functioning natural tooth.

Add tooth to existing partial denture to replace newly extracted Functional Natural Tooth — Only if more than 12 consecutive months have elapsed since the insertion of the partial denture.

Complete and partial overdentures — There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Cigna will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 84 consecutive months unless there is a necessary extraction of an additional functioning natural tooth.

Post and core (in conjunction with a fixed bridge) — Covered only for endodontically treated teeth with total loss of tooth structure.

Prosthesis Over Implant — A prosthetic device, supported by an implant or implant abutment, is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 84 consecutive months old, is not serviceable and cannot be repaired.

Fixed Partial Dentures (Nonprecious Metal Pontics, Retainer Crowns and Metallic Retainers) - Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.

Replacement: Benefits for the replacement of an existing bridge are payable only if the existing bridge is at least 84 consecutive months old, is not serviceable, and cannot be repaired.

Benefits for retainer crowns and pontics are based on the amount payable for nonprecious metal substrates.

Cast Metal Retainer for Resin Bonded Fixed Bridge - Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.

Replacement: Benefits are based on the amount payable for nonprecious metal substrates. Benefits for the replacement of an existing resin bonded bridge are payable only if the existing resin bonded bridge is at least 84 consecutive months old, is not serviceable, and cannot be repaired.

Anesthesia and IV Sedation

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

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

Additional Programs

We 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. This program is guaranteed renewable. We will not cancel this program for the duration of the contract period.

Oral Health Integration Program

Clinical research has established an association between dental disease and complication of some medical conditions, such as the conditions noted below.

If You are a Cigna Dental Covered Person and You have one or more of the conditions listed below, You are eligible for reimbursement of Your copayment or coinsurance for certain periodontal and preventive procedures as well as emergency pain management, up to the applicable plan maximum reimbursement levels and annual plan maximums.

If You have diabetes, cerebrovascular or cardiovascular disease, qualifying procedures include:

• periodontal scaling and root planing (sometimes referred to as “deep cleaning”)

• periodontal maintenance

If You are pregnant, qualifying procedures include:

- periodic, limited and comprehensive oral evaluation
- periodontal evaluation
- periodontal maintenance
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- treatment of inflamed gums around wisdom teeth
- an additional cleaning during pregnancy
- palliative (emergency) treatment – minor procedure

If You have chronic kidney disease, rheumatoid arthritis, Sjogren's syndrome, lupus, Parkinson's disease, amyotrophic lateral sclerosis, Huntington's disease, or going to or having undergone an organ transplant, or undergoing head and neck Cancer Radiation, qualifying procedures include:

- topical application of fluoride
- topical fluoride varnish
- application of sealant
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- periodontal maintenance
- interim caries arresting medicament application
- caries preventive medicament application

If You have opioid misuse and addiction, qualifying procedures include:

- periodic, limited and comprehensive oral evaluation
- topical application of fluoride
- topical fluoride varnish
- application of sealant
- periodontal scaling and root planing (sometimes referred to as “deep cleaning”)
- periodontal maintenance
- interim caries arresting medicament application
- caries preventive medicament application

To register for the program fill out the online registration form (Oral Health Integration Registration Form) found on myCigna.com, or call the number on the back of your ID Card, follow the prompts for Dental , and a representative will be happy to assist You.

Missing Teeth Limitation

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

This payment limitation no longer applies after 24 months of continuous coverage.

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.

Covered Hearing Services

The following section lists hearing 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 shown in The Schedule.

Examinations
One hearing examination performed by a Provider who is a Licensed Hearing Care Professional.

Materials
Hearing Aids prescribed by a Provider who is a Licensed Hearing Care Professional. This includes fittings and any necessary repairs to Hearing Aids purchased after the Effective Date.

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, Covered Vision Services, or Covered Hearing 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;
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage;
- Assistive Listening Devices (ALDs);
- medical and/or surgical treatment of the internal or external structures of the ear, including but not limited to Cochlear implants;
- Hearing Aids not prescribed by a Licensed Hearing Care Professional;
- ear protective devices or plugs;

- Hearing Aids maintenance/service contracts, ear molds and other miscellaneous repairs;
- Hearing Aids purchased online or over the counter (OTC); or
- Disposable Hearing Aids.

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, vision, or hearing 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.

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 if We file a petition to intervene and are independently represented by counsel. 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, reduced by a pro rata share of the court costs and legal fees incurred by the insured which are applicable to the portion of the settlement returned to the insurance company. 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. The amount will be determined by dividing the amount of the total recovery in the claim into the total amount of the attorney's fees incurred by the Covered Person for services rendered in connection with their claim, which will not exceed one-third, and multiplying that amount by the amount of the third party's claim.

Right of Recovery

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 recovery, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise. Any amount refunded to the insurance company will be reduced by a pro rata share of the court costs and legal fees incurred by the insured which are applicable to the portion of the settlement returned to the insurance company.

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 no coverage 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 410-468-2270 (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.

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.

Extension of Benefits:

1. If a Covered Person has ordered glasses or contact lenses before the date coverage terminates, We will continue to provide covered benefits, in accordance with the Policy in effect at the time the Covered Person's coverage terminates, for the glasses or contact lenses if the Covered Person receives the glasses or contact lenses within 30 days after the date of the order.

2. We will provide dental covered benefits, in accordance with the Policy in effect at the time the Covered Person's coverage terminates, for a course of treatment for at least 90 days after the date coverage terminates if the treatment:
   (i) begins before the date coverage terminates; and
   (ii) requires two or more visits on separate days to a Dentist's office.

3. We will provide covered benefits, in accordance with the Policy in effect at the time the Covered Person's coverage terminates, for orthodontic treatment:
   (i) for 60 days after the date coverage terminates if the orthodontist has agreed to or is receiving monthly payments; or
   (ii) until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

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.

No claim for loss incurred after the effective date from the date of issue of this Policy shall 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 had existed prior to 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.

Change of Beneficiary: The right to change a beneficiary is reserved to the Covered Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in 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 any fraud or deception in connection with this Policy or coverage has been performed by You or someone else on Your behalf.
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, vision, and hearing 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.

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: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age

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 the Insured resides on such date 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 during the time both policies were in effect, 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:
    - Any waiting period of this Policy will be reduced by the period the Covered Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Premiums

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

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

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

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

a. Deletion or addition of a new eligible 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.

Assistive Listening Devices (ALDs) means a device used by a hearing-impaired individual in specific environments where the hearing-impaired individual is unable to distinguish speech in noise. ALDs include devices such as infrared and FM personal amplifiers, amplification systems, alerting devices and closed captioning equipment. ALDs are not Hearing Aids.

Calendar Year is a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time on the Effective Date shown on the Policy's specification page.

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, vision or hearing 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 incurred 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.

Hearing Aid means a non-experimental, wearable electronic instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries, cords, and other Assistive Listening Devices, including, but not limited to, frequency modulation systems.

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

Licensed Hearing Care Professional means a Provider duly licensed and legally entitled to perform audiological services at the time and in the state or jurisdiction in which services are performed, other than a member of Your Immediate Family.

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, Periodontist or Licensed Hearing Care Professional.

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.