Filing at a Glance

Company:	Cigna Health and Life Insurance Company
Product Name:	Dental - Individual Exchange
State:	Tennessee
TOI:	H10I Individual Health - Dental
Sub-TOI:	H10I.000 Health - Dental
Filing Type:	Form/Rate
Date Submitted:	06/14/2013
SERFF Tr Num:	CCGH-129066489
SERFF Status:	Closed-Approved
State Tr Num:	H-130877
State Status:	Approved
Co Tr Num:	20994203
Implementation Date Requested:	01/01/2014
Author(s):	Debbie Kingsley, Jennifer Linstone, Maria Mahmood, June Goddard, Sue Roberts, Danielle Thalheimer
Reviewer(s):	Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt, Art Lucker
Disposition Date:	07/26/2013
Disposition Status:	Approved
Implementation Date:	

State Filing Description:

I HIX DEN PED P
INDDENPEDI.TN
individual pediatric dental health insurance exchange plans

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Dental - Individual Exchange*		
Project Name/Number:	*EHB Pediatric Dental/*		

General Information

Project Name: EHB Pediatric Dental
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Maria Mahmood

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 07/26/2013
State Status Changed: 07/26/2013
Created By: Maria Mahmood
Corresponding Filing Tracking Number: CCGH-TN14-125002477

Filing Description:
We are filing for your approval , the following policy forms:

In the Exchange:
• myCigna Dental Pediatric/99248TN0030001
Form number: INDDENPEDI.TN
• myCigna Dental Family + Pediatric/99248TN0030002
Form number: INDDENCOMB.TN

Outside the Exchange:
• myCigna Dental Pediatric
Form numbers: INDDENPEDI.TN
• Individual Dental Policy previously under CCGH-128735094

Additional forms to be used with this filing are the Specification page HC-CER33 previously approved under SERFF number CCGH-128735094, and Application INDDENTTN0712, previously approved under SERFF number CCGH-128729360.

Our HIOS Product Identification is 99248.

Rates are included in this filing.

Company and Contact

Filing Contact Information

Maria Mahmood, Compliance Specialist
900 Cottage Grove Road
Hartford, CT 06152

maria.mahmood@cigna.com
860-226-5080 [Phone]
860-226-3183 [FAX]

Filing Company Information

Cigna Health and Life Insurance Company
900 Cottage Grove Road
Bloomfield, CT 06002
(860) 226-6000 ext. [Phone]

CoCode: 67369
Group Code: 901
Group Name:
FEIN Number: 59-1031071

State of Domicile: Connecticut
Company Type: LAH
State ID Number:

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Dental - Individual Exchange*		
Project Name/Number:	*EHB Pediatric Dental/*		

Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

State: Tennessee
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Dental - Individual Exchange
Project Name/Number: EHB Pediatric Dental/

Filing Company: Cigna Health and Life Insurance Company

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Vicky Stotzer	07/26/2013	07/26/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Company Response	Art Lucker	07/12/2013	07/12/2013
Pending Company Response	Vicky Stotzer	07/08/2013	07/08/2013
Pending Company Response	Melissa Merritt	06/28/2013	06/28/2013

Response Letters

Responded By	Created On	Date Submitted
Maria Mahmood	07/18/2013	07/18/2013
Sue Roberts	07/18/2013	07/18/2013
Danielle Thalheimer	07/05/2013	07/05/2013

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Response Needed	Note To Filer	Brian Hoffmeister	07/17/2013	07/17/2013

State: *Tennessee*
Filing Company: *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*

Disposition

Disposition Date: 07/26/2013
Implementation Date:
Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Cigna Health and Life Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Cover Letter Accident & Health	Approved	Yes
Supporting Document	Description of Variables	Approved	Yes
Supporting Document	Filing Fees	Approved	Yes
Supporting Document	Readability Certification	Approved	Yes
Supporting Document	Third Party Authorization	Approved	Yes
Supporting Document (revised)	Actuarial Memorandum A & H Certification - Individual	Approved	Yes
Supporting Document	Actuarial Memorandum A & H Certification - Individual	Replaced	Yes
Supporting Document	Accident & Health - Individual New Rates	Approved	Yes
Supporting Document	Redlines	Approved	Yes
Supporting Document	Redlines 7.18.13	Approved	Yes
Supporting Document	Response Letter	Approved	Yes
Supporting Document	Redline Orthowaiting Period	Approved	Yes
Form (revised)	myCigna Dental Pediatric	Approved	Yes

State: *Tennessee*
Filing Company: *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	myCigna Dental Pediatric	Replaced	Yes
Form	myCigna Dental Pediatric	Replaced	Yes
Form	myCigna Dental Pediatric	Replaced	Yes
Form (revised)	myCigna Dental Family + Pediatric	Approved	Yes
Form	myCigna Dental Family + Pediatric	Withdrawn	Yes
Form	myCigna Dental Family + Pediatric	Replaced	Yes
Form	myCigna Dental Family + Pediatric	Replaced	Yes
Rate (revised)	Rate pages	Approved	Yes
Rate	Rate pages	Replaced	Yes

INS CONSULTANTS, INC.

Insurance Regulatory Consultants

419 S. 2nd Street
New Market, Suite 206
Philadelphia, PA 19147
Phone: (215) 625-9877
Fax: (215) 627-7104

TO: Vicky Stotzer
Health Analyst
Policy Analysis Section, Insurance Division
Tennessee Department of Commerce and Insurance

FROM: James Kuklinski, ASA, MAAA
INS Consultants, Inc.

DATE: July 22, 2013

SUBJECT: Cigna Health and Life Insurance Company
Individual Health – Dental
Forms: INDDENPEDI.TN, INDDENCOMB.TN
SERFF Tracking Number: CCGH-129066489
Tennessee Tracking Number: H-130877

INS Consultants, Inc. (INS) has reviewed Cigna Health and Life Insurance Company's (CHLIC) individual dental filing for plans On and Off the Tennessee Exchange. Please note that for plans which are marketed both On and Off the exchange, the rates are the same.

The filing was submitted on June 14, 2013 requesting approval of new myCigna Dental Pediatric and myCigna Dental Family policy forms and rates, to meet both the Tennessee regulatory requirements and the Federal Affordable Care Act (ACA) requirements for offering pediatric dental Essential Health Benefits (EHB) using a stand-alone dental plan in the individual market. The filing covers one pediatric-only Low plan, to be used both On and Off the exchange, and one family combination Low plan, incorporating the required pediatric dental EHB, to be used On the exchange; a previously approved Individual Dental Policy form will be used for family coverage off the exchange. Previously approved Specification page and Application forms will be used with the filed forms. Forms and rates are requested to become effective for new business on and after January 1, 2014.

In support of their request, Cigna has provided the proposed new forms and rates, an actuarial memorandum, rate data template, Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification form, and Stand-Alone Dental Plans-Description of EHB Allocation form. The actuarial memorandum includes, inter alia, plan descriptions, pricing assumptions and methodology, anticipated loss ratio (64%), and appropriate actuarial certifications.

After a review of the actuarial memorandum and related supporting materials, INS identified, on July 12, 2013, several matters that required additional clarification. Subsequently, on July 18, 2013, Cigna provided clarification that responded to the questions raised by INS.

INS has reviewed the submission in its entirety. INS has checked for compliance with Tennessee loss ratio requirements as well as for compliance with ACA requirements with respect to Actuarial Value. The anticipated loss ratio exceeds the Tennessee standard of 55% for guaranteed renewable business of this kind, and the Actuarial Value, at 71.8%, falls within +/-2% of the 70% standard for Low plans under ACA. INS's analysis also included (but was not limited to) a review of the rate manual, trend assumption, retention, administrative expense breakdown, and rate data template. Based on INS's review the rates are acceptable, the retention and administrative expenses are reasonable, the actuarial values appear to be calculated using a methodology that is reasonable, and the rates appear to be consistent across rating parameters and by plan differences.

Based on INS's review and on the certifying statements of Cigna's opining actuary, INS suggests that the subject filing is compliant with Tennessee and ACA regulatory requirements. Based on this conclusion, INS suggests that the submitted rate schedules are actuarially justified.

If you have any questions or would like additional information, please do not hesitate to call or e-mail.

_____

James Kuklinski, ASA, MAAA

State:	Tennessee	**Filing Company:**	Cigna Health and Life Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Dental - Individual Exchange		
Project Name/Number:	EHB Pediatric Dental/		

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/12/2013
Submitted Date	07/12/2013
Respond By Date	07/18/2013

Dear Maria Mahmood,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- Actuarial Memorandum A & H Certification - Individual (Supporting Document)

Comments: Please address the following:

1. Please provide, in the actuarial memorandum, a discussion of compliance with the ACA and State regulations regarding rates and benefits. Please cite the appropriate regulations.

2. Please comment on the reference to renewability as conditionally renewable in the policy, but as guaranteed renewable in the actuarial memorandum.

3. Please provide supporting documentation for the expected trend rate of 5.5%.

4. Please provide a discussion of the model used (including methodology) to produce the AV for the included low plan. What is the rationale for not offering a high plan?

5. Please explain why the rates in the Exhibit II Premium Rates table (pdf file) differ from those in the rate file in the binder.

6. Please provide the base costs used in pricing, their support, and support for the age distinctions in the rates.

7. Related to 1. above, please explain or correct what appears to be a non-compliant provision with respect to the ACA benefit requirements; for pediatric medically necessary orthodontia, the waiting period appears to amount to the imposition of a pre-existing condition exclusion.

Conclusion:

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Art Lucker

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Dental - Individual Exchange*		
Project Name/Number:	*EHB Pediatric Dental/*		

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/08/2013
Submitted Date	07/08/2013
Respond By Date	

Dear Maria Mahmood,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- myCigna Dental Pediatric, INDDENPEDI.TN (Form)

Comments: This is a stand alone pediatric dental and if it is purchased on the exchange, the 90 day grace period will apply to this product. The family product would not be required to have the grace period.

c. Pediatric Dental Coverage Section 36B(b)(3)(E) provides that, for purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan
and a plan providing dental coverage as described in section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 13031(d)(2)(B)(ii)), the portion of the premium for the dental plan that is properly allocable to pediatric dental benefits that are essential health benefits is treated as a premium payable for the individuals qualified health plan. Thus, the portion of the premium for the separate pediatric dental coverage is added to the premium for the benchmark plan in computing the credit. Comments are requested on methods of determining the amount of the premium properly allocable to pediatric dental benefits.

Federal Register /Vol. 76, No. 159 /Wednesday, August 17, 2011

Conclusion:

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons. If you have any questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

Sincerely,

Vicky Stotzer

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Dental - Individual Exchange*		
Project Name/Number:	*EHB Pediatric Dental/*		

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	06/28/2013
Submitted Date	06/28/2013
Respond By Date	

Dear Maria Mahmood,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- myCigna Dental Pediatric, INDDENPEDI.TN (Form)

Comments: Are your conditions of eligibility really appropriate for a pediatric dental?

Objection 2

- myCigna Dental Pediatric, INDDENPEDI.TN (Form)

Comments: Is the continuation provision really appropriate for the pediatric dental?

Objection 3

- myCigna Dental Pediatric, INDDENPEDI.TN (Form)

Comments: If this plan is sold on the exchange and if the person is receiving a subsidy, then the same 90 day grace period applies to the dental as to the medical.

Objection 4

- myCigna Dental Pediatric, INDDENPEDI.TN (Form)

Comments: For the pediatric plan, deductibles do apply to the individual/family out of pocket maximum. This is in the definition.

Objection 5

- myCigna Dental Family + Pediatric , INDDENCOMB.TN (Form)

Comments: For the pediatrice coverage the deductible must apply to the out of pocket maximum.

Conclusion:

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons. If you have any questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

Sincerely,

Melissa Merritt

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Dental - Individual Exchange
Project Name/Number: EHB Pediatric Dental/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/18/2013
Submitted Date	07/18/2013

Dear Vicky Stotzer,

Introduction:

Response 1

Comments:

Please see response letter and revised memorandum and exhibits.

Related Objection 1

Applies To:

- Actuarial Memorandum A & H Certification - Individual (Supporting Document)

Comments: Please address the following:

1. Please provide, in the actuarial memorandum, a discussion of compliance with the ACA and State regulations regarding rates and benefits. Please cite the appropriate regulations.

2. Please comment on the reference to renewability as conditionally renewable in the policy, but as guaranteed renewable in the actuarial memorandum.

3. Please provide supporting documentation for the expected trend rate of 5.5%.

4. Please provide a discussion of the model used (including methodology) to produce the AV for the included low plan. What is the rationale for not offering a high plan?

5. Please explain why the rates in the Exhibit II Premium Rates table (pdf file) differ from those in the rate file in the binder.

6. Please provide the base costs used in pricing, their support, and support for the age distinctions in the rates.

7. Related to 1. above, please explain or correct what appears to be a non-compliant provision with respect to the ACA benefit requirements; for pediatric medically necessary orthodontia, the waiting period appears to amount to the imposition of a pre-existing condition exclusion.

Changed Items:

State: *Tennessee*
Filing Company: *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum A & H Certification - Individual
Comments:	
Attachment(s):	Actuarial Memorandum EHB TN.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum A & H Certification - Individual*
Comments:	
Attachment(s):	*Actuarial Memorandum EHB TN.pdf*

Satisfied - Item:	Response Letter
Comments:	
Attachment(s):	Response to letter 7.12.2013.pdf

Satisfied - Item:	Redline Orthowaiting Period
Comments:	
Attachment(s):	INDDENCOMB.TN. 7.18.2013 redline ortho w.p..pdf INDDENPEDI.TN. 7.18.2013 redline ortho w.p..pdf

State: *Tennessee*
Filing Company: *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum A & H Certification - Individual
Comments:	
Attachment(s):	Actuarial Memorandum EHB TN.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum A & H Certification - Individual*
Comments:	
Attachment(s):	*Actuarial Memorandum EHB TN.pdf*

Satisfied - Item:	Response Letter
Comments:	
Attachment(s):	Response to letter 7.12.2013.pdf

Satisfied - Item:	Redline Orthowaiting Period
Comments:	
Attachment(s):	INDDENCOMB.TN. 7.18.2013 redline ortho w.p..pdf INDDENPEDI.TN. 7.18.2013 redline ortho w.p..pdf

State: *Tennessee*
Filing Company: *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum A & H Certification - Individual
Comments:	
Attachment(s):	Actuarial Memorandum EHB TN.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum A & H Certification - Individual*
Comments:	
Attachment(s):	*Actuarial Memorandum EHB TN.pdf*

Satisfied - Item:	Response Letter
Comments:	
Attachment(s):	Response to letter 7.12.2013.pdf

Satisfied - Item:	Redline Orthowaiting Period
Comments:	
Attachment(s):	INDDENCOMB.TN. 7.18.2013 redline ortho w.p..pdf INDDENPEDI.TN. 7.18.2013 redline ortho w.p..pdf

State: *Tennessee*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*
Filing Company: *Cigna Health and Life Insurance Company*

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	myCigna Dental Pediatric	INDDENPEDI.TN	POL	Initial		51.800	INDDENPEDI.TN. 7.18.2013 ortho w.p..pdf	Date Submitted: 07/18/2013 By: Maria Mahmood
Previous Version								
1	*myCigna Dental Pediatric*	*INDDENPEDI.TN*	*POL*	*Initial*		*51.800*	*INDDENPEDI.TN. 7.18.2013 grace period.pdf*	*Date Submitted: 07/18/2013 By: Sue Roberts*
Previous Version								
1	*myCigna Dental Pediatric*	*INDDENPEDI.TN*	*POL*	*Initial*		*51.800*	*INDDENPEDI.TN.7.5.2013.pdf*	*Date Submitted: 07/05/2013 By: Danielle Thalheimer*
Previous Version								
1	*myCigna Dental Pediatric*	*INDDENPEDI.TN*	*POL*	*Initial*		*51.800*	*INDDENPEDI.TN.pdf*	*Date Submitted: 06/14/2013 By: Maria Mahmood*
2	myCigna Dental Family + Pediatric	INDDENCOMB.TN	POL	Initial		50.600	INDDENCOMB.TN. 7.18.2013 ortho w.p..pdf	Date Submitted: 07/18/2013 By: Maria Mahmood
Previous Version								
2	*myCigna Dental Family + Pediatric*	*INDDENCOMB.TN*	*POL*	*Initial*		*50.600*	*INDDENCOMB.TN. 7.18.2013 grace period.pdf*	*Date Submitted: 07/18/2013 By: Sue Roberts*

State: *Tennessee*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*
Filing Company: *Cigna Health and Life Insurance Company*

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	myCigna Dental Pediatric	INDDENPEDI.TN	POL	Initial		51.800	INDDENPEDI.TN. 7.18.2013 ortho w.p..pdf	Date Submitted: 07/18/2013 By: Maria Mahmood
Previous Version								
2	*myCigna Dental Family + Pediatric*	*INDDENCOMB.TN*	*POL*	*Initial*		*50.600*	*INDDENCOMB.TN.7.5.2013.pdf*	*Date Submitted: 07/05/2013 By: Danielle Thalheimer*
Previous Version								
2	*myCigna Dental Family + Pediatric*	*INDDENCOMB.TN*	*POL*	*Initial*		*50.600*	*INDDENCOMB.TN.pdf*	*Date Submitted: 06/14/2013 By: Maria Mahmood*

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Rate pages	INDDENPEDI.TN, INDDENCOMB.TN	New		Dental Manual EHB TN.pdf,	07/18/2013 By: Maria Mahmood
Previous Version						
1	*Rate pages*	*INDDENPEDI.TN, INDDENCOMB.TN*	*New*		*Dental Manual EHB TN.pdf,*	*06/14/2013 By: Maria Mahmood*

Conclusion:

State: Tennessee
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Dental - Individual Exchange
Project Name/Number: EHB Pediatric Dental/

Filing Company: Cigna Health and Life Insurance Company

Sincerely,
Maria Mahmood

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Dental - Individual Exchange
Project Name/Number: EHB Pediatric Dental/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/18/2013
Submitted Date	07/18/2013

Dear Vicky Stotzer,

Introduction:

We received your letter of 7.8.13 and thank you for your continued review of our filing. Please see our comments to your question below.

Response 1

Comments:

We have revised the grace period per your concerns above. Revised redlines are under Supporting Documentation tab. Revised documents show under Form Schedule tab.

Related Objection 1

Applies To:

- myCigna Dental Pediatric, INDDENPEDI.TN (Form)

Comments: This is a stand alone pediatric dental and if it is purchased on the exchange, the 90 day grace period will apply to this product. The family product would not be required to have the grace period.

c. Pediatric Dental Coverage Section 36B(b)(3)(E) provides that, for purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan
and a plan providing dental coverage as described in section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 13031(d)(2)(B)(ii)), the portion of the premium for the dental plan that is properly allocable to pediatric dental benefits that are essential health benefits is treated as a premium payable for the individuals qualified health plan. Thus, the portion of the premium for the separate pediatric dental coverage is added to the premium for the benchmark plan in computing the credit. Comments are requested on methods of determining the amount of the premium properly allocable to pediatric dental benefits.

Federal Register /Vol. 76, No. 159 /Wednesday, August 17, 2011

Changed Items:

State: *Tennessee*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*
Filing Company: *Cigna Health and Life Insurance Company*

Supporting Document Schedule Item Changes	
Satisfied - Item:	Redlines 7.18.13
Comments:	
Attachment(s):	INDDENCOMB.TN. redline grace period 7.18.2013.pdf INDDENPEDI.TN. redline 7.18.2013 grace period.pdf

State: Tennessee
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Dental - Individual Exchange
Project Name/Number: EHB Pediatric Dental/
Filing Company: Cigna Health and Life Insurance Company

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	myCigna Dental Pediatric	INDDENPEDI.TN	POL	Initial		51.800	INDDENPEDI.TN. 7.18.2013 grace period.pdf	Date Submitted: 07/18/2013 By: Sue Roberts
Previous Version								
1	*myCigna Dental Pediatric*	*INDDENPEDI.TN*	*POL*	*Initial*		*51.800*	*INDDENPEDI.TN.7.5.2013.pdf*	*Date Submitted: 07/05/2013 By: Danielle Thalheimer*
Previous Version								
1	*myCigna Dental Pediatric*	*INDDENPEDI.TN*	*POL*	*Initial*		*51.800*	*INDDENPEDI.TN.pdf*	*Date Submitted: 06/14/2013 By: Maria Mahmood*
2	myCigna Dental Family + Pediatric	INDDENCOMB.TN	POL	Initial		50.600	INDDENCOMB.TN. 7.18.2013 grace period.pdf	Date Submitted: 07/18/2013 By: Sue Roberts
Previous Version								
2	*myCigna Dental Family + Pediatric*	*INDDENCOMB.TN*	*POL*	*Initial*		*50.600*	*INDDENCOMB.TN.7.5.2013.pdf*	*Date Submitted: 07/05/2013 By: Danielle Thalheimer*
Previous Version								
2	*myCigna Dental Family + Pediatric*	*INDDENCOMB.TN*	*POL*	*Initial*		*50.600*	*INDDENCOMB.TN.pdf*	*Date Submitted: 06/14/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Conclusion:

We hope we have properly addressed your concerns.

Sincerely,

Sue Roberts

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Dental - Individual Exchange
Project Name/Number: EHB Pediatric Dental/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/05/2013
Submitted Date	07/05/2013

Dear Vicky Stotzer,

Introduction:

Thank you for your comments.

Response 1

Comments:

The pediatric dental plan applies to children to or through age 19, who may have a spouse age 19 or under, or have a child, stepchild or possibly an adopted child, under age 19.

Related Objection 1

Applies To:

- myCigna Dental Pediatric, INDDENPEDI.TN (Form)

Comments: Are your conditions of eligibility really appropriate for a pediatric dental?

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Redlines
Comments:	
Attachment(s):	INDDENCOMB.TN.redline.7.5.2013.pdf INDDENPEDI.TN.redline.7.5.2013.pdf

State: *Tennessee* **Filing Company:** *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	myCigna Dental Pediatric	INDDENPEDI.TN	POL	Initial		51.800	INDDENPEDI.TN .7.5.2013.pdf	Date Submitted: 07/05/2013 By: Danielle Thalheimer
Previous Version								
1	*myCigna Dental Pediatric*	*INDDENPEDI.TN*	*POL*	*Initial*		*51.800*	*INDDENPEDI.TN .pdf*	*Date Submitted: 06/14/2013 By: Maria Mahmood*
2	myCigna Dental Family + Pediatric	INDDENCOMB.T N	POL	Initial		50.600	INDDENCOMB.T N.7.5.2013.pdf	Date Submitted: 07/05/2013 By: Danielle Thalheimer
Previous Version								
2	*myCigna Dental Family + Pediatric*	*INDDENCOMB.T N*	*POL*	*Initial*		*50.600*	*INDDENCOMB.T N.pdf*	*Date Submitted: 06/14/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Response 2

Comments:

Although it is probably a rare circumstance, we have included the continuation provision for the spouse or child of an insured person, who may lose coverage due to the insured persons death or divorce.

Related Objection 2

Applies To:

- *myCigna Dental Pediatric, INDDENPEDI.TN (Form)*

Comments: Is the continuation provision really appropriate for the pediatric dental?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments:

While the Company is participating on the Exchange, the Dental Plan that is being filed is a stand alone dental plan and therefore maintains its Excepted Benefit status under ERISA. As a result, the only PPACA requirements that would be applicable would be the prohibition on life time and annual limits. The 90 day grace period pursuant to acceptance of an advance premium tax credit would not be applicable.

Related Objection 3

Applies To:
- myCigna Dental Pediatric, INDDENPEDI.TN (Form)

Comments: If this plan is sold on the exchange and if the person is receiving a subsidy, then the same 90 day grace period applies to the dental as to the medical.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments:

Thank you for pointing this out. We have corrected the definitions of individual and family out-of-pocket to identify that deductibles do apply to the out-of-pocket.

Related Objection 4

Applies To:
- myCigna Dental Pediatric, INDDENPEDI.TN (Form)

Comments: For the pediatric plan, deductibles do apply to the individual/family out of pocket maximum. This is in the definition.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments:

Thank you for pointing this out. We have corrected the definitions of individual and family out-of-pocket to identify that deductibles do apply to the out-of-pocket.

Related Objection 5

Applies To:
- myCigna Dental Family + Pediatric , INDDENCOMB.TN (Form)

Comments: For the pediatrice coverage the deductible must apply to the out of pocket maximum.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review.

Sincerely,
Danielle Thalheimer

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Dental - Individual Exchange*		
Project Name/Number:	*EHB Pediatric Dental/*		

Note To Filer

Created By:

Brian Hoffmeister on 07/17/2013 02:52 PM

Last Edited By:

Brian Hoffmeister

Submitted On:

07/17/2013 02:52 PM

Subject:

Response Needed

Comments:

The approval deadline for this filing is July 31, 2013 since this filing is for plans that will be offered on the FFM in Tennessee. As of today, we have not received a response to our letter citing deficiencies in the filing. In order to meet the July 31st deadline set by HHS, we need to have your response no later than July 24, 2013. This will allow us time to review your response and ask for any additional corrections before the approval deadline.

If you have any questions, please contact Vicky Stotzer at 615-741-6259 or Victoria.stotzer@tn.gov.

Brian K. Hoffmeister
Director, Policy Analysis Section
Davy Crockett Tower 6th floor
500 James Robertson Pkwy
Nashville, TN 37243
Phone: 615-741-5602
Fax: 615-741-0648

State: *Tennessee*
Filing Company: *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 07/26/2013	myCigna Dental Pediatric	INDDENPEDI.TN	POL	Initial		51.800	INDDENPEDI.TN. 7.18.2013 ortho w.p..pdf
2	Approved 07/26/2013	myCigna Dental Family + Pediatric	INDDENCOMB.TN	POL	Initial		50.600	INDDENCOMB.TN. 7.18.2013 ortho w.p..pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Pediatric]

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224)).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. Pediatric coverage and benefits are only available to Insured Persons up to [and through] the age of 19. [Please note that benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.] 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Corporate Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Insured must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy if you are up to [and through] the age of 19 and when You have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Member(s) up to [and through] the age of 19:

- Your lawful spouse or domestic partner.
- Your children
- Your stepchildren
- Your own, or Your spouse's or domestic partner children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.]
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Benefit Schedule

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods

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

- there is no waiting period for Class I, II, III
- [after 12 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures]

What the Policy Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Covered Dental Expenses

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "Terms of the Policy", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, 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 Insured 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 Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

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

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Family + Pediatric]

NOTE: The [myCigna Dental Family + Pediatric] Dental Plan consists of the [myCigna Dental 1000] plan for members [19] [20] years of age and older as well as the [myCigna Dental Pediatric] plan for members up to [and through] the age of 19. Please see your associated sections based on your age.

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

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

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, Your spouse's, or domestic partner's unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period. Please see "Terms of the Policy", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, 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 Insured 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 Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

Policy Payment Information

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Insurance coverage is only for the classes of service referred to in The Schedule, however the covered person is also eligible for discounts for other selected services. Discounts for these select services are not insurance. The covered person will receive discounts from Cigna's contracted health care professionals for these services. Discounts are based on Cigna Dental contracted rates. Please call Cigna at 1.800.Cigna24 (1.800.244.6224) for details about this plan.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Service Area is any place that is within the state of Tennessee

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

[myCigna Dental 1000] Benefits

NOTE: The [myCigna Dental 1000] Benefits sections of this Policy are available to Insured Persons age [19] [20] and older.

Benefit Schedule – [myCigna Dental 1000]

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	**Participating Provider**	**Non –Participating Provider**
Calendar Year Maximum: Class I, II, III	$1,000 per person	
Calendar Year Deductible: Class I, II, III	$50 per person	
	$150 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I – Preventive/Diagnostic Services Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100% after Deductible	100% after Deductible
Class II – Basic Restorative Services Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after Deductible	80% after Deductible
Class III – Major Restorative Services Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental 1000]

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

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

What [myCigna Dental 1000] Pays For

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental 1000]

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

Class I Services - Diagnostic and Preventive Dental Services

- Bitewing x-rays – Only 1 set in any consecutive 12 month period Limited to a maximum of 4 films per set.
- Clinical oral evaluation – Only 1 per consecutive 6-month period
- Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure per consecutive 6-month period

Class II Services-Diagnostic Services

- Complete mouth survey or panoramic x-rays - only 1 in any consecutive 60-month period For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.
- Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period
- Intraoral occlusal x-rays - Limited to 2 films in any consecutive 12-month period

Fillings

- Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.
- Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least 12 consecutive months have passed since the existing filling was placed.
- Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.
- Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine Extractions

- Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.
- Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Miscellaneous Services

- Palliative (emergency) Treatment of Dental Pain - Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Class III Services

Diagnostic Procedures

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

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.

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 elapsed since the last placement.
- Benefits for crowns are based on the amount payable for nonprecious metal substrate.
- 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.

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.
- Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any consecutive 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

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.

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.

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.
- 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.

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Missing Teeth Limitation - [myCigna Dental 1000]

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

Exclusions And Limitations: What Is Not Covered By [myCigna Dental 1000]

Excluded Services

Covered Expenses do not include expenses incurred for:

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

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

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

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

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminate).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- treatment of jaw fractures and orthognathic surgery.
- orthodontic treatment.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- diagnostic casts, diagnostic models, or study models.

- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

such part by you or any one of your Dependents.

[myCigna Dental Pediatric] Benefits

NOTE: The myCigna Dental Pediatric Benefits sections of this Policy are available to Insured Persons up to [and through] the age of 19.

Benefit Schedule - [myCigna Dental Pediatric]

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental Pediatric]

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

- there is no waiting period for Class I, II, III
- [after 12 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures]

What [myCigna Dental Pediatric] Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental Pediatric]

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By [myCigna Dental Pediatric]

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

State: *Tennessee*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*
Filing Company: *Cigna Health and Life Insurance Company*

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Cigna Health and Life Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

State: *Tennessee*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*
Filing Company: *Cigna Health and Life Insurance Company*

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate pages	INDDENPEDI.TN, INDDENCOMB.TN	New		Dental Manual EHB TN.pdf,

Cigna Health and Life Insurance Company
Accident and Health Rate Filing
Individual Dental
Effective: 01/01/2014
Exhibit I - Geographic Classification

Code	Area Name *
1	Chattanooga
2	Jackson
3	Knoxville
4	Memphis
5	Nashville
6	Nationwide **

**Area Names are Cigna-defined. A detailed zip code to area mapping is available upon request.*

***All members who change residence outside of the state of Tennessee and wish to continue their current Tennessee policy will be subject to the Nationwide rates.*

Cigna Health and Life Insurance Company
Accident and Health Rate Filing
Individual Dental
Effective: 01/01/2014
Exhibit II - Premium Rates*

		Children 0-20	Adult Rate 21-24	Adult Rate 25-59	Adult Rate 60+
Area 1	Chattanooga	$26	$20.00	$26.00	$34.00
Area 2	Jackson	$26	$19.00	$25.00	$33.00
Area 3	Knoxville	$26	$19.00	$25.00	$34.00
Area 4	Memphis	$26	$19.00	$25.00	$34.00
Area 5	Nashville	$33	$25.00	$31.00	$40.00
Area 6	Nationwide	$76	$44.00	$52.00	$63.00

** Premium rates reflect per member per month rate.*

Exhibit III - Rate Development
CHLIC - Tennessee Individual Dental Plan

Illustrative Rate Development for Individual Dental Policy

(i) Expected Group Dental Cost Per Member Per Year		$ 137
Translation to Individual Basis	(a) 0% Employer Contribution Adjustment	1.17
	(b) SIC Unknown Adjustment	1.04
	(c) No Prior Coverage Adjustment	1.10
(ii) Group to Individual basis adjustment factor = (a) x (b) x (c)		1.33848
(iii) Expected Individual Dental Cost Per Member Per Year = (i) x (ii)		$183
(iv) Trend (Annual Trend 5.5%)		1.17
(v) Trended Individual Dental Cost Per Member Per Year = (iii) x (iv)		$215
(vi) Retention		36%
(vii) Average Premium Rate Per Member Per Year = (v) / [1- (vi)]		$336

State: *Tennessee*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*
Filing Company: *Cigna Health and Life Insurance Company*

Supporting Document Schedules

Satisfied - Item:	Cover Letter Accident & Health
Comments:	
Attachment(s):	Cover Letter 13 EHB TN.pdf
Item Status:	Approved
Status Date:	07/26/2013

Satisfied - Item:	Description of Variables
Comments:	
Attachment(s):	Statement of Variability Pediatric Plan.pdf Statement of Variability Comb Plan.pdf
Item Status:	Approved
Status Date:	07/26/2013

Bypassed - Item:	Filing Fees
Bypass Reason:	there is no domicile fee.
Attachment(s):	
Item Status:	Approved
Status Date:	07/26/2013

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	TN Readability Certification.pdf
Item Status:	Approved
Status Date:	07/26/2013

Bypassed - Item:	Third Party Authorization
Bypass Reason:	n/a

State: *Tennessee* **Filing Company:** *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*

Attachment(s):	
Item Status:	Approved
Status Date:	07/26/2013

Satisfied - Item:	Actuarial Memorandum A & H Certification - Individual
Comments:	
Attachment(s):	Actuarial Memorandum EHB TN.pdf
Item Status:	Approved
Status Date:	07/26/2013

Bypassed - Item:	Accident & Health - Individual New Rates
Bypass Reason:	Rates are included under the rate tab.
Attachment(s):	
Item Status:	Approved
Status Date:	07/26/2013

Satisfied - Item:	Redlines
Comments:	
Attachment(s):	INDDENCOMB.TN.redline.7.5.2013.pdf INDDENPEDI.TN.redline.7.5.2013.pdf
Item Status:	Approved
Status Date:	07/26/2013

Satisfied - Item:	Redlines 7.18.13
Comments:	
Attachment(s):	INDDENCOMB.TN. redline grace period 7.18.2013.pdf INDDENPEDI.TN. redline 7.18.2013 grace period.pdf
Item Status:	Approved
Status Date:	07/26/2013

State: *Tennessee*
Filing Company: *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Dental - Individual Exchange*
Project Name/Number: *EHB Pediatric Dental/*

Satisfied - Item:	Response Letter
Comments:	
Attachment(s):	Response to letter 7.12.2013.pdf
Item Status:	Approved
Status Date:	07/26/2013

Satisfied - Item:	Redline Orthowaiting Period
Comments:	
Attachment(s):	INDDENCOMB.TN. 7.18.2013 redline ortho w.p..pdf INDDENPEDI.TN. 7.18.2013 redline ortho w.p..pdf
Item Status:	Approved
Status Date:	07/26/2013

Megan Weaver
Actuarial Sr. Analyst
Cigna Dental

June 3, 2013

Routing B7CDH
900 Cottage Grove Road
Hartford, Connecticut
06152
Tel: 860.226.2994
Fax: 860.226.6776
megan.weaver@cigna.com

Tennessee Department of Commerce and Insurance
c/o Trey Hancock
500 James Patterson Pkwy
Davy Crockett Tower, 5th Floor
Nashville, TN 37243

RE: Cigna Health and Life Insurance Company
Individual Insurance Rate Filing Request
NAIC# 67369

Dear Mr. Hancock:

This rate filing is for the pediatric essential health benefit dental product offering effective January 1, 2014. Proposed rates for Cigna Health and Life Insurance Company's dental plan are enclosed. These rates are accompanied by Actuarial Memorandum and Actuarial Certification.

In my opinion the rates are based upon reasonable assumptions and appropriate methodology. I do not believe the rates to be excessive, inadequate, or unfairly discriminatory.

If you have any questions or need additional information, please contact me at 860.226.2994 or megan.weaver@cigna.com.

Sincerely,

Megan Weaver
Actuarial Sr. Analyst

CIGNA Health and Life Insurance Company

Statement of Variability
Tennessee
INDDENPEDI.TN

General

1. To the extent that variable changes are made, they will not be ambiguous or deceptive.

2. Titles or names – such as the product name – may change, but their relation to the matter to which they pertain will not be ambiguous or deceptive.

3. Catalog numbers shown in the lower right hand corner are used for internal tracking of forms prepared.

Cover Page

- Addresses and phone numbers may vary.
- Applicability of time frames regarding age requirements.
- Signatures/titles may vary.

Who is Eligible for Coverage?

- Insert the appropriate [month] [year] for effective date applicability.

Benefit Schedule

- Applicability of time frame regarding age requirements.

Terms of the Policy

- Addresses and phone numbers may vary.

CIGNA Health and Life Insurance Company

Statement of Variability
Tennessee
INDDENCOMB.TN

General

1. To the extent that variable changes are made, they will not be ambiguous or deceptive.

2. Titles or names – such as the product name – may change, but their relation to the matter to which they pertain will not be ambiguous or deceptive.

3. Catalog numbers shown in the lower right hand corner are used for internal tracking of forms prepared.

Cover Page

- Addresses and phone numbers may vary.
- Signatures/titles may vary.

Who is Eligible for Coverage?

- Insert the appropriate [month] [year] for effective date applicability.

Terms of the Policy

- Addresses and phone numbers may vary.

- Only variability is Product name (see item 2 above)

Benefit Schedule

- Applicability of time frames regarding age requirements.

CIGNA HEALTH AND LIFE INSURANCE COMPANY
Individual Forms

This is to certify that the forms listed below are in compliance with state readability laws and regulations and the NAIC Life and Health Insurance Policy Language Simplification Model Act.

A. Option Selected

Certificate pages are scored as a group for the Flesch reading ease test.

Form and Form Numbers to Which Certification is Applicable:

Form	Form Number	Flesch Score
Individual Dental Pediatric Policy	INDDENPEDI.TN	51.8
Individual Dental Family + Pediatric Policy	INDDENCOMB.TN	50.6

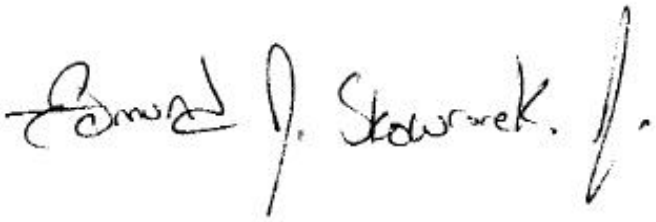
B. Test Option Selected

Test was applied to certificate insert pages as a group.

C. Standards for Certification

The following standards have been achieved:

1. The text achieved the minimum score of 40 on the Flesch reading ease test in accordance with section A above.
2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
3. The layout and spacing separate the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs, or constructions are not used.
6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
7. A table of contents or an index of the principal sections is included in the policy.
8. Any words which are defined in the policy(ies) and any medical terminology have been excluded from the Flesch test score.



	Director	06/13/13
Edmund J. Skowronek, Jr.	Officer's Title	Date

Cigna Health and Life Insurance Company (CHLIC)
Accident and Health Rate Filing
Actuarial Memorandum
Individual Dental

Scope and Purpose

The purpose of this memorandum is to file rates associated with the policy forms shown above. Please note that this is the initial rate filing for these forms. The memorandum includes a description of the product features underlying the product, as well as information related to the development of the premium rates. A Rate Table containing the detailed premium rates has been included with this filing. The rates contained in this filing are proposed for new contracts, on and after the effective date of January 1, 2014.

Benefit Description

1. myCigna Dental Pediatric Plan

For Children (Age 0-19)	**Participating Provider**	**Non –Participating Provider**
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Reimbursement Levels	Based on reduced contracted fees	Maximum Allowable Charge
Benefit	**Percentage of Covered Expenses the Plan Pays**	
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

2. myCigna Dental Family + Pediatric Plan

For Children (Age 0-19)	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Reimbursement Levels	Based on reduced contracted fees	Maximum Allowable Charge
Benefit	**Percentage of Covered Expenses the Plan Pays**	
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

For Adults (Age >19)	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	$1,000	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Reimbursement Levels	Based on reduced contracted fees	Maximum Allowable Charge
Benefit	**Percentage of Covered Expenses the Plan Pays**	
Class I - Preventive/Diagnostic Services	100% after Deductible	
Class II - Basic Restorative Services	50% after Deductible	
	6 Months Waiting Period	
Class III - Major Restorative Services	80% after Deductible	
	12 Months Waiting Period	
	No coverage for replacement of teeth missing prior to the effective date.	
Class IV – Medically Necessary Orthodontia	Plan pays 0%, network discounts apply	Not covered

Please note: The myCigna Dental Family + Pediatric plan will only be available on-Exchange.

Pricing Methodology

There is limited experience available for the individual dental product as this is a fairly new product. As a result premium rates were developed based on our existing group dental products along with publicly available premium rate information for various individual dental plans. From this information, an estimate of claims cost was developed and adjusted for differences in benefits and targeted population. Financial analysis was conducted to project future administrative expenses and other retention components. A trend factor and geographical differences were then applied based on large group methodology. Rates were then compiled to ensure an appropriate target loss ratio.

The individual dental premium rates submitted in this filing are for the dental plans described in Section 2 of the Actuarial Memorandum were developed using CHLIC's current Florida large group manual claim costs with adjustments, using the following methodology:

STEP 1:
Calculate large group manual claim cost for the plan design outlined in section 2 of the Actuarial Memorandum, using CHLIC's group rating engine.

The plan's benefit options were entered into the group rating engine, which calculates the expected cost of benefits by determining the cost differential, on a common morbidity basis, between the plan being priced and the normalized cost of a hypothetical 100% pay (no member cost sharing) dental plan design in Florida.

The cost of the 100% pay plan is built-up based on dental claims experience of the Florida large group manual rating pool, which included:

- Claims incurred between January 1, 2011 and December 31, 2011.
- Claims corresponding to groups
    - with in-network and out-of-network benefits of 100%/80%/50%, $50/$150 individual/family deductible, $1500 calendar year maximum
    - that existed prior to January 1, 2011

The group rating engine incorporates various cost sharing features including deductible, coinsurance and calendar year maximum, as well as expected cost differences by area, and applies those to the 100% pay plan using a dental claims probability distribution to determine the final large group manual (expected) claim cost for the plan being priced.

STEP 2:
Since the manual (expected) claim cost obtained in STEP 1 is on a group basis (100% employer paid coverage), the group manual claim cost is converted to an individual basis to reflect the utilization differences between large group and individual. The following adjustments were made to the large group manual rate:

• 0% employer contribution adjustment (1.17)
The 0% employer contribution adjustment is deemed to cover the voluntary nature of the individual product. The factors published by Milliman Health Cost Guidelines 2011 for voluntary loads indicate our projections to be in line with their analysis.

• Industry unknown adjustment (1.04)
One of CHLIC's group dental rating variables is SIC code. Expected dental costs vary based on the industry of the group. Since SIC code is not one of the rating variables on the Individual Dental product (premium rates only vary by age and location and effective month of coverage), it's necessary to reflect the average expected impact on costs due to occupation through this adjustment.

• No prior dental coverage adjustment (1.10)
This adjustment accounts for the expected increased cost due to no prior dental coverage at enrollment. Utilization during the first year of coverage is expected to be higher than in later years due to the individual nature of the coverage.

STEP 3:
The claim costs in STEP 2 were generated at the 3 digit zip code level, then were rolled up to each geographic classification level shown in Exhibit I. Projected expenses, shown in the next section of this memorandum, were then added to these rates.

Commissions, Expenses, and Profit

We estimate total retention to be approximately 36%. Total retention is comprised of administrative expenses, premium tax, commissions and a risk charge.

Administrative Expenses	13%
Commissions	10%
Profit	6%
Taxes*	4%
Exchange Fees	3%
Total	36%

** includes state premium tax and PPACA health insurance industry fee assessment*

Premium Rates

Premium rates will vary based on plan design, age, and geographic area. The geographic classification is as follows:

State	Code	Rating Area
TN	1	TNChattanooga
TN	2	TNJackson
TN	3	TNKnoxville
TN	4	TNMemphis
TN	5	TNNashville

A 15% dependent discount will be applied to the premium rate of any dependents of the primary insured. The policy premium rate will be equal to the sum of the primary insured rate and the discounted dependent rates.

The schedules of proposed individual rates are attached to this memorandum as Rate Table.

Anticipated Lifetime Loss Ratio

The anticipated lifetime loss ratio for the individual dental plan is expected to be 64%

Renewability Clause

The policy is conditionally renewable.

Premium Modalization Rules

The pricing methodology outlined in the CHLIC Accident and Health manual produces monthly premiums. Therefore, modalization factors are expressed as a function of these monthly rates as follows:

Modalization Factors

Weekly	0.231
Bi-Weekly	0.462
Monthly	1
Quarterly	2.989
Semi-Annual	5.945
Annual	11.761

Trend Assumptions

The expected annualized trend is 5.5%.

Component	
Inflation	5.1%
Utilization	3.0%
Leveraging	-2.5%
Total	5.5%

This factor reflects underlying differences in network costs and discounts, inflation/severity, cost-shifting, utilization, and cost share leveraging. Trend factors will be applied to the new business premium rates in Exhibit II on a semi-annual basis.

Proposed Effective Date

The rates contained in this filing are proposed for new contracts, on and after the effective date of January 1, 2014.

A & H Certification

Our EHB benefits and rates are in compliance with all ACA and state regulation requirements.

Actuarial Certification

I, Dipti Patel, FSA, MAAA, certify that to the best of my knowledge and judgment, these rates on average meet an Actuarial Value of 71.8%. This rate filing is in compliance with the applicable laws and regulations of this state and that the premiums charged are reasonable in relation to the benefits provided.

Dipti Patel

_____

Dipti Patel, FSA, MAAA
Actuarial Manager

_____7/18/2013_____
Date

Cigna Health and Life Insurance Company may change the premiums of this Policy after ~~[~~30~~-90]~~ day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")

[myCigna Dental Family + Pediatric]

NOTE: The [myCigna Dental Family + Pediatric] Dental Plan consists of the [myCigna Dental 1000] plan for members [19] [20] years of age and older as well as the [myCigna Dental Pediatric] plan for members up to [and through] the age of 19. Please see your associated sections based on your age.

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. 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.

~~Guaranteed~~ Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

~~Insert State specific information here~~

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of ~~Colorado~~Tennessee. The Insured must notify Us of all changes that may affect any Insured 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 Insured Persons may include the following Family Member(s):

- Your lawful spouse ~~[~~or domestic partner~~] [or partner to a civil union] [of the opposite sex]~~.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, Your spouse's, or domestic partner's unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- ~~Your own, or Your spouse's [or domestic partner] [or Your partner to a civil union's] children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.~~
- Your own, or Your spouse's ~~[~~or domestic partner~~] [or Your partner to a civil union's]~~ Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then

become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 [or domestic partner] [or partner to a civil union]: when the spouse is no longer married to the Insured [or when the union is dissolved].
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

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

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, ~~[State]~~Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in ~~[State]~~Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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. ~~There is a $50 fee for reinstatement.~~

Fraud: If the Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.

- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

Cigna also reserves the right to change the premium on [30-90] days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

Policy Payment Information

~~NOTE: Some states do not allow for MAC~~

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Insurance coverage is only for the classes of service referred to in The Schedule, however the covered person is also eligible for discounts for other selected services. Discounts for these select services are not insurance. The covered person will receive discounts from Cigna's contracted health care professionals for these services. Discounts are based on Cigna Dental contracted rates. Please call Cigna at 1.800.Cigna24 (1.800.244.6224) for details about this plan.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within ~~[12~~ 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months~~this time period~~.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

~~Use Language Filed for SAD - State Specific~~

General Provisions

~~Third Party Liability~~

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

~~We may have a right to a lien, to the extent of benefits advanced, upon any recovery that You receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Policy for the treatment of the Illness, disease, Injury or condition for which the third party is liable. We will be entitled to collect on our lien even if the amount recovered by or for the Insured Person (or his or her 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 Insured Person.~~

~~Right of Reimbursement~~

~~If an Insured 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 Insured Person may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.~~

Dispute Resolution

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

Binding Arbitration

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

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

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

effective in accordance with this section, notwithstanding the absence of such party.

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

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles ~~and non-compliance penalty charges do not~~ apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-

Pocket Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles ~~and non-compliance penalty charges do not~~ apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Service Area is any place that is within the state of ~~[State]~~Tennessee

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

[myCigna Dental 1000] Benefits

NOTE: The [myCigna Dental 1000] Benefits sections of this Policy are available to Insured Persons age [19] [20] and older.

Benefit Schedule – [myCigna Dental 1000]

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	**Participating Provider**	**Non –Participating Provider**
Calendar Year Maximum: Class I, II, III	$1,000 per person	
Calendar Year Deductible: Class I, II, III	$50 per person	
	$150 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I – Preventive/Diagnostic Services Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100% after Deductible	100% after Deductible
Class II – Basic Restorative Services Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after Deductible	80% after Deductible
Class III – Major Restorative Services Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental 1000]

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

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

What [myCigna Dental 1000] Pays For

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental 1000]

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

Class I Services - Diagnostic and Preventive Dental Services

- Bitewing x-rays – Only 1 set in any consecutive 12 month period Limited to a maximum of 4 films per set.
- Clinical oral evaluation – Only 1 per consecutive 6-month period
- Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure per consecutive 6-month period

Class II Services-Diagnostic Services

- Complete mouth survey or panoramic x-rays - only 1 in any consecutive 60-month period For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.
- Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period
- Intraoral occlusal x-rays - Limited to 2 films in any consecutive 12-month period

Fillings

- Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.
- Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least 12 consecutive months have passed since the existing filling was placed.
- Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.
- Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine Extractions

- Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.
- Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Miscellaneous Services

- Palliative (emergency) Treatment of Dental Pain - Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Class III Services

Diagnostic Procedures

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

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.

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 elapsed since the last placement.
- Benefits for crowns are based on the amount payable for nonprecious metal substrate.
- 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.

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.
- Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any consecutive 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

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.

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.

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.
- 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.

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Missing Teeth Limitation - [myCigna Dental 1000]

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

Exclusions And Limitations: What Is Not Covered By [myCigna Dental 1000]

Excluded Services

Covered Expenses do not include expenses incurred for:

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

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

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

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

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminate).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- treatment of jaw fractures and orthognathic surgery.
- orthodontic treatment~~, except for the treatment of cleft lip and cleft palate~~.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- diagnostic casts, diagnostic models, or study models.

- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.~~]~~

General Limitations

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

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

such part by you or any one of your Dependents.

[myCigna Dental Pediatric] Benefits

NOTE: The myCigna Dental Pediatric Benefits sections of this Policy are available to Insured Persons up to [and through] the age of 19.

Benefit Schedule - [myCigna Dental Pediatric]

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental Pediatric]

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

- there is no waiting period for Class I, II, III
- after ~~24~~ 12 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures

What [myCigna Dental Pediatric] Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental Pediatric]

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By [myCigna Dental Pediatric]

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

Cigna Health and Life Insurance Company may change the premiums of this Policy after ~~[30-90]~~30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Pediatric]

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224)~~(1.800.Cigna24/1.800.244.6224~~).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. Pediatric coverage and benefits are only available to Insured Persons up to [and through] the age of 19. [Please note that benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.] 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.

~~Guaranteed~~ Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Corporate Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

~~Insert State specific information here~~

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of ~~[State]~~Tennessee. The Insured must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy if you are up to [and through] the age of 19 and when You have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Member(s) up to [and through] the age of 19:

- Your lawful spouse ~~[~~or domestic partner~~] [or partner to a civil union] [of the opposite sex]~~.
- Your children
- Your stepchildren
- Your own, or Your spouse's or domestic partner children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.]
- Your own, or Your spouse's ~~[~~or domestic partner~~] [or Your partner to a civil union's]~~ Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 [or domestic partner] ~~[or partner to a civil union]~~: when the spouse is no longer married to the Insured [or when the union is dissolved].
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Benefit Schedule

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods

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

- there is no waiting period for Class I, II, III
- after ~~24~~ 12 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures

What the Policy Pays For

~~NOTE: Some states do not allow for MAC~~

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Covered Dental Expenses

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.

D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.
D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	

D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,
D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,

D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,
D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.

D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.
D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

General Provisions

~~Third Party Liability~~

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

~~We may have a right to a lien, to the extent of benefits advanced, upon any recovery that You receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Policy for the treatment of the Illness, disease, Injury or condition for which the third party is liable. We will be entitled to collect on our lien even if the amount recovered by or for the Insured Person (or his or her 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 Insured Person.~~

~~Right of Reimbursement~~

~~If an Insured 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 Insured Person may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.~~

Dispute Resolution

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

Binding Arbitration

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

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

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails

to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

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

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

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

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

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, ~~[State]~~Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in ~~[State]~~Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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. ~~There is a $50 fee for reinstatement.~~

Fraud: If the Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

  Cigna
  Individual Services
  [P. O. Box [XXXX]]
  [City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.

- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

Cigna also reserves the right to change the premium on ~~[30-90]~~30 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within ~~[12~~ 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months~~this time period~~.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

~~Use Language Filed for SAD - State Specific~~

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles ~~and non-compliance penalty charges do not~~ apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-

Pocket Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles ~~and non-compliance penalty charges do not~~ apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Service Area is any place that is within the state of ~~[State]~~Tennessee.

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Family + Pediatric]

NOTE: The [myCigna Dental Family + Pediatric] Dental Plan consists of the [myCigna Dental 1000] plan for members [19] [20] years of age and older as well as the [myCigna Dental Pediatric] plan for members up to [and through] the age of 19. Please see your associated sections based on your age.

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

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

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, Your spouse's, or domestic partner's unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "Terms of the Policy", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there~~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 Insured 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 Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

Policy Payment Information

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Insurance coverage is only for the classes of service referred to in The Schedule, however the covered person is also eligible for discounts for other selected services. Discounts for these select services are not insurance. The covered person will receive discounts from Cigna's contracted health care professionals for these services. Discounts are based on Cigna Dental contracted rates. Please call Cigna at 1.800.Cigna24 (1.800.244.6224) for details about this plan.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Service Area is any place that is within the state of Tennessee

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

[myCigna Dental 1000] Benefits

NOTE: The [myCigna Dental 1000] Benefits sections of this Policy are available to Insured Persons age [19] [20] and older.

Benefit Schedule – [myCigna Dental 1000]

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	**Participating Provider**	**Non –Participating Provider**
Calendar Year Maximum: Class I, II, III	$1,000 per person	
Calendar Year Deductible: Class I, II, III	$50 per person	
	$150 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I – Preventive/Diagnostic Services Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100% after Deductible	100% after Deductible
Class II – Basic Restorative Services Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after Deductible	80% after Deductible
Class III – Major Restorative Services Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental 1000]

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

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

What [myCigna Dental 1000] Pays For

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental 1000]

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

Class I Services - Diagnostic and Preventive Dental Services

- Bitewing x-rays – Only 1 set in any consecutive 12 month period Limited to a maximum of 4 films per set.
- Clinical oral evaluation – Only 1 per consecutive 6-month period
- Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure per consecutive 6-month period

Class II Services-Diagnostic Services

- Complete mouth survey or panoramic x-rays - only 1 in any consecutive 60-month period For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.
- Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period
- Intraoral occlusal x-rays - Limited to 2 films in any consecutive 12-month period

Fillings

- Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.
- Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least 12 consecutive months have passed since the existing filling was placed.
- Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.
- Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine Extractions

- Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.
- Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Miscellaneous Services

- Palliative (emergency) Treatment of Dental Pain - Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Class III Services

Diagnostic Procedures

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

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.

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 elapsed since the last placement.
- Benefits for crowns are based on the amount payable for nonprecious metal substrate.
- 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.

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.
- Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any consecutive 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

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.

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.

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.
- 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.

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Missing Teeth Limitation - [myCigna Dental 1000]

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

Exclusions And Limitations: What Is Not Covered By [myCigna Dental 1000]

Excluded Services

Covered Expenses do not include expenses incurred for:

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

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

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

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

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminate).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- treatment of jaw fractures and orthognathic surgery.
- orthodontic treatment.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- diagnostic casts, diagnostic models, or study models.

- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

such part by you or any one of your Dependents.

[myCigna Dental Pediatric] Benefits

NOTE: The myCigna Dental Pediatric Benefits sections of this Policy are available to Insured Persons up to [and through] the age of 19.

Benefit Schedule - [myCigna Dental Pediatric]

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental Pediatric]

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

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

What [myCigna Dental Pediatric] Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental Pediatric]

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By [myCigna Dental Pediatric]

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Pediatric]

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224)).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. Pediatric coverage and benefits are only available to Insured Persons up to [and through] the age of 19. [Please note that benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.] 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Corporate Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Insured must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy if you are up to [and through] the age of 19 and when You have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Member(s) up to [and through] the age of 19:

- Your lawful spouse or domestic partner.
- Your children
- Your stepchildren
- Your own, or Your spouse's or domestic partner children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.]
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Benefit Schedule

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods

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

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

What the Policy Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Covered Dental Expenses

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "Terms of the Policy", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there~~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 Insured 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 Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

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

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

Megan Weaver
Actuarial Sr. Analyst
Cigna Dental

July 16, 2013

Routing B7CDH
900 Cottage Grove Road
Hartford, Connecticut
06152
Tel: 860.226.2994
Fax: 860.226.6776
megan.weaver@cigna.com

Tennessee Department of Commerce and Insurance
c/o Victoria Stotzer
500 James Patterson Pkwy
Davy Crockett Tower, 5th Floor
Nashville, TN 37243

RE: Cigna Health and Life Insurance Company
Individual Insurance Rate Filing Request
NAIC# 67369

Dear Ms. Stotzer:

In response to your letter dated July 12, 2013, this letter provides additional information for your consideration.

Objection 1
- Actuarial Memorandum A & H Certification - Individual (Supporting Document)
Comments: Please address the following:
1. Please provide, in the actuarial memorandum, a discussion of compliance with the ACA and State regulations regarding rates and benefits. Please cite the appropriate regulations.

Please see "A & H Certification" in the Actuarial Memorandum.

2. Please comment on the reference to renewability as conditionally renewable in the policy, but as guaranteed renewable in the actuarial memorandum.

The policy is conditionally renewable. Please see revised Actuarial Memorandum for updated language.

3. Please provide supporting documentation for the expected trend rate of 5.5%.

Please see the update in the Actuarial Memo under "Trend Assumptions" to find the trend components.

4. Please provide a discussion of the model used (including methodology) to produce the AV for the included low plan. What is the rationale for not offering a high plan?

The 71.8% actuarial value is the percent of the total cost of services that we will pay after cost sharing. We calculated this value from our large group claim experience, which is based off the probability of a claim and the amount of each claim.

5. Please explain why the rates in the Exhibit II Premium Rates table (pdf file) differ from those in the rate file in the binder.

Please see the updated rate file in the binder.

6. Please provide the base costs used in pricing, their support, and support for the age distinctions in the rates.

The individual premium rates were based on our existing large group dental products. We expect Cigna's group experience to be a better source for following reasons:

- Our group book of business is deemed credible given the membership size and the time periods available.
- Detailed benefit, demographic, and geographic information on the group experience data allows us to better price for specific plan designs.
- The same provider network offered to Cigna's group business will be offered to the Individual segment. Therefore the cost and network usage assumptions inherent in our group rates that were derived from the group experience are appropriate.

Please see a more detailed claim cost explanation in the "Pricing Methodology" section of the Actuarial Memorandum. The base costs and adjustments are provided Exhibit III Rate Development.

Note that we used our large group dental rating areas for age distinctions. Please refer to the SERFF filing number CCGP-128661887 for more information.

7. Related to 1. above, please explain or correct what appears to be a non-compliant provision with respect to the ACA benefit requirements; for pediatric medically necessary orthodontia, the waiting period appears to amount to the imposition of a pre-existing condition exclusion.

The plan language submitted for approval may be used in two instances: (1) for pediatric plans offered on a standalone basis on-the-exchange, i.e., the Standalone Pediatric Only Dental Plan and the Standalone Pediatric + Family Dental Plan, and (2) for pediatric plans bundled in a Cigna medical plan offered off-the-exchange.

The Company has bracketed the waiting period because it is the Company's understanding that the pediatric dental plans offered on a standalone basis -- in this instance the Standalone Pediatric Only Dental Plan that will be offered on the exchange and the Standalone Pediatric + Family Dental Plan offered on the exchange -- are considered excepted benefits. Thus, the ACA's prohibition on preexisting condition limitations and/or waiting periods would not be applicable and in that case the Company can opt to apply a waiting period on orthodontic benefits.

However, for those pediatric plans that will be bundled with a Cigna medical plan and offered off-the-exchange, the Company would ensure that the bracketed waiting period would be removed because the Company understands that the pediatric benefits would no longer be excepted and the Company would therefore be required to comply with the ACA for its pediatric dental benefits, i.e., the waiting period would not be permitted.

If you have any questions or need additional information, please contact me at 860.226.2994 or megan.weaver@cigna.com.

Sincerely,

Megan Weaver
Actuarial Sr. Analyst

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Family + Pediatric]

NOTE: The [myCigna Dental Family + Pediatric] Dental Plan consists of the [myCigna Dental 1000] plan for members [19] [20] years of age and older as well as the [myCigna Dental Pediatric] plan for members up to [and through] the age of 19. Please see your associated sections based on your age.

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

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

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, Your spouse's, or domestic partner's unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period. Please see "Terms of the Policy", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, 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 Insured 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 Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

Policy Payment Information

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Insurance coverage is only for the classes of service referred to in The Schedule, however the covered person is also eligible for discounts for other selected services. Discounts for these select services are not insurance. The covered person will receive discounts from Cigna's contracted health care professionals for these services. Discounts are based on Cigna Dental contracted rates. Please call Cigna at 1.800.Cigna24 (1.800.244.6224) for details about this plan.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Service Area is any place that is within the state of Tennessee

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

[myCigna Dental 1000] Benefits

NOTE: The [myCigna Dental 1000] Benefits sections of this Policy are available to Insured Persons age [19] [20] and older.

Benefit Schedule – [myCigna Dental 1000]

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	**Participating Provider**	**Non –Participating Provider**
Calendar Year Maximum: Class I, II, III	$1,000 per person	
Calendar Year Deductible: Class I, II, III	$50 per person	
	$150 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I – Preventive/Diagnostic Services Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100% after Deductible	100% after Deductible
Class II – Basic Restorative Services Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after Deductible	80% after Deductible
Class III – Major Restorative Services Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental 1000]

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

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

What [myCigna Dental 1000] Pays For

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental 1000]

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

Class I Services - Diagnostic and Preventive Dental Services

- Bitewing x-rays – Only 1 set in any consecutive 12 month period Limited to a maximum of 4 films per set.
- Clinical oral evaluation – Only 1 per consecutive 6-month period
- Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure per consecutive 6-month period

Class II Services-Diagnostic Services

- Complete mouth survey or panoramic x-rays - only 1 in any consecutive 60-month period For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.
- Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period
- Intraoral occlusal x-rays - Limited to 2 films in any consecutive 12-month period

Fillings

- Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.
- Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least 12 consecutive months have passed since the existing filling was placed.
- Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.
- Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine Extractions

- Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.
- Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Miscellaneous Services

- Palliative (emergency) Treatment of Dental Pain - Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Class III Services

Diagnostic Procedures

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

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.

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 elapsed since the last placement.
- Benefits for crowns are based on the amount payable for nonprecious metal substrate.
- 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.

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.
- Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any consecutive 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

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.

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.

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.
- 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.

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Missing Teeth Limitation - [myCigna Dental 1000]

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

Exclusions And Limitations: What Is Not Covered By [myCigna Dental 1000]

Excluded Services

Covered Expenses do not include expenses incurred for:

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

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

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

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

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminate).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- treatment of jaw fractures and orthognathic surgery.
- orthodontic treatment.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- diagnostic casts, diagnostic models, or study models.

- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

such part by you or any one of your Dependents.

[myCigna Dental Pediatric] Benefits

NOTE: The myCigna Dental Pediatric Benefits sections of this Policy are available to Insured Persons up to [and through] the age of 19.

Benefit Schedule - [myCigna Dental Pediatric]

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental Pediatric]

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

- there is no waiting period for Class I, II, III
- [after 12 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures]

What [myCigna Dental Pediatric] Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental Pediatric]

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By [myCigna Dental Pediatric]

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Pediatric]

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224)).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. Pediatric coverage and benefits are only available to Insured Persons up to [and through] the age of 19. [Please note that benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.] 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Corporate Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Insured must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy if you are up to [and through] the age of 19 and when You have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Member(s) up to [and through] the age of 19:

- Your lawful spouse or domestic partner.
- Your children
- Your stepchildren
- Your own, or Your spouse's or domestic partner children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.]
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Benefit Schedule

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods

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

- there is no waiting period for Class I, II, III
- [after 12 consecutive months of coverage dental benefits will increase to include the list of Class IV procedures]

What the Policy Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Covered Dental Expenses

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "Terms of the Policy", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, 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 Insured 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 Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

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

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/18/2013	Replaced 07/26/2013	Form	myCigna Dental Pediatric	07/18/2013	INDDENPEDI.TN. 7.18.2013 grace period.pdf (Superceded)
07/18/2013	Withdrawn 07/26/2013	Form	myCigna Dental Family + Pediatric	07/18/2013	INDDENCOMB.TN. 7.18.2013 grace period.pdf (Superceded)
07/05/2013	Replaced 07/26/2013	Form	myCigna Dental Pediatric	07/18/2013	INDDENPEDI.TN.7.5.2013.pdf (Superceded)
07/05/2013	Replaced 07/26/2013	Form	myCigna Dental Family + Pediatric	07/18/2013	INDDENCOMB.TN.7.5.2013.pdf (Superceded)
06/12/2013	Replaced 07/26/2013	Form	myCigna Dental Pediatric	07/05/2013	INDDENPEDI.TN.pdf (Superceded)
06/12/2013	Replaced 07/26/2013	Form	myCigna Dental Family + Pediatric	07/05/2013	INDDENCOMB.TN.pdf (Superceded)
06/10/2013	Replaced 07/26/2013	Rate	Rate pages	07/18/2013	Dental Manual EHB TN.pdf (Superceded)
06/10/2013	Replaced 07/26/2013	Supporting Document	Actuarial Memorandum A & H Certification - Individual	07/18/2013	Actuarial Memorandum EHB TN.pdf (Superceded)

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Pediatric]

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224)).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. Pediatric coverage and benefits are only available to Insured Persons up to [and through] the age of 19. [Please note that benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.] 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Corporate Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Insured must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy if you are up to [and through] the age of 19 and when You have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Member(s) up to [and through] the age of 19:

- Your lawful spouse or domestic partner.
- Your children
- Your stepchildren
- Your own, or Your spouse's or domestic partner children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.]
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Benefit Schedule

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods

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

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

What the Policy Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Covered Dental Expenses

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "Terms of the Policy", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, 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 Insured 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 Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

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

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Family + Pediatric]

NOTE: The [myCigna Dental Family + Pediatric] Dental Plan consists of the [myCigna Dental 1000] plan for members [19] [20] years of age and older as well as the [myCigna Dental Pediatric] plan for members up to [and through] the age of 19. Please see your associated sections based on your age.

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

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

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, Your spouse's, or domestic partner's unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period. Please see "Terms of the Policy", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, 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 Insured 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 Insured Person notify Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

Policy Payment Information

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Insurance coverage is only for the classes of service referred to in The Schedule, however the covered person is also eligible for discounts for other selected services. Discounts for these select services are not insurance. The covered person will receive discounts from Cigna's contracted health care professionals for these services. Discounts are based on Cigna Dental contracted rates. Please call Cigna at 1.800.Cigna24 (1.800.244.6224) for details about this plan.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Service Area is any place that is within the state of Tennessee

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

[myCigna Dental 1000] Benefits

NOTE: The [myCigna Dental 1000] Benefits sections of this Policy are available to Insured Persons age [19] [20] and older.

Benefit Schedule – [myCigna Dental 1000]

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	**Participating Provider**	**Non –Participating Provider**
Calendar Year Maximum: Class I, II, III	$1,000 per person	
Calendar Year Deductible: Class I, II, III	$50 per person	
	$150 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I – Preventive/Diagnostic Services Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100% after Deductible	100% after Deductible
Class II – Basic Restorative Services Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after Deductible	80% after Deductible
Class III – Major Restorative Services Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental 1000]

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

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

What [myCigna Dental 1000] Pays For

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental 1000]

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

Class I Services - Diagnostic and Preventive Dental Services

- Bitewing x-rays – Only 1 set in any consecutive 12 month period Limited to a maximum of 4 films per set.
- Clinical oral evaluation – Only 1 per consecutive 6-month period
- Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure per consecutive 6-month period

Class II Services-Diagnostic Services

- Complete mouth survey or panoramic x-rays - only 1 in any consecutive 60-month period For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.
- Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period
- Intraoral occlusal x-rays - Limited to 2 films in any consecutive 12-month period

Fillings

- Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.
- Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least 12 consecutive months have passed since the existing filling was placed.
- Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.
- Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine Extractions

- Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.
- Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Miscellaneous Services

- Palliative (emergency) Treatment of Dental Pain - Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Class III Services

Diagnostic Procedures

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

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.

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 elapsed since the last placement.
- Benefits for crowns are based on the amount payable for nonprecious metal substrate.
- 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.

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.
- Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any consecutive 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

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.

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.

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.
- 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.

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Missing Teeth Limitation - [myCigna Dental 1000]

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

Exclusions And Limitations: What Is Not Covered By [myCigna Dental 1000]

Excluded Services

Covered Expenses do not include expenses incurred for:

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

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

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

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

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminate).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- treatment of jaw fractures and orthognathic surgery.
- orthodontic treatment.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- diagnostic casts, diagnostic models, or study models.

- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

such part by you or any one of your Dependents.

[myCigna Dental Pediatric] Benefits

NOTE: The myCigna Dental Pediatric Benefits sections of this Policy are available to Insured Persons up to [and through] the age of 19.

Benefit Schedule - [myCigna Dental Pediatric]

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental Pediatric]

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

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

What [myCigna Dental Pediatric] Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental Pediatric]

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By [myCigna Dental Pediatric]

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Pediatric]

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224)).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. Pediatric coverage and benefits are only available to Insured Persons up to [and through] the age of 19. [Please note that benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.] 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Corporate Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Insured must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy if you are up to [and through] the age of 19 and when You have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Member(s) up to [and through] the age of 19:

- Your lawful spouse or domestic partner.
- Your children
- Your stepchildren
- Your own, or Your spouse's or domestic partner children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.]
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Benefit Schedule

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods

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

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

What the Policy Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Covered Dental Expenses

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

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

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

  Cigna
  Individual Services
  [P. O. Box [XXXX]]
  [City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.

- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

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

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Family + Pediatric]

NOTE: The [myCigna Dental Family + Pediatric] Dental Plan consists of the [myCigna Dental 1000] plan for members [19] [20] years of age and older as well as the [myCigna Dental Pediatric] plan for members up to [and through] the age of 19. Please see your associated sections based on your age.

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

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

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, Your spouse's, or domestic partner's unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

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

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

  Cigna
  Individual Services
  [P. O. Box [XXXX]]
  [City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.

- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

Policy Payment Information

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Insurance coverage is only for the classes of service referred to in The Schedule, however the covered person is also eligible for discounts for other selected services. Discounts for these select services are not insurance. The covered person will receive discounts from Cigna's contracted health care professionals for these services. Discounts are based on Cigna Dental contracted rates. Please call Cigna at 1.800.Cigna24 (1.800.244.6224) for details about this plan.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered

Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Service Area is any place that is within the state of Tennessee

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

[myCigna Dental 1000] Benefits

NOTE: The [myCigna Dental 1000] Benefits sections of this Policy are available to Insured Persons age [19] [20] and older.

Benefit Schedule – [myCigna Dental 1000]

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	**Participating Provider**	**Non –Participating Provider**
Calendar Year Maximum: Class I, II, III	$1,000 per person	
Calendar Year Deductible: Class I, II, III	$50 per person	
	$150 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I – Preventive/Diagnostic Services Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100% after Deductible	100% after Deductible
Class II – Basic Restorative Services Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after Deductible	80% after Deductible
Class III – Major Restorative Services Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental 1000]

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

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

What [myCigna Dental 1000] Pays For

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental 1000]

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

Class I Services - Diagnostic and Preventive Dental Services

- Bitewing x-rays – Only 1 set in any consecutive 12 month period Limited to a maximum of 4 films per set.
- Clinical oral evaluation – Only 1 per consecutive 6-month period
- Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure per consecutive 6-month period

Class II Services-Diagnostic Services

- Complete mouth survey or panoramic x-rays - only 1 in any consecutive 60-month period For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.
- Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period
- Intraoral occlusal x-rays - Limited to 2 films in any consecutive 12-month period

Fillings

- Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.
- Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least 12 consecutive months have passed since the existing filling was placed.
- Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.
- Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine Extractions

- Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.
- Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Miscellaneous Services

- Palliative (emergency) Treatment of Dental Pain - Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Class III Services

Diagnostic Procedures

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

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.

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 elapsed since the last placement.
- Benefits for crowns are based on the amount payable for nonprecious metal substrate.
- 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.

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.
- Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any consecutive 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

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.

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.

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.
- 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.

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Missing Teeth Limitation - [myCigna Dental 1000]

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

Exclusions And Limitations: What Is Not Covered By [myCigna Dental 1000]

Excluded Services

Covered Expenses do not include expenses incurred for:

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

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

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

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

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminate).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- treatment of jaw fractures and orthognathic surgery.
- orthodontic treatment.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- diagnostic casts, diagnostic models, or study models.

- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

such part by you or any one of your Dependents.

[myCigna Dental Pediatric] Benefits

NOTE: The myCigna Dental Pediatric Benefits sections of this Policy are available to Insured Persons up to [and through] the age of 19.

Benefit Schedule - [myCigna Dental Pediatric]

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental Pediatric]

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

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

What [myCigna Dental Pediatric] Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental Pediatric]

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic ~~pulpotomy~~Pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By [myCigna Dental Pediatric]

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Pediatric]

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224)).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. Pediatric coverage and benefits are only available to Insured Persons up to [and through] the age of 19. [Please note that benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.] 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Corporate Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Insured must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy if you are up to [and through] the age of 19 and when You have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Member(s) up to [and through] the age of 19:

- Your lawful spouse or domestic partner.
- Your children
- Your stepchildren
- Your own, or Your spouse's or domestic partner children who are incapable of self support due to medically certified continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Benefit Schedule

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods

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

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

What the Policy Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Covered Dental Expenses

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By This Policy

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary.
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment.
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

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

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

  Cigna
  Individual Services
  [P. O. Box [XXXX]]
  [City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.

- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles and non-compliance penalty charges do not apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-

Pocket Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles and non-compliance penalty charges do not apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

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

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 day's written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[myCigna Dental Family + Pediatric]

NOTE: The [myCigna Dental Family + Pediatric] Dental Plan consists of the [myCigna Dental 1000] plan for members [19] [20] years of age and older as well as the [myCigna Dental Pediatric] plan for members up to [and through] the age of 19. Please see your associated sections based on your age.

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

Cigna
Individual Services
[P. O. Box [XXXX]]
[City, State Zip Code]
[1-XXX-XXX-XXXX]

Include Your Cigna identification number with any correspondence. This number can be found on the Policy Specification Page of this Policy or by calling 1.800.Cigna24 (1.800.244.6224).

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. It is intended to satisfy the pediatric essential health benefit requirement mandated by the Patient Protection and Affordable Care Act. 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.

Conditionally Renewable
This Policy is monthly dental coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy- POLICY CANCELLABLE BY COMPANY.

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:

[signature] [Name] [President] [signature] [Name], [Secretary]

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Introduction

About This Policy

Your dental 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 "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. You and all Family Member(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 Dentally Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Dentist prescribes or orders a service does not, in itself, mean that the service is Dentally Necessary or that the service is a Covered Service. Consult this Policy or phone Us at 1.800.Cigna24 (1.800.244.6224) if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Dentally 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 Family Member(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 Family Member(s) covered under the Policy.

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

Please Read The Following Important Notice

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

Who Is Eligible For Coverage?

Conditions Of Eligibility

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

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, Your spouse's, or domestic partner's unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self support due to continuing mental or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's or domestic partner Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member 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.
- 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 an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another. To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering

event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if the individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.

Except as described in the Continuation section, an Insured 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 or domestic partner: when the spouse is no longer married to the Insured or when the union is dissolved.
- With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates.
- When the Insured no longer lives in the Service Area.

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

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

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class, Tennessee law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; and (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual dental insurance coverage offered by Us at the time of discontinuation.
6. When We cease offering all dental plans in the individual market in Tennessee in accordance with applicable law, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
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.

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 Insured 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, 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. Such amendments and/or endorsements will apply only with respect to claims that are incurred for Covered Expenses on and or after the reinstatement date.

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 Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured 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 Insured Person while receiving care from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

  Cigna
  Individual Services
  [P. O. Box [XXXX]]
  [City, State Zip code]

- 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 provider or the Insured Person unless prohibited by law. Except in cases of fraud committed by the provider. We may only recover reimbursements from the provider during the eighteen-month period after the date that We paid the claim submitted by the provider.
- In order for an Insured 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 Insured Person(s) receives a service or supply for which the charge is made.

- We will pay all benefits of this Agreement directly to Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full, in which case we will reimburse the Insured Person. In addition, We may pay any covered provider of services directly when the Insured 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 Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured 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 Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Member(s) may be materially and adversely affected.
- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.
- 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 Insured 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 Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
    - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
    - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer: If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

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.

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

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

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

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

Policy Payment Information

Dental PPO – Participating and Non-Participating Providers

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

The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a non-Participating 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 Provider in the relevant 3-digit zip code.

The covered person is responsible for the balance of the provider's actual charge.

Insurance coverage is only for the classes of service referred to in The Schedule, however the covered person is also eligible for discounts for other selected services. Discounts for these select services are not insurance. The covered person will receive discounts from Cigna's contracted health care professionals for these services. Discounts are based on Cigna Dental contracted rates. Please call Cigna at 1.800.Cigna24 (1.800.244.6224) for details about this plan.

Alternate Benefit Provision

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

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of 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.

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 calling 1.800.Cigna24 (1.800.244.6224). 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 Cigna.com or by calling 1.800.Cigna24 (1.800.244.6224).

Proof of Loss: You must give Us written proof of loss within 15 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 (or deny) for benefits if it does not receive written proof of loss within 15 months.

Assignment of Claim Payments:

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

1. It is duly executed on a form acceptable to Us; 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 services provided by a Participating Provider is automatically assigned to the Provider unless the Participating Provider indicates that the Insured Person has paid the claim in full. The Participating 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 Provider are payable to the Insured Person unless assignment is made as above. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation.

Time Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to Participating Providers unless You instruct Us to do otherwise prior to Our payment. 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 dental care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

Physical Examination: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured 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.

When you Have a Complaint or an Appeal

The Following Will Apply To Residents of Tennessee When You Have a Complaint or an Appeal

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

We want You to be completely satisfied with the care You receive. That is why we have established a process for addressing Your concerns 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 1.800.Cigna24 (1.800.244.6224) or address that appears on explanation of benefits or claim form.

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

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

Appeals Procedure

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

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received Your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

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

Relevant Information

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

General Provisions

Dispute Resolution

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

Binding Arbitration

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

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

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

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

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

Definitions

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

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

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.

Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee refers to the total compensation level that a Participating Provider has agreed to accept as payment for dental procedures and services
performed on an Insured Person, according to the Insured 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 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 Insured Person receives the service or supply. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Dentally Necessary services or supplies that are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy.

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 is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

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.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Who is Eligible for Coverage?"

Family Out-of-Pocket Maximum means once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles and non-compliance penalty charges do not apply to the Family Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-

Pocket Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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.

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by Cigna.

Individual Out of Pocket Maximum means once the Individual Out-of-Pocket Maximum has been met for the Year for Covered Services received from Dental Providers, You will no longer have to pay any Coinsurance for dental services for Covered Expenses incurred during the remainder of that Year from Dental Providers. Deductibles and non-compliance penalty charges do not apply to the Individual Out of Pocket Maximum and will always be paid by You. The Individual Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Dental Providers. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

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 are services provided by a Dentist or physician as determined by Cigna are Medically/Dentally Necessary if they are:

(1) required for the diagnosis and/or treatment of the particular dental condition or disease; and

(2) consistent with the symptom or diagnosis and treatment of the dental condition or disease; and

(3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and

(4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

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).

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by Cigna in consultation with our dental consultant.

Newborn is an infant within 31 days of birth.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on the Primary Schedule aligned to the 3-digit zip code for the geographical area where the service is performed, which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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 or endorsements to this document.

Provider means a Dentist or any other health care practitioner acting within the scope of the practitioner's license.

Service Area is any place that is within the state of Tennessee

Simultaneous Accumulation of Amounts are expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule. Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

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.

[myCigna Dental 1000] Benefits

NOTE: The [myCigna Dental 1000] Benefits sections of this Policy are available to Insured Persons age [19] [20] and older.

Benefit Schedule – [myCigna Dental 1000]

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	**Participating Provider**	**Non –Participating Provider**
Calendar Year Maximum: Class I, II, III	$1,000 per person	
Calendar Year Deductible: Class I, II, III	$50 per person	
	$150 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I – Preventive/Diagnostic Services Preventive Care Oral Exams Routine Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (non-orthodontic)	100% after Deductible	100% after Deductible
Class II – Basic Restorative Services Fillings Non-Routine X-rays Emergency Care to Relieve Pain Oral Surgery, Simple Extractions	80% after Deductible	80% after Deductible
Class III – Major Restorative Services Crowns / Inlays / Onlays Root Canal Therapy / Endodontics Minor Periodontics Major Periodontics Oral Surgery, All Except Simple Extractions Surgical Extraction of Impacted Teeth Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs – Dentures Anesthetics Dentures Bridges	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental 1000]

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

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

What [myCigna Dental 1000] Pays For

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental 1000]

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

Class I Services - Diagnostic and Preventive Dental Services

- Bitewing x-rays – Only 1 set in any consecutive 12 month period Limited to a maximum of 4 films per set.
- Clinical oral evaluation – Only 1 per consecutive 6-month period
- Prophylaxis (Cleaning) – Only 1 prophylaxis or periodontal maintenance procedure per consecutive 6-month period

Class II Services-Diagnostic Services

- Complete mouth survey or panoramic x-rays - only 1 in any consecutive 60-month period For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.
- Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period
- Intraoral occlusal x-rays - Limited to 2 films in any consecutive 12-month period

Fillings

- Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.
- Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least 12 consecutive months have passed since the existing filling was placed.
- Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.
- Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine Extractions

- Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.
- Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Miscellaneous Services

- Palliative (emergency) Treatment of Dental Pain - Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Class III Services

Diagnostic Procedures

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

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.

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 elapsed since the last placement.
- Benefits for crowns are based on the amount payable for nonprecious metal substrate.
- 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.

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.
- Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any consecutive 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

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.

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.

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.
- 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.

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Missing Teeth Limitation - [myCigna Dental 1000]

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

Exclusions And Limitations: What Is Not Covered By [myCigna Dental 1000]

Excluded Services

Covered Expenses do not include expenses incurred for:

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

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

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

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

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (laminate).
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- treatment of jaw fractures and orthognathic surgery.
- orthodontic treatment.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 years, as determined by Cigna.
- diagnostic casts, diagnostic models, or study models.

- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period);
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

such part by you or any one of your Dependents.

[myCigna Dental Pediatric] Benefits

NOTE: The myCigna Dental Pediatric Benefits sections of this Policy are available to Insured Persons up to [and through] the age of 19.

Benefit Schedule - [myCigna Dental Pediatric]

Following is a Benefit Schedule of the Policy.

The Pediatric Dental benefits described within the following pages apply to Insured Persons up to [and through] the age of 19. [Benefits will apply until the end of the [calendar year] [month] in which this limiting age is reached.]

The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **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.

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

Benefit	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Benefit	**Percentage of Covered Expenses the Plan Pays**	
	Participating Provider	**Non –Participating Provider**
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Waiting Periods for [myCigna Dental Pediatric]

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

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

What [myCigna Dental Pediatric] Pays For

Before this Participating Provider Policy pays for any benefits, You and Your Family Member(s) must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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 Insured 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 Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the 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 Benefit Provision;
- For Class I, II or III; the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Covered Services - [myCigna Dental Pediatric]

The following section lists covered dental services, if a service is not listed there is no coverage**:**

Class I - Preventive/Diagnostic Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0120	Periodic oral evaluation	1 per 6 consecutive month period
D0140	Limited oral evaluation - problem focused	1 per 6 consecutive month period
D0150	Comprehensive oral evaluation - new or established patient	1 per 6 consecutive month period
D0180	Comprehensive periodontal evaluation - new or established patient	1 per 6 consecutive month period
RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)		
Claim Code	**Description**	**Frequency**
D0210	Intraoral - complete series (including bitewings)	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0272	Bitewings - two films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0273	Bitewings - three films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0274	Bitewings - four films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0277	Vertical bitewings - 7 to 8 films	1 set per calendar year. For Children, 1 per 6 consecutive month period
D0330	Panoramic film	1 in any consecutive 60-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays
D0340	Cephalometric film	
D0350	Oral / facial photographic images	
TESTS AND EXAMINATIONS		
Claim Code	**Description**	**Frequency**
D0470	Diagnostic casts	
DENTAL PROPHYLAXIS		
Claim Code	**Description**	**Frequency**
D1110	Prophylaxis – adult	1 per 6 consecutive month period (includes periodontal maintenance).

D1120	Prophylaxis - child	1 per 6 consecutive month period (includes periodontal maintenance).
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
Claim Code	**Description**	**Frequency**
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	1 per 12 consecutive month period.
D1208	Topical application of fluoride (prophylaxis not included)	2 per 12 consecutive month period
OTHER PREVENTIVE SERVICES		
Claim Code	**Description**	**Frequency**
D1351	Sealant-per tooth	1 treatment per tooth per 36 consecutive month period. Unrestored permanent molar teeth only
D1352	Preventative resin restorations in a moderate to high caries risk patient -	1 treatment per tooth per 36 consecutive month period. Unrestored permanent teeth only.
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
Claim Code	**Description**	**Frequency**
D1515	Space maintainer - fixed - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1520	Space maintainer - removable - unilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1525	Space maintainer - removable - bilateral	Non-orthodontic treatment for prematurely removed or missing teeth.
D1550	Re-cementation of space maintainer	Non-orthodontic treatment for prematurely removed or missing teeth.
UNCLASSIFIED TREATMENT		
Claim Code	**Description**	**Frequency**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	

Class II - Basic Restorative Services

AMALGAM RESTORATIONS (INCLUDING POLISHING)		
Claim Code	**Description**	**Frequency**
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
Claim Code	**Description**	**Frequency**
D2330	Resin-based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2910	Recement inlay, onlay, or partial coverage restoration	
D2920	Recement crown	
D2930	Prefabricated stainless steel crown - primary tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2931	Prefabricated stainless steel crown - permanent tooth	Covered when the tooth cannot be restored by a filling and only allowed on primary teeth. 1 time in any consecutive 60-month period. Allowable for persons **under 15 years of age.**
D2940	Sedative filling	
D2951	Pin retention - per tooth, in addition to restoration	
PULPOTOMY		
Claim Code	**Description**	**Frequency**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. Payable on primary teeth only

ENDODONTIC THERAPY ON PRIMARY TEETH		
Claim Code	**Description**	**Frequency**
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 per tooth per lifetime. Allowable on primary incisor teeth for members **up to age 6** and for primary molars and cuspids for members **up to age 11.**
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	1 per 24 consecutive month period.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	1 per 24 consecutive month period.
OTHER PERIODONTAL SERVICES		
Claim Code	**Description**	**Frequency**
D4910	Periodontal maintenance	
ADJUSTMENTS TO DENTURES		
Claim Code	**Description**	**Frequency**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture - maxillary	
D5422	Adjust partial denture - mandibular	
REPAIRS TO COMPLETE DENTURES		
Claim Code	**Description**	**Frequency**
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
REPAIRS TO PARTIAL DENTURES		
Claim Code	**Description**	**Frequency**
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
DENTURE REBASE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5710	Rebase complete maxillary denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5720	Rebase maxillary partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.

D5721	Rebase mandibular partial denture	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
DENTURE RELINE PROCEDURES		
Claim Code	**Description**	**Frequency**
D5730	Reline complete maxillary denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5731	Reline complete mandibular denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5740	Reline maxillary partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5741	Reline mandibular partial denture (chairside)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5750	Reline complete maxillary denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5751	Reline complete mandibular denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5760	Reline maxillary partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
D5761	Reline mandibular partial denture (laboratory)	1 per 36 consecutive month period. Covered if more than 6 months after initial installation.
OTHER REMOVABLE PROSTHETIC SERVICES		
Claim Code	**Description**	**Frequency**
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
OTHER FIXED PARTIAL DENTURE SERVICES		
Claim Code	**Description**	**Frequency**
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	

OTHER SURGICAL PROCEDURES		
Claim Code	**Description**	**Frequency**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
Claim Code	**Description**	**Frequency**
D7310	Alveoloplasty in conjunction with extractions - per quadrant	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
EXCISION OF BONE TISSUE		
Claim Code	**Description**	**Frequency**
D7471	Removal of lateral exostosis (maxilla or mandible)	
SURGICAL INCISION		
Claim Code	**Description**	**Frequency**
D7510	Incision and drainage of abscess - intraoral soft tissue	
REPAIR OF TRAUMATIC WOUNDS		
Claim Code	**Description**	**Frequency**
D7910	Suture of recent small wounds up to 5 cm	
OTHER REPAIR PROCEDURES		
Claim Code	**Description**	**Frequency**
D7971	Excision of pericoronal gingiva	

Class III - Major Restorative Services

CLINICAL ORAL EVALUATIONS		
Claim Code	**Description**	**Frequency**
D0160	Detailed and extensive oral evaluation - problem focused, by report	
INLAY/ONLAY RESTORATIONS		
Claim Code	**Description**	**Frequency**
D2510	Inlay - metallic - one surface	**Alternate benefit to D2140** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2520	Inlay - metallic - two surfaces	**Alternate benefit to D2150** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2530	Inlay - metallic - three or more surfaces	**Alternate benefit to D2160** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2542	Onlay - metallic-two surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2543	Onlay - metallic-three surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2544	Onlay - metallic-four or more surfaces	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
CROWNS - SINGLE RESTORATIONS ONLY		
Claim Code	**Description**	**Frequency**
D2740	Crown - porcelain/ceramic substrate	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2751	Crown - porcelain fused to predominantly base metal	**Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.

D2752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D2751** **Molars: Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2781	Crown - 3/4 cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2783	Crown - 3/4 porcelain/ceramic	**Molars: Alternate Benefits to D2781** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2790	Crown - full cast high noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2791	Crown - full cast predominantly base metal	1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2792	Crown - full cast noble metal	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
D2794	Crown - titanium	**Alternate Benefits to D2791** 1 per tooth per 60 consecutive month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture.
OTHER RESTORATIVE SERVICES		
Claim Code	**Description**	**Frequency**
D2950	Core buildup, including any pins	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2954	Prefabricated post and core in addition to crown	1 per tooth per 60 consecutive month period. Covered only for endodontically treated teeth with total loss of tooth structure
D2980	Crown repair, by report	
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
Claim Code	**Description**	**Frequency**
D3310	Endodontic therapy, anterior (excluding final restoration)	
D3320	Endodontic therapy, bicuspid (excluding final restoration)	
D3330	Endodontic therapy, molar (excluding final restoration)	

ENDODONTIC RETREATMENT		
Claim Code	**Description**	**Frequency**
D3346	Retreatment of previous root canal therapy - anterior	
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
APEXIFICATION/RECALCIFICATION PROCEDURES		
Claim Code	**Description**	**Frequency**
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration	
APICOECTOMY/PERIRADICULAR SERVICES		
Claim Code	**Description**	**Frequency**
D3410	Apicoectomy/periradicular surgery - anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
OTHER ENDODONTIC PROCEDURES		
Claim Code	**Description**	**Frequency**
D3920	Hemisection (including any root removal), not including root canal therapy	
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
Claim Code	**Description**	**Frequency**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
D4249	Clinical crown lengthening - hard tissue	1 per 36 consecutive month period.
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	1 per 36 consecutive month period.
D4270	Pedicle soft tissue graft procedure	1 per 36 consecutive month period.

D4271	Free soft tissue graft procedure (including donor site surgery)	1 per 36 consecutive month period.
D4273	Subepithelial connective tissue graft procedures, per tooth	1 per 36 consecutive month period.
NON-SURGICAL PERIODONTAL SERVICE		
Claim Code	**Description**	**Frequency**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime per patient.
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5110	Complete denture - maxillary	1 **per arch** per 60 consecutive month period.
D5120	Complete denture - mandibular	1 **per arch** per 60 consecutive month period.
D5130	Immediate denture - maxillary	1 **per arch** per 60 consecutive month period.
D5140	Immediate denture - mandibular	1 **per arch** per 60 consecutive month period.
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)		
Claim Code	**Description**	**Frequency**
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 **per arch** per 60 consecutive month period, unless there is a necessary extraction of an additional functioning natural tooth.
IMPLANT SUPPORTED PROSTHETICS		
Claim Code	**Description**	**Frequency**
D6010	Surgical placement of implant body: endosteal implant	1 per 60 consecutive month period,
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	1 per 60 consecutive month period,
D6040	Surgical placement: eposteal implant	1 per 60 consecutive month period,
D6050	Surgical placement: transosteal implant	1 per 60 consecutive month period,
D6053	Implant/abutment supported removable denture for completely edentulous arch	
D6054	Implant/abutment supported removable denture for partially edentulous arch	
D6055	Dental implant supported connecting bar	1 per 60 consecutive month period,

D6056	Prefabricated abutment – includes placement	1 per 60 consecutive month period,
D6058	Abutment supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6061	Abutment supported porcelain fused to metal crown (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6062	Abutment supported cast metal crown (high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6063	Abutment supported cast metal crown (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6064	abutment supported cast metal crown (noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6065	Implant supported porcelain/ceramic crown	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6060** **Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	**Molars: Alternate Benefits to D6063** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6068	Abutment supported retainer for porcelain/ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6074	Abutment supported retainer for cast metal FPD (noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6075	Implant supported retainer for ceramic FPD	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	**Anterior/Bicuspids: Alternate Benefit to D6070** **Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	**Molars: Alternate Benefits to D6073** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6078	Implant/abutment supported fixed denture for completely edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6079	Implant/abutment supported fixed denture for partially edentulous arch	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
OTHER IMPLANT SERVICES		
Claim Code	**Description**	**Frequency**
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	1 per 60 consecutive month period,
D6090	Repair implant supported prosthesis, by report	1 per 60 consecutive month period,
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment support prosthesis, per attachment	1 per 60 consecutive month period,
D6095	Repair implant abutment, by report	1 per 60 consecutive month period,

D6100	Implant removal, by report	1 per 60 consecutive month period,
D6190	Radiographic/surgical implant index, by report	1 per 60 consecutive month period,
PROSTHODONTICS - FIXED		
Claim Code	**Description**	**Frequency**
D6210	Pontic - cast high noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6211	Pontic - cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6212	Pontic - cast noble metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6214	Pontic – titanium	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6240	Pontic - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6241	Pontic - porcelain fused to predominantly base metal	**Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6242	Pontic - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6245	Pontic - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6250	Pontic - resin with high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6241** **Molars: Alternate Benefits to D6211** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
Claim Code	**Description**	**Frequency**
D6519	Inlay/onlay – porcelain/ceramic	1 per tooth per 60 consecutive month period.
D6520	Inlay – metallic – two surfaces	1 per tooth per 60 consecutive month period.
D6530	Inlay – metallic – three or more surfaces	1 per tooth per 60 consecutive month period.
D6543	Onlay – metallic – three surfaces	1 per tooth per 60 consecutive month period.
D6544	Onlay – metallic – four or more surfaces	1 per tooth per 60 consecutive month period.

D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	**Alternate Benefits to D6545** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
Claim Code	**Description**	**Frequency**
D6740	Crown - porcelain/ceramic	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6750	Crown - porcelain fused to high noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6751	Crown - porcelain fused to predominantly base metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6752	Crown - porcelain fused to noble metal	**Anterior/Bicuspids: Alternate Benefit to D6751** **Molars: Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6780	Crown - 3/4 cast high noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6781	Crown - 3/4 cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6782	Crown - 3/4 cast noble metal	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6783	Crown - 3/4 porcelain/ceramic	**Alternate Benefits to D6781** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6790	Crown - full cast high noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6791	Crown - full cast predominantly base metal	1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
D6792	Crown - full cast noble metal	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired

D6794	Crown - titanium	**Alternate Benefits to D6791** 1 per 60 consecutive months if the previous prosthesis is not serviceable and cannot be repaired
ANESTHESIA		
Claim Code	**Description**	**Frequency**
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
MISCELLANEOUS SERVICES		
Claim Code	**Description**	**Frequency**
D9940	Occlusal guard, by report	1 per 12 consecutive month period. Allowable for persons **13 to 19 years of age.**

Class IV - Medically Necessary Orthodontia

LIMITED ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
INTERCEPTIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
COMPREHENSIVE ORTHODONTIC TREATMENT		
Claim Code	**Description**	**Frequency**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
Claim Code	**Description**	**Frequency**
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
OTHER ORTHODONTIC SERVICES		
Claim Code	**Description**	**Frequency**
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Exclusions and Limitations: What Is Not Covered By [myCigna Dental Pediatric]

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of “Covered Dental Expenses”.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant. Except in cases where it is Dentally Necessary
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- orthodontic treatment. Except in cases where it is Dentally Necessary
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient’s dental condition for a period of at least 3 years, as determined by Cigna.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment
- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services that are deemed to be medical services;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

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

Cigna Health and Life Insurance Company
Accident and Health Rate Filing
Individual Dental
Effective: 01/01/2014
Exhibit I - Geographic Classification

Code	Area Name *
1	Chattanooga
2	Jackson
3	Knoxville
4	Memphis
5	Nashville
6	Nationwide **

**Area Names are Cigna-defined. A detailed zip code to area mapping is available upon request.*

***All members who change residence outside of the state of Tennessee and wish to continue their current Tennessee policy will be subject to the Nationwide rates.*

Cigna Health and Life Insurance Company
Accident and Health Rate Filing
Individual Dental
Effective: 01/01/2014
Exhibit II - Premium Rates*

		Children 0-20	Adult Rate 21-24	Adult Rate 25-59	Adult Rate 60+
Area 1	Chattanooga	$26	$20.00	$26.00	$34.00
Area 2	Jackson	$26	$19.00	$25.00	$33.00
Area 3	Knoxville	$26	$19.00	$25.00	$34.00
Area 4	Memphis	$26	$19.00	$25.00	$34.00
Area 5	Nashville	$33	$25.00	$31.00	$40.00
Area 6	Nationwide	$76	$44.00	$52.00	$63.00

** Premium rates reflect per member per month rate.*

Cigna Health and Life Insurance Company (CHLIC)
Accident and Health Rate Filing
Actuarial Memorandum
Individual Dental

Scope and Purpose

The purpose of this memorandum is to file rates associated with the policy forms shown above. Please note that this is the initial rate filing for these forms. The memorandum includes a description of the product features underlying the product, as well as information related to the development of the premium rates. A Rate Table containing the detailed premium rates has been included with this filing. The rates contained in this filing are proposed for new contracts, on and after the effective date of January 1, 2014.

Benefit Description

1. myCigna Dental Pediatric Plan

For Children (Age 0-19)	**Participating Provider**	**Non –Participating Provider**
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Reimbursement Levels	Based on reduced contracted fees	Maximum Allowable Charge
Benefit	**Percentage of Covered Expenses the Plan Pays**	
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

2. myCigna Dental Family + Pediatric Plan

For Children (Age 0-19)	Participating Provider	Non –Participating Provider
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	$700 per person	
	$1400 per family	
Reimbursement Levels	Based on reduced contracted fees	Maximum Allowable Charge
Benefit	**Percentage of Covered Expenses the Plan Pays**	
Class I - Preventive/Diagnostic Services	100% after Deductible	100% after Deductible
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

For Adults (Age >19)	Participating Provider	Non –Participating Provider

Calendar Year Maximum: Class I, II, III & IV	$1,000	
Calendar Year Deductible: Class I, II, III & IV	$50 per person	
	$150 per family	
Reimbursement Levels	Based on reduced contracted fees	Maximum Allowable Charge
Benefit	**Percentage of Covered Expenses the Plan Pays**	
Class I - Preventive/Diagnostic Services	100% after Deductible	
Class II - Basic Restorative Services	50% after Deductible	
	6 Months Waiting Period	
Class III - Major Restorative Services	80% after Deductible	
	12 Months Waiting Period	
	No coverage for replacement of teeth missing prior to the effective date.	
Class IV – Medically Necessary Orthodontia	Plan pays 0%, network discounts apply	Not covered

Please note: The myCigna Dental Family + Pediatric plan will only be available on-Exchange.

Pricing Methodology

There is limited experience available for the individual dental product as this is a fairly new product. As a result premium rates were developed based on our existing group dental products along with publicly available premium rate information for various individual dental plans. From this information, an estimate of claims cost was developed and adjusted for differences in benefits and targeted population. Financial analysis was conducted to project future administrative expenses and other retention components. A trend factor and geographical differences were then applied based on large group methodology. Rates were then compiled to ensure an appropriate target loss ratio.

Commissions, Expenses, and Profit

We estimate total retention to be approximately 36%. Total retention is comprised of administrative expenses, premium tax, commissions and a risk charge.

Administrative Expenses	13%
Commissions	10%
Profit	6%
Taxes*	4%
Exchange Fees	3%
Total	36%

** includes state premium tax and PPACA health insurance industry fee assessment*

Premium Rates

Premium rates will vary based on plan design, age, and geographic area. The geographic classification is as follows:

State	Code	Rating Area
TN	1	TNChattanooga
TN	2	TNJackson
TN	3	TNKnoxville
TN	4	TNMemphis
TN	5	TNNashville

A 15% dependent discount will be applied to the premium rate of any dependents of the primary insured. The policy premium rate will be equal to the sum of the primary insured rate and the discounted dependent rates.

The schedules of proposed individual rates are attached to this memorandum as Rate Table.

Anticipated Lifetime Loss Ratio

The anticipated lifetime loss ratio for the individual dental plan is expected to be 64%

Renewability Clause

The policy is guaranteed renewable.

Premium Modalization Rules

The pricing methodology outlined in the CHLIC Accident and Health manual produces monthly premiums. Therefore, modalization factors are expressed as a function of these monthly rates as follows:

Modalization Factors

Weekly	0.231
Bi-Weekly	0.462
Monthly	1
Quarterly	2.989
Semi-Annual	5.945
Annual	11.761

Trend Assumptions

The expected annualized trend is 5.5%.
This factor reflects underlying differences in network costs and discounts, inflation/severity, cost-shifting, utilization, and cost share leveraging.

Proposed Effective Date

The rates contained in this filing are proposed for new contracts, on and after the effective date of January 1, 2014.

Actuarial Certification

I, Dipti Patel, FSA, MAAA, certify that to the best of my knowledge and judgment, these rates on average meet an Actuarial Value of 71.8%. This rate filing is in compliance with the applicable laws and regulations of this state and that the premiums charged are reasonable in relation to the benefits provided.

Dipti Patel

_____

Dipti Patel, FSA, MAAA
Actuarial Manager

_____6/13/2013_____
Date