City of Fort Lauderdale • Procurement Services Division
100 N. Andrews Avenue, 619 • Fort Lauderdale, Florida 33301
954-828-5933 Fax 954-828-5576
www.fortlauderdale.gov/purchasing

ORIGINAL BID

BEST AND FINAL - COST PROPOSAL PAGE

Proposer Name: Cigna

Proposer agrees to supply the products and services at the prices bid below in accordance with the terms, conditions and specifications contained in this RFP.

	Fully-Insured Cigna **P4IOX** DHMO for Management & Teamsters	Fully-Insured DPPO for Management & Teamsters	Fully-Insured DPPO for Firefighters
Employee Only	$16.43	$51.59	$30.26
Employee + Spouse	$28.76	$96.67	$55.32
Employee + Child or Children	$34.52	$99.38	$49.05
Employee + Family	$48.38	$125.26	$86.66

The premiums listed above are guaranteed for

1 year X 2 years X 3 years X 4 years Rate Cap 5 years Rate Cap

Rate cap and details for any renewal not guaranteed: In addition to the 3 year rates above, Cigna is providing a rate cap that will not exceed a +7% increase on the 4th and 5th year of the contract.

Submitted by:

Scott E. Evelyn
Name (printed)

Signature

June 1, 2017
Date

Vice President, CHLIC
President Cigna South Florida
Title

(Cigna)
RFP 575-11928, Group DHMO and DPPO Dental Plan Benefits
Best and Final Offer

City of Fort Lauderdale • Procurement Services Division
100 N. Andrews Avenue, 619 • Fort Lauderdale, Florida 33301
954-828-5933 Fax 954-828-5576
www.fortlauderdale.gov/purchasing

QUESTIONNAIRE

1. As a Best and Final offer, is Cigna willing to decrease the proposed DHMO and DPPO rates?
   (If so, please complete the attached Cost Proposal Page.)

   Yes, Cigna is willing to modify the proposed DHMO and DPPO rates. Please see the attached Cost Proposal Page.

2. Is Cigna willing to provide rate caps for the 4th and 5th year of the contract? If so, please specify.

   Yes, Cigna is willing to provide rate caps for the 4th and 5th year will not exceed a certain amount. Please see the attached Cost Proposal Page.

3. Can the benefit for routine cleanings be increased to 4 times per year on the proposed DPPO plan for non-firefighter employees?

   Yes, Cigna will increase the DPPO plan for non-firefighter employees. Please see the attached revised DPPO Summary showing 4 cleanings per calendar year.

4. In addition to providers in the Miami-Fort Lauderdale-Pompano Beach area noted in your proposal, is Cigna willing to add Martin County providers to the recruitment performance guarantee?
   Yes, Cigna can include Martin County providers in the recruitment performance guarantee. Please see the attached revised recruitment performance guarantee.

(Cigna)
RFP 575-11928, Group DHMO and DPPO Dental Plan Benefits
Best and Final Offer

City of Fort Lauderdale

Guaranteed Cost Funding
Non-Participating
January 01, 2018 - December 31, 2018

Tier	Expected Lives	Current Rates	36 Month Rates*
Dental PPO - City Plan			
Employee Only	396	$52.64	$51.59
Employee + Spouse	210	$98.64	$96.67
Employee + Child(ren)	95	$101.40	$99.38
Employee + Family	273	$127.81	$125.26
Annual Cost	974	$1,033,020	$1,012,396
Percent Change (Quoted vs Current)			**-2.00%**

**The above quoted rates do not include any commissions.*
**The above quoted rates include 3.5% Health Insurance Assessment fees (PPACA).*

Tier	Expected Lives	Current Rates	36 Month Rates*
Dental PPO - Firefighters			
Employee Only	131	$30.88	$30.26
Employee + Spouse	49	$56.45	$55.32
Employee + Child(ren)	49	$50.05	$49.05
Employee + Family	143	$88.42	$86.66
Annual Cost	372	$262,894	$257,642
Percent Change (Quoted vs Current)			**-2.00%**

**The above quoted rates do not include any commissions.*
**The above quoted rates include 3.5% Health Insurance Assessment fees (PPACA).*

Tier	Expected Lives	Current Rates	36 Month Rates*
Dental HMO [P4IOX]			
Employee Only	261	$16.77	$16.43
Employee + Spouse	87	$29.35	$28.76
Employee + Child(ren)	72	$35.22	$34.52
Employee + Family	87	$49.37	$48.38
Annual Cost	507	$165,137	$161,835
Percent Change (Quoted vs Current)			**-2.00%**

**The above quoted rates do not include any commissions.*
**The above quoted rates include 3.5% Health Insurance Assessment fees (PPACA).*

The above quoted rates include a rate cap which will not exceed 7.0% for the 1/1/2021 renewal increase.
The above quoted rates include a rate cap which will not exceed 7.0% for the 1/1/2022 renewal increase.

Cigna

Cigna Healthcare Financial Exhibit for:

City of Fort Lauderdale (City Population)

Effective Date: January 01, 2018

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Cigna DPPO Advantage	Out-of-Network
Calendar Year Maximum		
(Class I, II, III, IX Expenses)	$1500, Class I Applies	$1500, Class I Applies
Calendar Year Deductible		
Per Individual	$0	$100
Per Family	$0	$300
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Non-Routine X-rays Emergency Care to Relieve Pain	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Space Maintainers (limited to non-orthodontic treatment) Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Brush Biopsy	100%, No Deductible	60%, After Deductible
Class III Expenses - Major Restorative Care		
Relines, Rebases, and Adjustments Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	60%, No Deductible	60%, After Deductible
Class IV Expenses - Orthodontia		
Coverage for Eligible Children and Adults Lifetime Maximum	60%, No Ortho Deductible $2500	60%, No Ortho Deductible $2500
Class IX Expenses - Implants		
Plan Calendar Year Max	60%, No Deductible $1500	60%, After Deductible $1500
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on Maximum Allowable Charge (for location of service rendered).
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

P0002 (NS001) Network. Prepared by Underwriting. 04/04/2017 01:42 PM

Cigna Healthcare Financial Exhibit for:

City of Fort Lauderdale (City Population)

Effective Date: January 01, 2018

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Four per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns	Replacement every 5 years
Prosthesis over Implants	1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Orthodontia	Not covered
Missing Tooth Provision	Teeth missing prior to coverage under the Cigna Dental plan are not covered
Late Entrant Limit	50% coverage on Class III and IV for a specified time period
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons;
* Replacement of a lost or stolen appliance;
* Replacement of a bridge or denture within five years following the date of its original installation;
* Replacement of a bridge or denture which can be made useable according to accepted dental standards;
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion;
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
* Bite registrations; precision or semi-precision attachments; splinting;
* Instruction for plaque control, oral hygiene and diet;
* Dental services that do not meet common dental standards;
* Services that are deemed to be medical services;
* Services and supplies received from a hospital;
* Charges which the person is not legally required to pay;
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
* Experimental or investigational procedures and treatments;
* Any injury resulting from, or in the course of, any employment for wage or profit;
* Any sickness covered under any workers' compensation or similar law;
* Charges in excess of the reasonable and customary allowances;
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; 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;
* 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 HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

City of Fort Lauderdale
DENTAL NETWORK RECRUITMENT PERFORMANCE GUARANTEE

Network Utilized: DPPO Advantage, DHMO

Cigna will commit to $1,346 in Guarantees toward the implementation of the dental network recruitment plan outlined below. This recruitment effort has already begun and will be fully complete by 06/2018. The specific guarantee consists of the following:

1) Cigna will put $673 at risk to contact all dentists utilized by your employees that are not currently contracted with Cigna by 08/2017.*

4) Cigna will put $673 at risk to add a minimum of 20 DHMO dental offices in the Miami-Fort Lauderdale-Pompano Beach, FL CBSA and or Martin County by 06/2018.*

Cigna Dental has assigned Dawn Applewhite as the recruitment project manager to implement the plan, administrate specific provider recruitment requests, and provide consultation regarding future network expansion needs. Under the direction of the project manager, a team of highly-experienced expansion specialists will be assigned to this recruitment. The members of our network expansion team are skilled in negotiation techniques and have the authority to negotiate the best possible discounts, at the office level, to ensure provider participation.

Guarantee Assumptions:

The Dental Network Recruitment Guarantee is contingent upon the ability to use City of Fort Lauderdale name verbally and in writing for recruitment purposes and notification of sale by 06/01/2017. If notification date is later than originally stated the PG due dates will be adjusted accordingly.

The baseline recruitment number could change due to the validity of the data that may be identified.

**** This contract commitment is contingent upon receipt of a complete disruption report that includes TIN, dentist name, address, city, state and zip. Upon receipt of a full disruption this commitment could potentially change.***

This guarantee is based upon recruitment of a specific number of Dentists:
The contracts that will be eligible in order to meet the performance guarantee are:

Exact match to the disruption record
Associate dentist(s) or new owner dentist(s) in the same office of location listed
Associate dentist(s) or new owner dentist(s) in additional locations will be counted
Location listed is no longer valid and new location for same dentist is contracted (dentist moved)
Every listed location for each individual dentist will count separately

Any pay-out of the Performance Guarantee will be prorated per access point.
Cigna will provide progress reporting on a quarterly basis with final reconciliation reported out by third quarter of 2018.

Any matches within the criteria will be validated in the recruitment process and any non-valid matches will be included in the recruitment initiative.

Upon hitting the goal of 20 dentist access points, the Performance Guarantee will be considered complete and goals met.
5/31/2017

City of Fort Lauderdale

RFP #575-11928

Table of Contents

Cigna Benefit Solutions for:

City of Fort Lauderdale

RFP #575-11928

COPY

April, 2017

A Proposal for:

Dental Coverages

Provided by:

Listed below are the legal names of the companies submitting this response to the City of Fort Lauderdale Request for Proposal. In this proposal, the name "Cigna" and other service marks, or division/trade names, may be used to refer to these companies and/or the products and services offered by them or their affiliates. All affiliated Cigna companies and operating subsidiaries are indirectly wholly owned subsidiaries of Cigna Corporation, a publicly traded corporation.
Cigna Health and Life Insurance Company (CHLIC)
Cigna Dental Health of California, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Florida, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Texas, Inc.

Together, all the way.®

1571 Sawgrass Corporate Parkway
Sunrise, Florida 33323
Tel 954.514.6650
eMail: John.Coolican@cigna.com

April 10th, 2017

AnnDebra Diaz, Senior Procurement Specialist
City of Fort Lauderdale
Procurement Services Division
100 N. Andrews Avenue, #619
Fort Lauderdale, Florida 33301

RE: #575-11928 - Group DHMO and DPPO Dental Plan Benefits

Dear Ms. Diaz:

On behalf of Cigna, thank you for the opportunity to participate in the competitive bid process for City of Fort Lauderdale's Group Dental Plans.

At Cigna, we put our dental experience to work for you. With more than 50 years of proven dental leadership and stability, we understand just how important it is to provide dental solutions that satisfy today's changing needs. We are confident in our ability to service the continued needs of the City of Fort Lauderdale as we have been offering health plans to America's local governments and school districts for more than half a century. In the State of Florida, we provide benefit programs to a total of 63 government and Education clients.

We are externally focused, tailoring solutions to meet our customers' needs. Our proposal is built on these pillars:

- *Flexible, Innovative Products* – Cigna is proposing DHMO and DPPO options which closely match your current plan designs.
- *Broad, Comprehensive Networks* - When you choose Cigna, you gain access to some of the largest local and national dental provider networks. We have the nation's largest true DPPO network. Because of our breadth and nationwide scope, we are able to offer some of the industry's most competitive discounts.
- *Commitment to Service Excellence* - Our Customer Service call centers are open 24 hours a day, 7 days a week**. Only Cigna offers 24-hour Customer Service - Saturdays, Sundays and holidays!**

Below, we have listed our proposal highlights and additional commitments:

Cigna Dental Oral Health Integration Program®

Our dental proposal includes the **Cigna Dental Oral Health Integration Program®**. This program enhances dental benefits for 7 medical "at risk" populations. We reimburse 100% of the out of pocket costs for a certain set of dental procedures that can improve overall health. This is included in Cigna's DHMO and DPPO products.

Cost/Financial Guarantees

- Cigna is proposing a multi-year fully insured products
- Service and Implementation Performance Guarantees
- DPPO and DHMO rates are guaranteed for 36 months
- Network Recruitment Guarantees
- $40,000 Annual Oral Health Wellness Fund

Service & Dental Wellness Commitments

- Cigna will offer *true* 24/7/365 live customer service at 1.800.Cigna24
- Cigna will provide benefit booklets and dental directory links for posting to your intranet/internet sites.

- Innovative Capabilities Reporting which Includes an Oral Health Dashboard

- Cigna will provide our industry leading customer portal, myCigna.com, with online capabilities such as claims and provider search, ID card printing, treatment cost estimator and access to Oral Health Assessment tools. These tools will also be accessible via the MyCigna Mobile application.
- Cigna is the first health services company to partner with Brighter by seamlessly connecting patients and providers with Cigna to transform the member experience and improve outcomes. Features include: expanded cost and quality tools, detailed provider profiles which highlight background/credentials, reviews/ratings from verified patients, online appointment scheduling 24/7 and automated re-care reminders to keep patients on track. When you engage members and empower providers, you get better outcomes, lower costs and happy customers. Brighter is automatically included on all Cigna DPPO offerings.
- Exceptional Cigna account team to assist in a smooth implementation and ongoing service excellence on dental.
- Onsite Oral Health Wellness Services can be incorporated into the current wellness program

The primary contacts for the purpose of this RFP are as follows:

John Coolican
Client Manager
1571 Sawgrass Corporate Parkway, Suite 300
Sunrise, Florida 33323
eMail: john.coolican@cigna.com
Tel 954.514.6650

Yesenia Sanchez
Vice President of Government and Education
1571 Sawgrass Corporate Parkway, Suite 300
Sunrise, Florida 33323
eMail: Yesenia.sanchez@cigna.com
Tel 954.514.6887

Additionally, please see below a list of the individuals who will be directly involved in working with The City. Additional details provided in organizational chart included in this section

Scott E. Evelyn
Vice President, CHLIC
President, Cigna South Florida
Scott.Evelyn@Cigna.com

Yesenia Sanchez
Regional Vice President
Government & Education
Yesenia.Sanchez@Cigna.com

Pam Serrani
Regional Vice President
Sales – Existing Business
Pamela.Serrani@Cigna.com

John Coolican
Senior Client Manager
John.Coolican@cigna.com

Lisa McDonald
Dental Sales Manager
Lisa.McDonald@Cigna.com

Malena Mayea
Client Engagement Manager
Malena.Mayea@Cigna.com

Melissa Menendez
Client Service Executive
Melissa.Menendez@Cigna.com

Kerri Holden
Onsite Wellness Coordinator
for the City of Fort Lauderdale

Diane Buchman
Implementation Manager
Diane.Buchman@Cigna.com

We are confident in the strength of our proposal and our ability to meet the dental needs of The City of Fort Lauderdale. We would value the opportunity to become your dental service provider. We look forward to meeting with you to further review what Cigna has offered.

Sincerely,

Scott E. Evelyn

4.2.2 Executive Summary

Each Proposer must submit an executive summary that identifies the business entity, its background, main office(s), and office location that will service this contract. Identify the officers, principals, supervisory staff and key individuals who will be directly involved with the work and their office locations. The executive summary should also summarize the key elements of the proposal.

Business Entities:

Listed below are the legal names of the companies submitting this response to the City of Fort Lauderdale Request for Proposal.:

Cigna Health and Life Insurance Company
Cigna Dental Health of California, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Florida, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Texas, Inc.

Background:

Cigna Health and Life Insurance Company (CHLIC) is a corporation, originally incorporated May 2, 1963, as Orange State Life Insurance Company. After several transactions, it was acquired by Cigna Corporation on April 1, 2008. The company was renamed to CHLIC on March 5, 2010. It is wholly owned by CGLIC a publicly traded corporation. CHLIC is licensed to transact the business of insurance by the insurance department of each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, and is subject to regulation of those jurisdictions within the scope of applicable law.

DHMO

The Cigna Dental Care® plan is underwritten by Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), or the subsidiaries of Cigna Dental Health, Inc., depending upon state laws and licensing requirements. We have specialized in a dental management program since 1974 when Florida granted Dental Health, Inc. a Certificate of Authority to provide managed dental care. In 1984, Dental Health, Inc. became a subsidiary of Cigna Corporation, marking the first entry of a major national insurance organization into the managed dental care field.

Cigna Dental Health, Inc. is an indirect, wholly owned subsidiary of Cigna Corporation; its wholly owned subsidiaries, have been licensed in certain states at varying times as prepaid dental plan organizations, prepaid limited health services organization, dental HMOs, etc., (depending upon state laws) to offer the Cigna Dental Care plan coverage. Cigna Dental Health of Florida, Inc. was incorporated on November 29, 1973 and first received its license in Florida (under a prior name, Dental Health, Inc.) on March 11, 1974.

DPPO
The Cigna DPPO plans are underwritten or administered by Connecticut General Life Insurance Company (CGLIC) or Cigna Health and Life Insurance Company (CHLIC). Certain administration and network management services for the DPPO plan coverage are performed on behalf of CGLIC and CHLIC by their affiliate, Cigna Dental Health, Inc. The DPPO plan was introduced in July 1996, and licensed at varying times in states throughout the U.S.
CGLIC, CHLIC, Cigna Dental Health, Inc., and its subsidiaries are operating subsidiaries of Cigna Corporation, our parent company. Plans and services referenced above are provided exclusively by such operating subsidiaries and not by Cigna Corporation.

Main Offices:

Cigna Health and Life Insurance Company
900 Cottage Grove Road, Bloomfield, CT 06002
Phone Number - 860.226.6000
www.cigna.com

Cigna Dental Health of California, Inc.
400 N. Brand Blvd, Glendale, CA 91203
Phone: 818.546.5000

Cigna Dental Health of Colorado, Inc.; Cigna Dental Health of Florida, Inc.; Cigna Dental Health of New Jersey, Inc.; and Cigna Dental Health of Ohio, Inc.:

1571 Sawgrass Corporate Parkway Suite 140 Sunrise, FL 33323
Phone: 954.514.6600

Cigna Dental Health of Texas, Inc.
1640 Dallas Parkway, Plano, TX 75093
Phone: 215.761.1000

Contact Person/Office Location:
Senior Client Manager, John Coolican
1571 Sawgrass Corporate Parkway , Suite 140, Sunrise, FL 33323
Phone: 954.514-6650
Fax: +1 877.301.5413
Email: John.Coolican@cigna.com

We have provided an organizational chart detailing the key personnel involved to provide the requested services and their office locations directly following this document.

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Account Team:
City of Fort Lauderdale

Executive Management Team

Scott E. Evelyn
Vice President, CHLIC
President, Cigna South Florida
1571 Sawgrass Corporate Parkway
Sunrise , FL 33323
Scott.Evelyn@Cigna.com

Yesenia Sanchez
Regional Vice President
Government & Education
1571 Sawgrass Corporate Parkway
Sunrise , FL 33323
Yesenia.Sanchez@Cigna.com

Pam Serrani
Regional Vice President
Sales – Existing Business
1571 Sawgrass Corporate Parkway
Sunrise , FL 33323
Pamela.Serrani@Cigna.com

Core Account Management Team

John Coolican
Senior Client Manager
1571 Sawgrass Corporate Parkway
Sunrise , FL 33323
John.Coolican@cigna.com

Lisa McDonald
Dental Sales Manager
1571 Sawgrass Corporate Parkway
Sunrise , FL 33323
Lisa.McDonald@Cigna.com

Core Account Service Team

Kerri Holden
Onsite Wellness Coordinator
for the City of Fort Lauderdale
1571 Sawgrass Corporate Parkway
Sunrise , FL 33323
Kerri.Holden@Cigna.com

Diane Buchman
Implementation Manager
1571 Sawgrass Corporate Parkway
Sunrise , FL 33323
Diane.Buchman@Cigna.com

Core Account Service Team

Malena Mayea
Client Engagement Manager
1571 Sawgrass Corporate Parkway
Sunrise , FL 33323
Malena.Mayea@Cigna.com

Melissa Menendez
Client Service Executive
1571 Sawgrass Corporate Parkway
Sunrise , FL 33323
Melissa.Menendez@Cigna.com

SECTION IV – SUBMITTAL REQUIREMENTS

4.2.3 Experience and Qualifications

Indicate the firm's number of years of experience in providing the professional services as it relates the work contemplated. Provide details of past projects for agencies of similar size and scope. Indicate business structure, IE: Corp., Partnership, LLC. Firm should be registered as a legal entity in the State of Florida; Minority or Woman owned Business (if applicable); Company address, phone number, fax number, E-Mail address, web site, contact person(s), etc. Relative size of the firm, including management, technical and support staff; licenses and any other pertinent information shall be submitted.

Cigna Health and Life Insurance Company (CHLIC) is a corporation, originally incorporated May 2, 1963, as Orange State Life Insurance Company. After several transactions, it was acquired by Cigna Corporation on April 1, 2008. The company was renamed to CHLIC on March 5, 2010. It is wholly owned by CGLIC a publicly traded corporation. CHLIC is licensed to transact the business of insurance by the insurance department of each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, and is subject to regulation of those jurisdictions within the scope of applicable law.

DHMO

The Cigna Dental Care® plan is underwritten by Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), or the subsidiaries of Cigna Dental Health, Inc., depending upon state laws and licensing requirements. We have specialized in a dental management program since 1974 when Florida granted Dental Health, Inc. a Certificate of Authority to provide managed dental care. In 1984, Dental Health, Inc. became a subsidiary of Cigna Corporation, marking the first entry of a major national insurance organization into the managed dental care field.

Cigna Dental Health, Inc. is an indirect, wholly owned subsidiary of Cigna Corporation; its wholly owned subsidiaries, have been licensed in certain states at varying times as prepaid dental plan organizations, prepaid limited health services organization, dental HMOs, etc., (depending upon state laws) to offer the Cigna Dental Care plan coverage. Cigna Dental Health of Florida, Inc. was incorporated on November 29, 1973 and first received its license in Florida (under a prior name, Dental Health, Inc.) on March 11, 1974.

DPPO

The Cigna DPPO plans are underwritten or administered by Connecticut General Life Insurance Company (CGLIC) or Cigna Health and Life Insurance Company (CHLIC). Certain administration and network management services for the DPPO plan coverage are performed on behalf of CGLIC and CHLIC by their affiliate, Cigna Dental Health, Inc. The DPPO plan was introduced in July 1996, and licensed at varying times in states throughout the U.S.

CGLIC, CHLIC, Cigna Dental Health, Inc., and its subsidiaries are operating subsidiaries of Cigna Corporation, our parent company. Plans and services referenced above are provided exclusively by such operating subsidiaries and not by Cigna Corporation.

We have been licensed in the state of Florida to transact business since February 17, 1964.

Cigna has over 48 years of experience with government clients and currently serves over 800 government clients resulting in 2.7 million government customers[12]

12. Cigna Book of Business, September 2016.

Contact Information

Cigna Health and Life Insurance Company
900 Cottage Grove Road, Bloomfield, CT 06002
Phone Number - 860.226.6000
www.cigna.com

Cigna Dental Health of California, Inc.
400 N. Brand Blvd, Glendale, CA 91203
Phone: 818.546.5000

Cigna Dental Health of Colorado, Inc.; Cigna Dental Health of Florida, Inc.; Cigna Dental Health of New Jersey, Inc.; and Cigna Dental Health of Ohio, Inc.:

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Cigna Dental Health of Texas, Inc.
1640 Dallas Parkway, Plano, TX 75093
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Contact Person:
Senior Client Manager, John Coolican
1571 Sawgrass Corporate Parkway , Suite 140, Sunrise, FL 33323
Phone: 954.514-6650
Fax: +1 877.301.5413
Email: John.Coolican@cigna.com

Organizational Structure
Our organizational structure ensures we meet the needs of every client while maximizing operational efficiency. Cigna has dedicated senior leadership in the following:

- U.S. Commercial Markets and Global Health Care Operations
- Global Corporate Team

David Cordani led Cigna's transformation from a traditional health insurer to a leading global health service company with a focus on helping people improve their health, well-being, and sense of security.
Since becoming president and CEO in 2009, Cordani successfully galvanized Cigna's 42,000-plus employees in more than 30 countries around a global product and service repositioning that has been guided by the company's differentiating "Go Deep, Go Global, Go Individual" strategy.

SECTION IV – SUBMITTAL REQUIREMENTS

4.2.4 Approach to Scope of Work

Provide in concise narrative form, your understanding of the City's needs, goals and objectives as they relate to the project, and your overall approach to accomplishing the project. Give an overview on your proposed vision, ideas and methodology. Describe your proposed approach to the project. As part of the project approach, the proposer shall propose a scheduling methodology (time line) for effectively managing and executing the work in the optimum time. Also provide information on your firm's current workload and how this project will fit into your workload. Describe available facilities, technological capabilities and other available resources you offer for the project.

Cigna is pleased that we currently provide medical, pharmacy, behavioral, and choice fund coverages to the City. The inclusion of dental coverages will be handled by your current account team, allowing for seamless, uninterrupted support. This includes the City's onsite representative and client engagement manager. Rather than viewing dental, medical, vision, pharmacy, behavioral, or disability covered services as stand-alone services with distinct value and costs, we recognize the intrinsic connection across the health and productivity spectrum as well as between physical and psychological health. Because we understand that physical health and mental health are interdependent, we can identify risks and potential risks to health earlier and more accurately. It also means that our health advocacy programs can more effectively engage members in their health, helping to drive behavior changes and achieve better outcomes. Integration helps improve overall employee health and helps clients save money.

Our integration solution provides the following benefits:

- plan integration, which allows us to deliver programs that provide cost advantages to clients and better health outcomes for their employees
- tightly integrated systems that provide total coverage information (medical, pharmacy, behavioral, disability, and dental) on employees, driving the innovation that aligns consumerism, health management, and service operations with our focus on health
- sophisticated data management tools that let us search our databases to identify opportunities to improve employee health and overall wellness
- Oral Health Wellness Campaign to support current overall health and wellness initiatives. Cigna's Client Engagement Manager and Cigna Onsite representative will develop an Oral Health Wellness Campaign to increase the importance of good oral health. The campaign can include challenges like Dental Jeopardy where the winners can be entered to win a raffle of an Oral B toothbrush that links to an App on the phone and will tell you how often you've brushed and which teeth you may have missed.

Dental and Medical Integration

We developed the Cigna Dental Oral Health Integration Program in 2006 to encourage members to seek appropriate treatment for gum disease as part of their overall treatment plan. This made us the first carrier in the dental insurance industry to offer enhanced coverage for members who have cardiovascular disease, diabetes or who are pregnant. Research shows an association between gum disease and other health

conditions such as diabetes, heart disease, and stroke. This coverage includes 100 percent payment of coinsurance or copays for certain dental procedures associated with treating gum disease.

Research continues to associate oral health with overall health. Gum disease may have a potentially significant impact on systemic health, and the implications for cost of care and quality of life can be staggering. If oral disease is unchecked, it may result in health complications that take a real toll on quality of life for an affected member. Treating oral diseases like gum disease may improve overall health and lessen complications with other medical conditions. Regular routine oral care helps address minor problems before they become major, and more expensive to treat.

Our internationally published study supports an association between treated gum disease and lower medical costs for people with diabetes, cardiovascular disease, and stroke. Patients previously treated for periodontal (gum) disease who received maintenance care demonstrated reduced medical costs when compared to patients undergoing initial treatment for gum disease. This study supports a potentially adverse association between untreated gum disease and higher medical costs for these three medical conditions. The numbers speak for themselves in our published study "Appropriate Periodontal Therapy Associated with Lower Medical utilization and Costs," presented at the International Association for Dental Research Meeting in March 2013, in Seattle, Washington:

Population	Savings
Overall(1)	$1,020 or 27.5%
Diabetes(2)	$1,292 or 27.6%
Heart Disease(2)	$2,183 or 25.4%
Stroke(2)	$2,831 or 34.7%

(1) "Appropriate Periodontal Therapy Associated with Lower Medical Utilization and Costs." Alex Marano, Michael Hahn, Miles Hall, Clay Hedlund, Cary Sun, Robert Genco, presented at the International Association for Dental Research Meeting, March 2013, Seattle.

(2) Internal 2012 Cigna studies

Our 2014 refresh of the study continues to support this relationship:

Population	Savings
Overall(3)	$1,111 or 29.6%
Cardiovascular(3)	$2,101 or 23.2%
Chronic Kidney Disease(3)	$1,111 or 29.6%
Diabetes(3)	$1,687 or

	29.9%
Pregnancy[3]	$1,111 or 29.6%
Stroke[3]	$1,111 or 29.6%
Organ Transplants[3]	$1,111 or 29.6%
Head & Neck Cancer Radiation[3]	$1,111 or 29.6%

(3) 2014 Refresh of study: "Appropriate Periodontal Therapy Associated with Lower Medical Utilization and Costs." Alex Marano, Michael Hahn, Miles Hall, Clay Hedlund, Cary Sun, Robert Genco, presented at the International Association for Dental Research Meeting, March 2013, Seattle. Includes internal 2014 Cigna studies.

The Cigna Dental Oral Health Integration Program was first to use improved oral health to reduce risks related to pregnancy, diabetes, and heart disease. Studies show that patients with the following conditions are frequently prone to dry mouth, a condition associated with a higher risk of dental cavities: head and neck cancer radiation, organ transplants, and chronic kidney disease. As a result, we have enhanced our program. Dental members can get 100 percent payment of their out-of-pocket costs for certain dental services if they have any of the following medical conditions: maternity, diabetes, heart disease, stroke, head and neck cancer radiation, organ transplants, and chronic kidney disease.

Members participating in the program are also eligible for the following additional coverage:

- discounts of up to 50 percent off retail prices for chlorhexidine, fluoride toothpaste, and other dental prescription plan product's targeted at patients with a high risk for oral health problems through Cigna Home Delivery Pharmacy
- behavioral guidance on subjects such as fear of going to the dentist, tobacco cessation, and stress and its impact on oral health

The enhancements made to the oral health integration program truly demonstrate Cigna's total integration capabilities as a health service company.

We have provided a detailed implementation calendar directly following this document.

Cigna Implementation Calendar

City of Fort Lauderdale - Dental Add
Account Number: 3333519
Effective Date: January 1, 2018

Task	Responsibility		Start Date	Target Completion Date	Actual Completion Date	Comments
	Cigna	City of Fort Lauderdale				
Receive Notification of Sale	**X**	**X**	**9/1/2017**	**9/1/2017**		
Hold Customer Interface Session (CIS) (Discuss benefits, structure, billing, eligibility, enrollment materials, claim forms, ID cards, schedule on-going weekly implementation status calls)	X	X	9/8/2017	9/8/2017		
Provide updated documents (including employer benefit summaries) with changes from the Implementation Meeting	X		9/15/2017	9/15/2017		
Confirm approval of medical/dental employer summaries, structure document and administrative summary		X	9/22/2017	9/22/2017		
Medical SBCs/Dental Employee summaries sent for review and approval	X		9/29/2017	9/29/2017		
Confirm approval of medical SBCs/Dental Employee summary		X	10/6/2017	10/6/2017		
Meet with Eligibility Analyst to review automated file specifications	X	X	10/11/2017	10/11/2017		
Account structure in production, Cigna can now accept live eligibility	X		10/6/2017	11/3/2017		
Set up the Pre-Enrollment Line. Cigna Sales will test line to ensure appropriate handling of questions. (cannot initiate set up request until employer benefits are approved.)	X	X	Date determined by client	Date determined by client		
Submit test file to Cigna		X	11/6/2017	11/6/2017		
Eligibility test file results returned	X		11/6/2017	11/9/2017		
Request Non-Personalized Dental PPO ID Cards	X		11/20/2017	11/20/2017		
Submit 01/01/18 Open Enrollment eligibility to Cigna		X	12/4/2017	12/4/2017		
Load eligibility into Cigna's eligibility system	X		12/5/2017	12/8/2017		
Release eligibility to ID card vendor for production/mailing	X		12/14/2017	12/14/2017		
All medical/DHMO ID cards are in the mail	X		12/21/2017	12/21/2017		
Call ready/Claim system released	X		12/29/2017	12/29/2017		
Review and approve summary plan description rider draft(s)	X	X	1/2/2018	1/12/2018		

The term "Cigna" refers to the various entities which will provide the coverage and/or services described, including, but not limited to, Connecticut General Life Insurance Company, Cigna HealthCare, Cigna Dental, Intracorp, and Cigna Behavioral Care.

Cigna Healthcare Financial Exhibit for:

City of Fort Lauderdale (City Population)

Effective Date: January 01, 2018

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Cigna DPPO Advantage	Out-of-Network
Calendar Year Maximum		
(Class I, II, III, IX Expenses)	$1500, Class I Applies	$1500, Class I Applies
Calendar Year Deductible		
Per Individual	$0	$100
Per Family	$0	$300
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Non-Routine X-rays Emergency Care to Relieve Pain	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Space Maintainers (limited to non-orthodontic treatment) Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Brush Biopsy	100%, No Deductible	60%, After Deductible
Class III Expenses - Major Restorative Care		
Relines, Rebases, and Adjustments Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	60%, No Deductible	60%, After Deductible
Class IV Expenses - Orthodontia		
Coverage for Eligible Children and Adults Lifetime Maximum	60%, No Ortho Deductible $2500	60%, No Ortho Deductible $2500
Class IX Expenses - Implants		
Plan Calendar Year Max	60%, No Deductible $1500	60%, After Deductible $1500
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on Maximum Allowable Charge (for location of service rendered).
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

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Cigna Healthcare Financial Exhibit for:

City of Fort Lauderdale (City Population)

Effective Date: January 01, 2018

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns	Replacement every 5 years
Prosthesis over Implants	1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Orthodontia	Not covered
Missing Tooth Provision	Teeth missing prior to coverage under the Cigna Dental plan are not covered
Late Entrant Limit	50% coverage on Class III and IV for a specified time period
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons;
* Replacement of a lost or stolen appliance;
* Replacement of a bridge or denture within five years following the date of its original installation;
* Replacement of a bridge or denture which can be made useable according to accepted dental standards;
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion;
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
* Bite registrations; precision or semi-precision attachments; splinting;
* Instruction for plaque control, oral hygiene and diet;
* Dental services that do not meet common dental standards;
* Services that are deemed to be medical services;
* Services and supplies received from a hospital;
* Charges which the person is not legally required to pay;
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
* Experimental or investigational procedures and treatments;
* Any injury resulting from, or in the course of, any employment for wage or profit;
* Any sickness covered under any workers' compensation or similar law;
* Charges in excess of the reasonable and customary allowances;
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; 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;
* 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 HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

Cigna Healthcare Financial Exhibit for:

City of Fort Lauderdale (Firefighters)

Effective Date: January 01, 2018

This is a summary of benefits for your dental plan.

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Cigna DPPO Advantage	Out-of-Network
Calendar Year Maximum		
(Class I, II, III Expenses)	$1500, Class I Applies	$1500, Class I Applies
Calendar Year Deductible		
Per Individual	$100	$100
Per Family	No Limit	No Limit
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Non-Routine X-rays	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Space Maintainers (limited to non-orthodontic treatment) Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Stainless Steel/Resin Crowns Brush Biopsy	80%, After Deductible	80%, After Deductible
Class III Expenses - Major Restorative Care		
Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Crowns/Inlays/Onlays Dentures Bridges	50%, After Deductible	50%, After Deductible
Class IV Expenses - Orthodontia		
Coverage for Eligible Children and Adults	50%, No Ortho Deductible	50%, No Ortho Deductible
Lifetime Maximum	$1500	$1500
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on Maximum Allowable Charge (for location of service rendered).
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

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Cigna Healthcare Financial Exhibit for:

City of Fort Lauderdale (Firefighters)

Effective Date: January 01, 2018

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns	Replacement every 5 years
Prosthesis over Implants	1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Orthodontia	Not covered
Missing Tooth Provision	Teeth missing prior to coverage under the Cigna Dental plan are not covered
Late Entrant Limit	50% coverage on Class III and IV for a specified time period
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons;
* Replacement of a lost or stolen appliance;
* Replacement of a bridge or denture within five years following the date of its original installation;
* Replacement of a bridge or denture which can be made useable according to accepted dental standards;
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion;
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
* Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type;
* Instruction for plaque control, oral hygiene and diet;
* Dental services that do not meet common dental standards;
* Services that are deemed to be medical services;
* Services and supplies received from a hospital;
* Charges which the person is not legally required to pay;
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
* Experimental or investigational procedures and treatments;
* Any injury resulting from, or in the course of, any employment for wage or profit;
* Any sickness covered under any workers' compensation or similar law;
* Charges in excess of the reasonable and customary allowances;
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; 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;
* 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 HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

DENTAL COVERAGE THAT FITS

Cigna Dental Care DHMO[1]

Regular dental care is important for a healthy smile. And a healthy body. With Cigna Dental Care® DHMO, you get comprehensive dental coverage that's easy to use. At a wallet-friendly price. Now that's something to smile about.

This overview shows you a sampling of covered services. And your estimated costs with – and without – coverage. For a full listing of covered services, please call Customer Service at **800.Cigna24 (800.244.6224)**.

Get the most value from your plan

With your Cigna DHMO plan, some preventive services are covered at no extra cost to you. (See below.) Your plan also covers many other dental services that can help your mouth stay healthy.

Your Cigna DHMO plan is a **copayment** plan. Here's how it works. When you get a dental service, Cigna allows your network dentist to charge a certain amount. Then you **pay a fixed portion** of that cost. And your plan pays the rest. There are **no annual maximums** and **no deductibles**!

Review your plan materials for more information about how your plan works. If you have questions before enrollment, call **800.Cigna24 (800.244.6224)** and select the "Enrollment Information" prompt.

	WHAT YOU'LL PAY[2]	
Sampling of covered procedures	**With Cigna Dental Care**	**Without dental coverage**
Adult cleaning (two per calendar year – each at $0) (additional cleanings available at $35 each)	$0	$69 - $139 each
Child cleaning (two per calendar year – each at $0) (additional cleanings available at $25 each)	$0	$69 - $139 each
Periodic oral evaluation	$0	$40 - $81
Comprehensive oral evaluation	$0	$62 - $126
Topical fluoride (two per calendar year – each at $0) (additional topic fluoride available at $15 each)	$0	$28 - $57
X-rays – (bitewings) 2 films	$0	$32 - $66
X-rays – panoramic film	$0	$83 - $168
Sealant – per tooth	$0	$41 - $84
Amalgam filling (silver colored – 2 surfaces	$0	$116 - $237
Composite filling (tooth – colored) – 1 surface, Anterior	$0	$119 - $241
Molar root canal (excluding final restoration)	$75	$847 - $1,720
Comprehensive orthodontic treatment of the adolescent detention – Banding	$370	$987 - $2,004
Periodontal (gum) scaling & root planning – 1 quadrant	$15	$181 - $367
Periodontal (gum) maintenance	$15	$107 - $217
Removal / extraction of erupted tooth	$0	$123 - $250
Removal / extraction of impacted tooth – completely bony	$55	$366 - $743
Crown – porcelain fused to high noble metal	$50	$845 - $1,717
Implant supported retainer for porcelain fused to metal fixed partial denture	$530	$1,200 - $2,437
Surgical placement of implant body within jawbone	$1,025	$1,523 - $3,094
Occlusal appliance, by report (for treatment of TMJ)	$135	$632 - $1,284

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

Smile. You're covered.

You can save money on a wide range of services, including:

- **Preventive care** – cleanings, fluoride, sealants, bitewing X-rays, full mouth X-rays and more
- **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam)
- **Major services** – crowns, bridges, dentures (including those placed over implants), root canals, oral surgery, extractions, treatment for periodontal (gum) disease and more
- **Orthodontic care** – braces for children and adults
- **General anesthesia** – when medically necessary
- **Temporomandibular joint (TMJ)** – diagnosis and treatment, including cone beam x-ray and appliance
- **Athletic mouth guard** – including creation and adjustments
- **Dental implant surgery** or services assocated with placement, repair, removal or restoration of a dental implant.

More about your DHMO coverage

- **No deductibles** You don't have to reach an out-of-pocket cost before your insurance starts.
- **No dollar maximums** Your coverage isn't limited by a dollar amount. No matter the amount of your covered expenses.
- **Easy to understand plan.** Dentist fees are clearly listed on your Patient Charge Schedule (PCS).
- **No claim forms to file.** And no waiting periods for coverage.
- **No age limit on sealants.** Helps prevent tooth decay.
- **Cancer detection** Your plan covers procedures such as biopsy and light detection to help find oral cancer in its early stages.
- **24/7 access to dental information line.** Trained professionals can help answer your questions about dental treatment and clinical symptoms.
- **Cigna's Identity Theft Program.**[3] Help resolving critical identity theft issues.
- **Cigna Dental Oral health Integration Program®.** Enhanced dental coverage for enrolled Cigna dental plan participants with certain medical conditions.

How the plan works

- You must choose a network general dentist to manage your overall care. You won't be covered if you go to a dentist who's not in our network.
- Each family member can choose their own dentist
- Referrals are required for specialty care services. Exceptions are pediatric dentists for children under 7, orthodontics and endodontics.*

Finding a network dentist is easy.

Visit **Cigna.com** to find a network general dentist.

Call **800.Cigna24 (800.244.6224)** to speak with a customer service representative. You can ask for a customized dental directory to be sent to you via email.

* Coverage for treatment by a pediatric dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services generally must be obtained from a network general dentist.

Limitations

PROCEDURE	LIMIT
Oral evaluations	Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145)
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Periodontal root planning and scaling	Limit 4 quadrants per consecutive 12 months
Periodontal maintenance	Limited to 4 per year and (only covered after active periodontal therapy)
Crowns and inlays	Replacement 1 every 5 years
Bridges	Replacement 1 every 5 years
Dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient
Relines, rebases	One every 36 months
Denture adjustments	Four within the first 6 months after installation

Limitations

PROCEDURE	LIMIT
Prosthesis over implant	Replacement 1 every 5 years if unserviceable and cannot be repaired
Surgical placement of implant	Surgical Placement of Implants (D6010, D6012, D6040, and D6050) have a limit of 1 implant per calendar year with a replacement of 1 per 10 years
Temporomandibular Joint (TMJ) treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months
General anesthesia/IV sedation	General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the PCS. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the PCS. Plan limitation for this benefit is 1 hour per appointment.

Specialty treatment plans require payment authorization for services to be covered. Before treatment starts, you should verify with your network specialty dentist that your treatment plan has been authorized for payment by Cigna.

Listed below are the services or expenses which are NOT covered under your Dental plan. You will be responsible for these services at the dentist's usual fees. There's no coverage for:

- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States government or by a state or municipal government if the person had no insurance
- Services received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- Services for the charges which the person is not legally required to pay
- Charges which would not have been made if the person had no insurance
- Services received due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)[4]
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- General anesthesia or IV sedation when used for the purpose of anxiety control or patient management
- Prescription medications
- Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- Surgical implant of any type unless specifically listed on your PCS
- Services considered unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage[5]
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[5]
- Consultations and/or evaluations associated with services that are not covered

- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics
- As to orthodontic treatment: incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment.

If any law requires coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) does not apply.

This document outlines the highlights of your plan. For a complete list of both covered and non-covered services, including benefits required by your state, see your insurance certificate or plan description. If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.

1. The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The Cigna DHMO is not available in the following states: AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VT, VT, WV, and WY.
2. Costs listed for the Cigna Dental Care plan do not vary. Estimated costs without dental coverage may vary based on location and dentists' actual charges. These estimated costs are based on charges submitted to Cigna in 2014/2015 and are intended to reflect national average charges as of July 2016 assuming an annual cost increase of three percent. Estimates have been adjusted to reflect the 2015 Cigna DHMO geographical membership distribution. Office visit fee may also apply.
3. This is NOT insurance and does not provide for reimbursement of financial losses. Cigna's Identity Theft services are provided under a contract with Europ Assistance USA. Full terms are contained in Cigna's Identity Theft Program service agreement.
4. **Minnesota residents:** You must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. Of course, you'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Services for more information.

   Oklahoma residents: DHMO for Oklahoma is an Employer Group Pre-Paid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. Of course, you'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Services for more information.
5. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under your PCS.

Dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided and are not agents of Cigna.

DENTAL COVERAGE THAT FITS

Cigna Dental Care DHMO[1]

Regular dental care is important for a healthy smile. And a healthy body. With Cigna Dental Care® DHMO, you get comprehensive dental coverage that's easy to use. At a wallet-friendly price. Now that's something to smile about.

This overview shows you a sampling of covered services. And your estimated costs with – and without – coverage. For a full listing of covered services, please call Customer Service at **800.Cigna24 (800.244.6224)**.

Get the most value from your plan

With your Cigna DHMO plan, some preventive services are covered at no extra cost to you. (See below.) Your plan also covers many other dental services that can help your mouth stay healthy.

Your Cigna DHMO plan is a **copayment** plan. Here's how it works. When you get a dental service, Cigna allows your network dentist to charge a certain amount. Then you **pay a fixed portion** of that cost. And your plan pays the rest. There are **no annual maximums** and **no deductibles**!

Review your plan materials for more information about how your plan works. If you have questions before enrollment, call **800.Cigna24 (800.244.6224)** and select the "Enrollment Information" prompt.

	WHAT YOU'LL PAY[2]	
Sampling of covered procedures	**With Cigna Dental Care**	**Without dental coverage**
Adult cleaning (two per calendar year – each at $0) (additional cleanings available at $45 each)	$0	$69 - $139 each
Child cleaning (two per calendar year – each at $0) (additional cleanings available at $35 each)	$0	$69 - $139 each
Periodic oral evaluation	$0	$40 - $81
Comprehensive oral evaluation	$0	$62 - $126
Topical fluoride (two per calendar year – each at $0) (additional topic fluoride available at $15 each)	$0	$28 - $57
X-rays – (bitewings) 2 films	$0	$32 - $66
X-rays – panoramic film	$0	$83 - $168
Sealant – per tooth	$7	$41 - $84
Amalgam filling (silver colored – 2 surfaces	$0	$116 - $237
Composite filling (tooth – colored) – 1 surface, Anterior	$0	$119 - $241
Molar root canal (excluding final restoration)	$195	$847 - $1,720
Comprehensive orthodontic treatment of the adolescent detention – Banding	$390	$987 - $2,004
Periodontal (gum) scaling & root planning – 1 quadrant	$35	$181 - $367
Periodontal (gum) maintenance	$25	$107 - $217
Removal / extraction of erupted tooth	$3	$123 - $250
Removal / extraction of impacted tooth – completely bony	$80	$366 - $743
Crown – porcelain fused to high noble metal	$130	$845 - $1,717
Implant supported retainer for porcelain fused to metal fixed partial denture	$610	$1,200 - $2,437
Surgical placement of implant body within jawbone	$1,025	$1,523 - $3,094
Occlusal appliance, by report (for treatment of TMJ)	$150	$632 - $1,284

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

Smile. You're covered.

You can save money on a wide range of services, including:

- **Preventive care** – cleanings, fluoride, sealants, bitewing X-rays, full mouth X-rays and more
- **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam)
- **Major services** – crowns, bridges, dentures (including those placed over implants), root canals, oral surgery, extractions, treatment for periodontal (gum) disease and more
- **Orthodontic care** – braces for children and adults
- **General anesthesia** – when medically necessary
- **Temporomandibular joint (TMJ)** – diagnosis and treatment, including cone beam x-ray and appliance
- **Athletic mouth guard** – including creation and adjustments
- **Dental implant surgery** or services assocated with placement, repair, removal or restoration of a dental implant.

More about your DHMO coverage

- **No deductibles** You don't have to reach an out-of-pocket cost before your insurance starts.
- **No dollar maximums** Your coverage isn't limited by a dollar amount. No matter the amount of your covered expenses.
- **Easy to understand plan.** Dentist fees are clearly listed on your Patient Charge Schedule (PCS).
- **No claim forms to file.** And no waiting periods for coverage.
- **No age limit on sealants.** Helps prevent tooth decay.
- **Cancer detection** Your plan covers procedures such as biopsy and light detection to help find oral cancer in its early stages.
- **24/7 access to dental information line.** Trained professionals can help answer your questions about dental treatment and clinical symptoms.
- **Cigna's Identity Theft Program.**[3] Help resolving critical identity theft issues.
- **Cigna Dental Oral health Integration Program®.** Enhanced dental coverage for enrolled Cigna dental plan participants with certain medical conditions.

How the plan works

- You must choose a network general dentist to manage your overall care. You won't be covered if you go to a dentist who's not in our network.
- Each family member can choose their own dentist
- Referrals are required for specialty care services. Exceptions are pediatric dentists for children under 7, orthodontics and endodontics.*

Finding a network dentist is easy.

Visit **Cigna.com** to find a network general dentist.

Call **800.Cigna24 (800.244.6224)** to speak with a customer service representative. You can ask for a customized dental directory to be sent to you via email.

* Coverage for treatment by a pediatric dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services generally must be obtained from a network general dentist.

Limitations

PROCEDURE	LIMIT
Oral evaluations	Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145)
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Periodontal root planning and scaling	Limit 4 quadrants per consecutive 12 months
Periodontal maintenance	Limited to 4 per year and (only covered after active periodontal therapy)
Crowns and inlays	Replacement 1 every 5 years
Bridges	Replacement 1 every 5 years
Dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient
Relines, rebases	One every 36 months
Denture adjustments	Four within the first 6 months after installation

Limitations

PROCEDURE	LIMIT
Prosthesis over implant	Replacement 1 every 5 years if unserviceable and cannot be repaired
Surgical placement of implant	Surgical Placement of Implants (D6010, D6012, D6040, and D6050) have a limit of 1 implant per calendar year with a replacement of 1 per 10 years
Temporomandibular Joint (TMJ) treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months
General anesthesia/IV sedation	General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the PCS. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the PCS. Plan limitation for this benefit is 1 hour per appointment.

Specialty treatment plans require payment authorization for services to be covered. Before treatment starts, you should verify with your network specialty dentist that your treatment plan has been authorized for payment by Cigna.

Listed below are the services or expenses which are NOT covered under your Dental plan. You will be responsible for these services at the dentist's usual fees. There's no coverage for:

- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States government or by a state or municipal government if the person had no insurance
- Services received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
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- Charges which would not have been made if the person had no insurance
- Services received due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)[4]
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- General anesthesia or IV sedation when used for the purpose of anxiety control or patient management
- Prescription medications
- Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- Surgical implant of any type unless specifically listed on your PCS
- Services considered unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage[5]
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[5]
- Consultations and/or evaluations associated with services that are not covered

- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics
- As to orthodontic treatment: incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment.

If any law requires coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) does not apply.

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2. Costs listed for the Cigna Dental Care plan do not vary. Estimated costs without dental coverage may vary based on location and dentists' actual charges. These estimated costs are based on charges submitted to Cigna in 2014/2015 and are intended to reflect national average charges as of July 2016 assuming an annual cost increase of three percent. Estimates have been adjusted to reflect the 2015 Cigna DHMO geographical membership distribution. Office visit fee may also apply.
3. This is NOT insurance and does not provide for reimbursement of financial losses. Cigna's Identity Theft services are provided under a contract with Europ Assistance USA. Full terms are contained in Cigna's Identity Theft Program service agreement.
4. **Minnesota residents:** You must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. Of course, you'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Services for more information.

   Oklahoma residents: DHMO for Oklahoma is an Employer Group Pre-Paid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. Of course, you'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Services for more information.
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DENTAL COVERAGE THAT FITS

Cigna Dental Care DHMO[1]

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Get the most value from your plan

With your Cigna DHMO plan, some preventive services are covered at no extra cost to you. (See below.) Your plan also covers many other dental services that can help your mouth stay healthy.

Your Cigna DHMO plan is a **copayment** plan. Here's how it works. When you get a dental service, Cigna allows your network dentist to charge a certain amount. Then you **pay a fixed portion** of that cost. And your plan pays the rest. There are **no annual maximums** and **no deductibles**!

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	WHAT YOU'LL PAY[2]	
Sampling of covered procedures	**With Cigna Dental Care**	**Without dental coverage**
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Child cleaning (two per calendar year – each at $0) (additional cleanings available at $35 each)	$0	$69 - $139 each
Periodic oral evaluation	$0	$40 - $81
Comprehensive oral evaluation	$0	$62 - $126
Topical fluoride (two per calendar year – each at $0) (additional topic fluoride available at $15 each)	$0	$28 - $57
X-rays – (bitewings) 2 films	$0	$32 - $66
X-rays – panoramic film	$0	$83 - $168
Sealant – per tooth	$10	$41 - $84
Amalgam filling (silver colored – 2 surfaces	$0	$116 - $237
Composite filling (tooth – colored) – 1 surface, Anterior	$0	$119 - $241
Molar root canal (excluding final restoration)	$250	$847 - $1,720
Comprehensive orthodontic treatment of the adolescent detention – Banding	$400	$987 - $2,004
Periodontal (gum) scaling & root planning – 1 quadrant	$40	$181 - $367
Periodontal (gum) maintenance	$30	$107 - $217
Removal / extraction of erupted tooth	$5	$123 - $250
Removal / extraction of impacted tooth – completely bony	$90	$366 - $743
Crown – porcelain fused to high noble metal	$185	$845 - $1,717
Implant supported retainer for porcelain fused to metal fixed partial denture	$665	$1,200 - $2,437
Surgical placement of implant body within jawbone	$1,025	$1,523 - $3,094
Occlusal appliance, by report (for treatment of TMJ)	$160	$632 - $1,284

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- **Preventive care** – cleanings, fluoride, sealants, bitewing X-rays, full mouth X-rays and more
- **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam)
- **Major services** – crowns, bridges, dentures (including those placed over implants), root canals, oral surgery, extractions, treatment for periodontal (gum) disease and more
- **Orthodontic care** – braces for children and adults
- **General anesthesia** – when medically necessary
- **Temporomandibular joint (TMJ)** – diagnosis and treatment, including cone beam x-ray and appliance
- **Athletic mouth guard** – including creation and adjustments
- **Dental implant surgery** or services assocated with placement, repair, removal or restoration of a dental implant.

More about your DHMO coverage

- **No deductibles** You don't have to reach an out-of-pocket cost before your insurance starts.
- **No dollar maximums** Your coverage isn't limited by a dollar amount. No matter the amount of your covered expenses.
- **Easy to understand plan.** Dentist fees are clearly listed on your Patient Charge Schedule (PCS).
- **No claim forms to file.** And no waiting periods for coverage.
- **No age limit on sealants.** Helps prevent tooth decay.
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Limitations

PROCEDURE	LIMIT
Oral evaluations	Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145)
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X-rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Periodontal root planning and scaling	Limit 4 quadrants per consecutive 12 months
Periodontal maintenance	Limited to 4 per year and (only covered after active periodontal therapy)
Crowns and inlays	Replacement 1 every 5 years
Bridges	Replacement 1 every 5 years
Dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient
Relines, rebases	One every 36 months
Denture adjustments	Four within the first 6 months after installation

Limitations

PROCEDURE	LIMIT
Prosthesis over implant	Replacement 1 every 5 years if unserviceable and cannot be repaired
Surgical placement of implant	Surgical Placement of Implants (D6010, D6012, D6040, and D6050) have a limit of 1 implant per calendar year with a replacement of 1 per 10 years
Temporomandibular Joint (TMJ) treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months
General anesthesia/IV sedation	General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the PCS. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the PCS. Plan limitation for this benefit is 1 hour per appointment.

Specialty treatment plans require payment authorization for services to be covered. Before treatment starts, you should verify with your network specialty dentist that your treatment plan has been authorized for payment by Cigna.

Listed below are the services or expenses which are NOT covered under your Dental plan. You will be responsible for these services at the dentist's usual fees. There's no coverage for:

- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States government or by a state or municipal government if the person had no insurance
- Services received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
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- Services not listed on the PCS
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- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
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- General anesthesia or IV sedation when used for the purpose of anxiety control or patient management
- Prescription medications
- Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- Surgical implant of any type unless specifically listed on your PCS
- Services considered unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage[5]
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[5]
- Consultations and/or evaluations associated with services that are not covered

- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics
- As to orthodontic treatment: incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment.

If any law requires coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) does not apply.

This document outlines the highlights of your plan. For a complete list of both covered and non-covered services, including benefits required by your state, see your insurance certificate or plan description. If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.

1. The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The Cigna DHMO is not available in the following states: AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VT, VT, WV, and WY.
2. Costs listed for the Cigna Dental Care plan do not vary. Estimated costs without dental coverage may vary based on location and dentists' actual charges. These estimated costs are based on charges submitted to Cigna in 2014/2015 and are intended to reflect national average charges as of July 2016 assuming an annual cost increase of three percent. Estimates have been adjusted to reflect the 2015 Cigna DHMO geographical membership distribution. Office visit fee may also apply.
3. This is NOT insurance and does not provide for reimbursement of financial losses. Cigna's Identity Theft services are provided under a contract with Europ Assistance USA. Full terms are contained in Cigna's Identity Theft Program service agreement.
4. **Minnesota residents:** You must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. Of course, you'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Services for more information.

   Oklahoma residents: DHMO for Oklahoma is an Employer Group Pre-Paid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. Of course, you'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Services for more information.
5. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under your PCS.

Dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided and are not agents of Cigna.

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
	Specialist Services				
	Are charges for noble & high noble metal included in listed copays?				
	Are lab charges included in listed copays?				
	Charge for cases involving more than 6 crowns, implants and/or fixed bridge units				
	Office Visit Copay in addition to copay for specific service				
Diagnostic					
Clinical Oral Evaluations					
D0120	Periodic Oral Evaluation				
D0140	Limited Oral Evaluation				
D0145	Oral Evaluation for a Patient Under 3 Years of Age				
D0150	Comprehensive Oral Evaluation				
D0160	Detailed and Extensive Oral Evaluation				
D0170	Re-evaluation - Limited, Problem Focused				
D0180	Comprehensive Periodontal Evaluation				
Pre-diagnostic Services					
D0190	Screening of a patient				
D0191	Assessment of a patient				
Radiographs/Diagnostic Imaging (Including Interpretation)					
D0210	Intraoral - Complete Series (Including Bitewings)				
D0220	Intraoral - Periapical, First Film				
D0230	Intraoral - Periapical, Each Additional Film				
D0240	Intraoral - Occlusal Film				
D0250	Extraoral - First Film				
D0260	Extraoral - Each Additional Film				
D0270	Bitewing - Single Film				
D0272	Bitewings - Two Films				
D0273	Bitewings - Three Films				
D0274	Bitewings - Four Films				
D0277	Vertical Bitewings - 7 to 8 Films				
D0290	Posterior-Anterior or Lateral Skull and Facial Bone Survey Film				
D0310	Sialography				
D0320	Temporomandibular Joint Arthrogram				
D0321	Other Temporomandibular Joint Films, By Report				
D0322	Tomographic Survey				
D0330	Panoramic Film				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D0340	Cephalometric Film				
D0350	Oral/Facial Photographic Images				
D0360	Cone Beam CT				
D0362	Cone Beam - Two-Dimensional Image Reconstruction				
D0363	Cone Beam - Three-Dimensional Image Reconstruction				
D0364	Cone Beam CT capture and interpretation with limited field of view				
D0365	Cone Beam CT capture and interpretation with field of view of one full dental arch-mandible				
D0366	Cone Beam CT capture and interpretation with field of view of one full dental arch-maxilla, with or without cranium				
D0367	Cone Beam CT capture and interpretation with field of view of both jaws with or withour cranium				
D0368	Cone Beam CT capture and interpretation for TMJ series				
D0369	Maxillofacial MRI capture and interpretation				
D0370	Maxillofacial ultrasound capture and interpretation				
D0371	Sialoendoscopy capture and interpretation				
Image Capture Only					
D0380	Cone Beam CT image capture with limited field of view-less than one whole jaw				
D0381	Cone Beam CT image capture with field of view of one full dental arch-mandible				
D0382	Cone Beam CT image capture with field of view of one full dental arch-maxilla, with or without cranium				
D0384	Cone Beam image capture for TMJ series including two or more exposures				
D0385	Maxillofacial MRI image capture				
D0386	Maxillofacial ultrasound image capture				
Image Capture Only					
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report				
Tests and Examinations					
D0415	Collection of Microorganisms for Culture and Sensitivity				
D0416	Viral Culture				
D0417	Collection and Preparation of Saliva Sample for Laboratory Diagnostic Testing				
D0418	Analysis of Saliva Sample				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D0421	Genetic Test for Susceptibility to Oral Diseases				
D0425	Caries Susceptibility Tests				
D0431	Adjunctive Pre-diagnostic Test, Not to Include Cytology or Biopsy Procedures				
D0460	Pulp Vitality Tests				
D0470	Diagnostic Casts				
Oral Pathology Laboratory					
D0472	Accession of Tissue, Gross Examination, Preparation and Transmission of Written Report				
D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report				
D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical margins for presence of Disease, Preparation and Transmission of Written Report				
D0480	Accession of Exfoliative Cytologic Smears, Microscopic Examination, Preparation and Transmission of Written Report				
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report				
D0475	Decalcification Procedure				
D0476	Special Stains for Microorganisms				
D0477	Special Stains, not for Microorganisms				
D0478	Immunohistochemical Stains				
D0479	Tissue In-Situ Hybridization, Including Interpretation				
D0481	Electron Microscopy - Diagnostic				
D0482	Direct Immunofluorescence				
D0483	Indirect Immunofluorescence				
D0484	Consultation on Slides Prepared Elsewhere				
D0485	Consultation, Including Preparation of Slides From Biopsy Material Supplied By Referring Source				
D0502	Other Oral Pathology Procedures, By Report				
D0999	Unspecified Diagnostic Procedure, By Report				
Preventive					
Dental Prophylaxis					
D1110	Prophylaxis - Adult				
	(Additional Cleaning, In Addition to the One Allowed Every 6 Months)				
D1120	Prophylaxis - Child				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
	(Additional Cleaning, In Addition to the One Allowed Every 6 Months)				
Topical Fluoride Treatment (Office Procedure)					
D1203	Topical Application of Fluoride - Child				
D1204	Topical Application of Fluoride - Adult				
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients				
D1208	Topical application of fluoride				
Other Preventive Services					
D1310	Nutritional Counseling for Control of Dental Disease				
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease				
D1330	Oral Hygiene Instructions				
D1351	Sealant - Per Tooth				
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth				
Space Maintenance (Passive Appliances)					
D1510	Space Maintainer - Fixed - Unilateral				
D1515	Space Maintainer - Fixed - Bilateral				
D1520	Space Maintainer - Removable - Unilateral				
D1525	Space Maintainer - Removable - Bilateral				
D1550	Re-cementation of Space Maintainer				
D1555	Removal of Fixed Space Maintainer				
Restorative					
Amalgam Restorations (Including Polishing)					
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					
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)				
D2390	Resin-Based Composite Crown, Anterior				
D2391	Resin-Based Composite - One Surface, Posterior				
D2392	Resin-Based Composite - Two Surfaces, Posterior				

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Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D2393	Resin-Based Composite - Three Surfaces, Posterior				
D2394	Resin-Based Composite - Four or More Surfaces, Posterior				
Gold Foil Restorations					
D2410	Gold Foil - One Surface				
D2420	Gold Foil - Two Surfaces				
D2430	Gold Foil - Three Surfaces				
Inlay/Onlay Restorations					
D2510	*Inlay - Metallic - One Surface*				
D2520	*Inlay - Metallic - Two Surfaces*				
D2530	*Inlay - Metallic - Three or More Surfaces*				
D2542	*Onlay - Metallic - Two Surfaces*				
D2543	*Onlay - Metallic - Three Surfaces*				
D2544	*Onlay - Metallic - Four or More Surfaces*				
D2610	*Inlay - Porcelain/Ceramic - One Surface*				
D2620	*Inlay - Porcelain/Ceramic - Two Surfaces*				
D2630	*Inlay - Porcelain/Ceramic - Three or More Surfaces*				
D2642	*Onlay - Porcelain/Ceramic - Two Surfaces*				
D2643	*Onlay - Porcelain/Ceramic - Three Surfaces*				
D2644	*Onlay - Porcelain/Ceramic - Four or More Surfaces*				
D2650	*Inlay - Resin-Based Composite - One Surface*				
D2651	*Inlay - Resin-Based Composite - Two Surfaces*				
D2652	*Inlay - Resin-Based Composite - Three or More Surfaces*				
D2662	*Onlay - Resin-Based Composite - Two Surfaces*				
D2663	*Onlay - Resin-Based Composite - Three Surfaces*				
D2664	*Onlay - Resin-Based Composite - Four or More Surfaces*				
Crowns - Single Restorations Only					
D2710	*Crown - Resin-Based Composite (Indirect)*				
D2712	*Crown - 3/4 Resin-Based Composite (Indirect)*				
D2720	*Crown - Resin with High Noble Metal*				
D2721	Crown - Resin with Predominantly Base Metal				
D2722	*Crown - Resin with Noble Metal*				
D2740	*Crown - Porcelain/Ceramic Substrate*				
D2750	*Crown - Porcelain Fused to High Noble Metal*				
D2751	Crown - Porcelain Fused to Predominantly Base Metal				
D2752	*Crown - Porcelain Fused to Noble Metal*				
D2780	*Crown - 3/4 Cast High Noble Metal*				

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Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D2781	Crown - 3/4 Cast Predominantly Base Metal				
D2782	*Crown - 3/4 Cast Noble Metal*				
D2783	Crown - 3/4 Porcelain/Ceramic				
D2790	*Crown - Full Cast High Noble Metal*				
D2791	Crown - Full Cast Predominantly Base Metal				
D2792	*Crown - Full Cast Noble Metal*				
D2794	*Crown - Titanium*				
D2799	Provisional Crown				
Other Restorative Services					
D2910	Recement Inlay, Onlay, or Partial Coverage Restoration				
D2915	Recement Cast or Prefabricated Post and Core				
D2920	Recement Crown				
D2929	Prefabricated porcelain/ceramic crown-primary tooth				
D2930	Prefabricated Stainless Steel Crown - Primary Tooth				
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth				
D2932	Prefabricated Resin Crown				
D2933	Prefabricated Stainless Steel Crown with Resin Window				
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth				
D2940	Protective Restoration				
D2950	Core Buildup, Including Any Pins				
D2951	Pin Retention - Per Tooth, In Addition to Restoration				
D2952	*Post and Core In Addition to Crown, Indirectly Fabricated*				
D2953	*Each Additional Indirectly Fabricated Post - Same Tooth*				
D2954	Prefabricated Post and Core In Addition to Crown				
D2955	Post Removal (Not in Conjunction with Endodontic Therapy)				
D2957	Each Add Prefabricated Post - Same Tooth				
D2960	Labial Veneer (Resin Laminate) - Chairside				
D2961	*Labial Veneer (Resin Laminate) - Laboratory*				
D2962	*Labial veneer (Porcelain Laminate) - Laboratory*				
D2970	Temporary Crown (Fractured Tooth)				
D2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework				
D2975	Coping				
D2980	Crown Repair, By Report				
D2981	Inlay repair necessitated by restorative material failure				
D2982	Onlay repair necessitated by restorative material failure				

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Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D2983	Veneer repair necessitated by restorative material failure				
D2990	Resin infiltration of incipient smooth surface lesions				
D2999	Unspecified Restorative Procedure, By Report				
Endodontics					
Pulp Capping					
D3110	Pulp Cap - Direct (Excluding Final Restoration)				
D3120	Pulp Cap - Indirect (Excluding Final Restoration)				
Pulpotomy					
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) - Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament				
D3221	Pulpal Debridement, Primary and Permanent Teeth				
D3222	Partial Pulpotomy for Apexogenesis - Permanent Tooth with Incomplete Root Development				
Endodontic Therapy on Primary Teeth					
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)				
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)				
Endodontic Therapy					
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)				
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)				
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)				
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access				
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth				
D3333	Internal Root Repair or Perforation Defects				
Endodontic Retreatment					
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					
D3351	Apexification/Recalcification - Initial Visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)				
D3352	Apexification/Recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root rsorption, pulp space disinfection, etc.)				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
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					
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)				
D3430	Retrograde Filling - Per Root				
D3450	Root Amputation - Per Root				
D3460	Endodontic Endosseous Implant				
D3470	Intentional Reimplantation (Including Necessary Splinting)				
Other Endodontic Procedures					
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam				
D3920	Hemisection (Including any Root Removal), Not Including Root Canal Therapy				
D3950	Canal Preparation and Fitting of Preformed Dowel or Post				
D3999	Unspecified Endodontic Procedure, By Report				
Periodontics					
Surgical Services (Including Usual Postoperative Care)					
D4210	Gingivectomy of Gingivoplasty - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant				
D4211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant				
D4212	Gingivectomy of Gingivoplasty to allow access for restorative procedure, per tooth				
D4230	Anatomical Crown Exposure - Four or More Teeth Per Quadrant				
D4231	Anatomical Crown Exposure - One to Three Teeth Per Quadrant				
D4240	Gingival Flap Procedure, Including Root Planing - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant				
D4241	Gingival Flap Procedure, Including Root Planing - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant				
D4245	Apically Positioned Flap				

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Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D4249	Clinical Crown Lengthening - Hard Tissue				
D4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant				
D4261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant				
D4263	Bone Replacement Graft - First Site in Quadrant				
D4264	Bone Replacement Graft - Each Additional Site in Quadrant				
D4265	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration				
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site				
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)				
D4268	Surgical Revision Procedure, Per Tooth				
D4270	Pedicle Soft Tissue Graft Procedure				
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)				
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth				
D4274	Distal or Proximal Wedge Procedure (When Not performed in Conjunction With Surgical Procedures in the Same Anatomical Area)				
D4275	Soft Tissue Allograft				
D4276	Combined Connective Tissue and Double Pedicle Graft, Per Tooth				
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft				
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site				
Non-Surgical Periodontal Service					
D4320	Provisional Splinting, Intracoronal				
D4321	Provisional Splinting, Extracoronal				
D4341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant				
D4342	Periodontal Scaling and Root Planing - One to Three Teeth Per Quadrant				
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis				
D4381	Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth, By Report				
Other Periodontal Services					
D4910	Periodontal Maintenance				
	Additional Periodontal Maintenance				
D4920	Unscheduled Dressing Change (by someone other than treating dentist)				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D4999	Unspecified Periodontal Procedure, By Report				
Prosthodontics (Removable)					
Complete Dentures					
D5110	*Complete Denture - Maxillary*				
D5120	*Complete Denture - Mandibular*				
D5130	*Immediate Denture - Maxillary*				
D5140	*Immediate Denture - Mandibular*				
Partial Dentures (Including Routine Post-delivery Care)					
D5211	*Maxillary Partial Denture - Resin Base (Including any Conventional Clasps, Rests and Teeth)*				
D5212	*Mandibular Partial Denture - Resin Base (Including any Conventional Clasps, Rests and Teeth)*				
D5213	*Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)*				
D5214	*Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)*				
D5225	*Maxillary Partial Denture - Flexible Base (Including any Clasps, Rests and Teeth)*				
D5226	*Mandibular Partial Denture - Flexible Base (Including any Clasps, Rests and Teeth)*				
D5281	*Removable Unilateral Partial Denture - One Piece Cast Metal (Including Clasps and Teeth)*				
Adjustments to Dentures					
D5410	Adjust Complete Denture - Maxillary				
D5411	Adjust Complete Denture - Mandibular				
D5421	Adjust Partial Denture - Maxillary				
D5422	Adjust Partial Denture - Mandibular				
Repairs to Complete Dentures					
D5510	*Repair Broken Complete Denture Base*				
D5520	*Replace Missing or Broken Teeth - Complete Denture (Each Tooth)*				
Repairs to Partial Dentures					
D5610	*Repair Resin Denture Base*				
D5620	*Repair Cast Framework*				
D5630	*Repair or Replace Broken Clasp*				

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Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D5640	*Replace Broken Teeth - Per Tooth*				
D5650	*Add Tooth to Existing Partial Denture*				
D5660	*Add Clasp to Existing Partial Denture*				
D5670	*Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)*				
D5671	*Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)*				
Denture Rebase Procedures					
D5710	*Rebase Complete Maxillary Denture*				
D5711	*Rebase Complete Mandibular Denture*				
D5720	*Rebase Maxillary Partial Denture*				
D5721	*Rebase Mandibular Partial Denture*				
Denture Reline Procedures					
D5730	Reline Complete Maxillary Denture (Chairside)				
D5731	Reline Complete Mandibular Denture (Chairside)				
D5740	Reline Maxillary Partial Denture (Chairside)				
D5741	Reline Mandibular Partial Denture (Chairside)				
D5750	*Reline Complete Maxillary Denture (Laboratory)*				
D5751	*Reline Complete Mandibular Denture (Laboratory)*				
D5760	*Reline Maxillary Partial Denture (Laboratory)*				
D5761	*Reline Mandibular Partial Denture (Laboratory)*				
Interim Prosthesis					
D5810	*Interim Complete Denture (Maxillary)*				
D5811	*Interim Complete Denture (Mandibular)*				
D5820	*Interim Partial Denture (Maxillary)*				
D5821	*Interim Partial Denture (Mandibular)*				
Other Removable Prosthetic Services					
D5850	Tissue Conditioning, Maxillary				
D5851	Tissue Conditioning, Mandibular				
D5860	Overdenture - Complete, By Report				
D5861	Overdenture - Partial, By Report				
D5862	Precision Attachment, By report				
D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)				
D5875	Modification of Removable Prosthesis Following Implant Surgery				
D5899	Unspecified Removable Prosthodontic Procedure, By Report				
Maxillofacial Prosthetics					

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D5911	Facial Moulage (Sectional)				
D5912	Facial Moulage (Complete)				
D5913	Nasal Prosthesis				
D5914	Auricular Prosthesis				
D5915	Orbital Prosthesis				
D5916	Ocular Prosthesis				
D5919	Facial Prosthesis				
D5922	Nasal Septal Prosthesis				
D5923	Ocular Prosthesis, Interim				
D5924	Cranial Prosthesis				
D5925	Facial Augmentation Implant Prosthesis				
D5926	Nasal Prosthesis, Replacement				
D5927	Auricular Prosthesis, Replacement				
D5928	Orbital Prosthesis, Replacement				
D5929	Facial Prosthesis, Replacement				
D5931	Obturator Prosthesis, Surgical				
D5932	Obturator Prosthesis, Definitive				
D5933	Obturator Prosthesis, Modification				
D5934	Mandibular Resection Prosthesis with Guide Flange				
D5935	Mandibular Resection Prosthesis without Guide Flange				
D5936	Obturator Prosthesis, Interim				
D5937	Trismus Appliance (Not for TMD Treatment)				
D5951	Feeding Aid				
D5952	Speech Aid Prosthesis, Pediatric				
D5953	Speech Aid Prosthesis, Adult				
D5954	Palatal Augmentation Prosthesis				
D5955	Palatal Lift Prosthesis, Definitive				
D5958	Palatal Lift Prosthesis, Interim				
D5959	Palatal Lift Prosthesis, Modification				
D5960	Speech Aid Prosthesis, Modification				
D5982	Surgical Stent				
D5983	Radiation Carrier				
D5984	Radiation Shield				
D5985	Radiation Cone Locator				
D5986	Fluoride Gel Carrier				
D5987	Commissure Splint				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D5988	Surgical Splint				
D5991	Topical Medicament Carrier				
D5992	Adjust maxillofacial prosthetic appliance, by report				
D5993	Maintenance and Cleaning of a Maxillofacial Prosthesis (Extra or Intraoral) Other Than Required Adjustments, By Report				
D5999	Unspecified Maxillofacial Prosthesis, By Report				
Implant Services					
Pre-Surgical Services					
D6190	Radiographic/surgical Implant Index, By Report				
Surgical Services					
D6010	Surgical Placement of Implant Body: Endosteal Implant				
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant				
D6040	Surgical Placement: Eposteal Implant				
D6050	Surgical Placement: Transosteal Implant				
D6100	Implant Removal, By Report				
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure				
D6102	Ddebridement of osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure				
D6103	Bone graft for repair of periimplant defect-not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration				
D6104	Bone graft at time of implant placement				
Implant Supported Prosthetics					
Supporting Structures					
D6051	Interim abutment				
D6055	Connecting Bar - Implant Supported or Abutment Supported				
D6056	Prefabricated Abutment - Includes Placement				
D6057	Custom Abutment - Includes Placement				
Implant/Abutment Supported Removable Dentures					
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch				
D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch				
Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)					

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D6078	Implant/Abutment Supported Fixed Denture for Completely Edentulous Arch				
D6079	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch				
Single Crowns, Abutment Supported					
D6058	*Abutment Supported Porcelain/Ceramic Crown*				
D6059	*Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)*				
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)				
D6061	*Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)*				
D6062	*Abutment Supported Cast Metal Crown (High Noble Metal)*				
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)				
D6064	*Abutment Supported Cast Metal Crown (Noble Metal)*				
D6094	*Abutment Supported Crown - (Titanium)*				
Single Crowns, Implant Supported					
D6065	*Implant Supported Porcelain/Ceramic Crown*				
D6066	*Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, or High Noble Metal)*				
D6067	*Implant Supported Metal Crown (Titanium, Titanium Alloy, or High Noble Metal)*				
Fixed Partial Denture, Abutment Supported					
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD				
D6069	*Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)*				
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)				
D6071	*Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)*				
D6072	*Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)*				
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)				
D6074	*Abutment Supported Retainer for Cast Metal FPD (Noble Metal)*				
D6194	*Abutment Supported Retainer Crown for FPD- (Titanium)*				
Fixed Partial Denture, Implant Supported					
D6075	Implant Supported Retainer for Ceramic FPD				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D6076	*Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)*				
D6077	*Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)*				
Other Implant Services					
D6080	Implant Maintenance Procedures, Including Removal of Prosthesis, Cleansing of Prosthesis and Abutments and Reinsertion of Prosthesis				
D6090	Repair Implant Supported Prosthesis, By Report				
D6095	Repair Implant Abutment, By Report				
D6091	Replacement of Semi-Precision or Precision Attachment (Male or Female Component) of Implant/Abutment Supported Prosthesis, Per Attachment				
D6092	Recement Implant/Abutment Supported Crown				
D6093	Recement Implant/Abutment Supported Fixed Partial Denture				
D6199	Unspecified Implant Procedure, By Report				
Prosthodontics, Fixed					
Fixed Partial Denture Pontics					
D6205	Pontic - Indirect Resin Based Composite				
D6210	*Pontic - Cast High Noble Metal*				
D6211	Pontic - Cast Predominantly Base Metal				
D6212	*Pontic - Cast Noble Metal*				
D6214	*Pontic - Titanium*				
D6240	*Pontic - Porcelain Fused to High Noble Metal*				
D6241	Pontic - Porcelain Fused to Predominantly Base Metal				
D6242	*Pontic - Porcelain Fused to Noble Metal*				
D6245	*Pontic - Porcelain/Ceramic*				
D6250	*Pontic - Resin with High Noble Metal*				
D6251	Pontic - Resin with Predominantly Base Metal				
D6252	*Pontic - Resin with Noble Metal*				
D6253	*Provisional Pontic*				
D6254	Interim Pontic				
Fixed Partial Denture Retainers - Inlays/Onlays					
D6545	*Retainer - Cast Metal for Resin Bonded Fixed Prosthesis*				
D6548	Retainer - Porcelain/Ceramic for Resin Bonded Fixed Prosthesis				
D6600	*Inlay - Porcelain/Ceramic - Two Surfaces*				
D6601	*Inlay - Porcelain/Ceramic - Three or More Surfaces*				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D6602	*Inlay - Cast High Noble Metal, Two Surfaces*				
D6603	*Inlay - Cast High Noble Metal, Three or More Surfaces*				
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces				
D6605	Inlay - Cast Predominantly Base Metal, Three or More Surfaces				
D6606	*Inlay - Cast Noble Metal, Two Surfaces*				
D6607	*Inlay - Cast Noble Metal, Three or More Surfaces*				
D6624	Inlay - Titanium				
D6608	*Onlay - Porcelain/Ceramic - Two Surfaces*				
D6609	*Onlay - Porcelain/Ceramic - Three or More Surfaces*				
D6610	*Onlay - Cast High Noble Metal, Two Surfaces*				
D6611	*Onlay - Cast High Noble Metal, Three or More Surfaces*				
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces				
D6613	*Onlay - Cast Predominantly Base Metal, Three or More Surfaces*				
D6614	*Onlay - Cast Noble Metal, Two Surfaces*				
D6615	*Onlay - Cast Noble Metal, Three or More Surfaces*				
D6634	Onlay - Titanium				
Fixed Partial Denture Retainers - Crowns					
D6710	*Crown - Indirect Resin Based Composite*				
D6720	*Crown - Resin with High Noble Metal*				
D6721	Crown - Resin with Predominantly Base Metal				
D6722	*Crown - Resin with Noble Metal*				
D6740	*Crown - Porcelain/Ceramic*				
D6750	*Crown - Porcelain Fused to High Noble Metal*				
D6751	Crown - Porcelain Fused to Predominantly Base Metal				
D6752	*Crown - Porcelain Fused to Noble Metal*				
D6780	*Crown - 3/4 Cast High Noble Metal*				
D6781	Crown - 3/4 Cast Predominantly Base Metal				
D6782	*Crown - 3/4 Cast Noble Metal*				
D6783	*Crown - 3/4 Porcelain/Ceramic*				
D6790	*Crown - Full Cast High Noble Metal*				
D6791	Crown - Full Cast Predominantly Base Metal				
D6792	*Crown - Full Cast Noble Metal*				
D6794	*Crown - Titanium*				
D6793	Provisional Retainer Crown				
D6795	Interim Retainer Crown				
Other Fixed Partial Denture Services					

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D6920	Connector Bar				
D6930	Recement Fixed Partial Denture				
D6940	Stress Breaker				
D6950	Precision Attachment				
D6970	*Cast Post and Core In Addition to Fixed Partial Denture Retainer, Indirectly Fabricated*				
D6972	Prefabricated Post and Core In Addition to Fixed Partial Denture Retainer				
D6973	Core Buildup for Retainer, Including Any Pins				
D6975	Coping - Metal				
D6976	Each Additional Indirectly Fabricated Post - Same Tooth				
D6977	Each Additional Prefabricated Post - Same Tooth				
D6980	*Fixed Partial Denture Repair By Report*				
D6985	Pediatric Partial Denture, Fixed				
D6999	Unspecified Fixed Prosthodontic Procedure, By Report				
Oral and Maxillofacial Surgery					
Extractions					
D7111	Extraction of Coronal Remnants - Deciduous Tooth				
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)				
Surgical Extractions					
D7210	Surgical Removal of Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and Including Elevation of Mucoperiosteal Flap if Indicated				
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					
D7260	Oroantral Fistula Closure				
D7261	Primary Closure of a Sinus Perforation				
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D7272	Tooth Transplantation (Includes Reimplantation from One Site to Another and Splinting and/or Stabilization)				
D7280	Surgical Access of an Unerupted Tooth				
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption				
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth				
D7285	Biopsy of Oral Tissue - Hard (Bone, Tooth)				
D7286	Biopsy of Oral Tissue - Soft				
D7287	Exfoliative Cytological Sample Collection				
D7288	Brush Biopsy - Transepithelial Sample Collection				
D7290	Surgical Repositioning of Teeth				
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report				
D7292	Surgical Placement; Temporary Anchorage Device (Screw Retained Plate) Requiring Surgical Flap				
D7293	Surgical Placement; Temporary Anchorage Device Requiring Surgical Flap				
D7294	Surgical Placement; Temporary Anchorage Device without Surgical Flap				
D7295	Harvest of Bone Fur Use In Autogenous Grafting Procedure				
Alveoloplasty - Surgical Preparation of Ridge for Dentures					
D7310	Alveoloplasty in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant				
D7311	Alveoloplasty in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant				
D7320	Alveoloplasty not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant				
D7321	Alveoloplasty not in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant				
Vestibuloplasty					
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)				
D7350	Vestibuloplasty - Ridge Extension (Including Soft Tissue Grafts, Muscle Reattachment, etc.)				
Surgical Excision of Soft Tissue Lesions					
D7410	Excision of Benign Lesion Up to 1.25 cm				
D7411	Excision of Benign Lesion Greater than 1.25 cm				
D7412	Excision of Benign Lesion, Complicated				
D7413	Excision of Malignant Lesion Up to 1.25 cm				
D7414	Excision of Malignant Lesion Greater than 1.25 cm				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D7415	Excision of Malignant Lesion, Complicated				
D7465	Destruction of Lesion(s) By Physical or Chemical Method, By Report				
Surgical Excision of Intra-Osseous Lesions					
D7440	Excision of Malignant Tumor - Lesion Diameter Up to 1.25 cm				
D7441	Excision of Malignant Tumor - Lesion Diameter Greater than 1.25 cm				
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm				
D7451	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Greater than 1.25 cm				
D7460	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm				
D7461	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter Greater than 1.25 cm				
Excision of Bone Tissue					
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)				
D7472	Removal of Torus Palatinus				
D7473	Removal of Torus Mandibularis				
D7485	Surgical Reduction of Osseous Tuberosity				
D7490	Radical Resection of Maxilla or Mandible				
Surgical Incision					
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue				
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage of Multiple Fascial Spaces)				
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue				
D7521	Incision and Drainage of Abscess - Extraoral Soft Tissue Complicated (Includes Drainage of Multiple Fascial Spaces)				
D7530	Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue				
D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System				
D7550	Partial Ostectomy/Sequestrectomy for Removal of Non-vital Bone				
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body				
Treatment of Fractures - Simple					
D7610	Maxilla - Open Reduction (Teeth Immobilized, if Present)				
D7620	Maxilla - Closed Reduction (Teeth Immobilized, if Present)				
D7630	Mandible - Open Reduction (Teeth Immobilized, if Present)				
D7640	Mandible - Closed Reduction (Teeth Immobilized, if Present)				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D7650	Malar and/or Zygomatic Arch - Open Reduction				
D7660	Malar and/or Zygomatic Arch - Closed Reduction				
D7670	Alveolus - Closed Reduction, May Include Stabilization of Teeth				
D7671	Alveolus - Open Reduction, May Include Stabilization of Teeth				
D7680	Facial Bones - Complicated Reduction with Fixation and Multiple Surgical Approaches				
Treatment of Fractures - Compound					
D7710	Maxilla - Open Reduction				
D7720	Maxilla - Closed Reduction				
D7730	Mandible - Open Reduction				
D7740	Mandible - Closed Reduction				
D7750	Malar and/or Zygomatic Arch - Open Reduction				
D7760	Malar and/or Zygomatic Arch - Closed Reduction				
D7770	Alveolus - Open Reduction Stabilization of Teeth				
D7771	Alveolus - Closed Reduction Stabilization of Teeth				
D7780	Facial Bones - Complicated Reduction with Fixation and Multiple Surgical Approaches				
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions					
D7810	Open Reduction of Dislocation				
D7820	Closed Reduction of Dislocation				
D7830	Manipulation under Anesthesia				
D7840	Condylectomy				
D7850	Surgical Discectomy, with/without Implant				
D7852	Disc Repair				
D7854	Synovectomy				
D7856	Myotomy				
D7858	Joint Reconstruction				
D7860	Arthrotomy				
D7865	Arthroplasty				
D7870	Arthrocentesis				
D7871	Non-arthroscopic Lysis and Lavage				
D7872	Arthroscopy - Diagnosis, with or without Biopsy				
D7873	Arthroscopy - Surgical: Lavage and Lysis of Adhesions				
D7874	Arthroscopy - Surgical: Disc Repositioning and Stabilization				
D7875	Arthroscopy - Surgical: Synovectomy				
D7876	Arthroscopy - Surgical: Discectomy				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D7877	Arthroscopy - Surgical: Debridement				
D7880	Occlusal Orthotic Device, By Report				
D7899	Unspecified TMD Therapy By Report				
Repair of Traumatic Wounds					
D7910	Suture of Recent Small Wounds up to 5 cm				
Complicated Suturing					
D7911	Complicated Suture - Up to 5 cm				
D7912	Complicated Suture - Greater than 5 cm				
Other Repair Procedures					
D7920	Skin Graft (Identify Defect Covered, Location and Type of Graft)				
D7921	Collection and application of autologous blood concentrate product				
D7940	Osteoplasty - For Orthognathic Deformities				
D7941	Osteotomy - Mandibular Rami				
D7943	Osteotomy - Mandibular Rami with Bone Graft; Includes Obtaining the Graft				
D7944	Osteotomy - Segmented or Subapical				
D7945	Osteotomy - Body of Mandible				
D7946	LeFort I (Maxilla - Total)				
D7947	LeFort I (Maxilla - Segmented)				
D7948	LeFort II or LeFort III - without Bone Graft				
D7949	LeFort II or LeFort III - with Bone Graft				
D7950	Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Maxilla - Autogenous or Nonautogenous, By Report				
D7951	Sinus Augmentation with Bone or Bone Substitutes				
D7952	Sinus augmentation via a vertical approach				
D7953	Bone Replacement Graft for Ridge Preservation - Per Site				
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect				
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate procedure				
D7963	Frenuloplasty				
D7970	Excision of Hyperplastic Tissue -Per Arch				
D7971	Excision of Pericoronal Gingival				
D7972	Surgical Reduction of Fibrous Tuberosity				
D7980	Sialolithotomy				
D7981	Excision of Salivary Gland, By Report				
D7982	Sialodochoplasty				
D7983	Closure of Salivary Fistula				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D7990	Emergency Tracheotomy				
D7991	Coronoidectomy				
D7995	Synthetic Graft - Mandible or Facial Bones, By Report				
D7996	Implant - Mandible for Augmentation Purposes (Excluding Alveolar Ridge), By Report				
D7997	Appliance Removal (Not by Dentist who Placed Appliance), Includes Removal of Archbar				
D7998	Intraoral Placement of a Fixation Device not in Conjunction with a Fracture				
D7999	Unspecified Oral Surgery Procedure, By Report				
Orthodontics					
Limited Orthodontic Treatment					
D8010	Limited Orthodontic Treatment of the Primary Dentition				
D8020	Limited Orthodontic Treatment of the Transition Dentition				
D8030	Limited Orthodontic Treatment of the Adolescent Dentition				
D8040	Limited Orthodontic Treatment of the Adult Dentition				
Interceptive Orthodontic Treatment					
D8050	Interceptive Orthodontic Treatment of the Primary Dentition				
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition				
Comprehensive Orthodontic					
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition				
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition				
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition				
Minor Treatment to Control Harmful Habits					
D8210	Removable Appliance Therapy				
D8220	Fixed Appliance Therapy				
Other Orthodontic Services					
D8660	Pre-Orthodontic Treatment Visit				
D8670	Periodic Orthodontic Treatment Visit (As Part of Contract)				
	Children (Up to 19th Birthday):				
	24 Month Treatment Fee				
	Charge Per Month for 24 Months				
	Adults:				
	24 Month Treatment Fee				
	Charge Per Month for 24 Months				
	Ortho Visits Beyond 24 Months of Active Treatment or Retention				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer (s))				
D8690	Orthodontic Treatment (Alternative Billing to a Contract Fee)				
D8691	Repair of Orthodontic Appliance				
D8692	Replacement of Lost or Broken Retainer				
D8693	Rebonding or Recementing; and/or Repair, as Required, of Fixed Retainers				
D8999	Unspecified Orthodontic Procedure, By Report				
Adjunctive General Services					
Unclassified Treatment					
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure				
D9120	Fixed Partial Denture Sectioning				
Anesthesia					
D9210	Local Anesthesia Not in Conjunction with Operative or Surgical Procedures				
D9211	Regional Block Anesthesia				
D9212	Trigeminal Division Block Anesthesia				
D9215	Local Anesthesia in Conjunction With Operative or Surgical Proedures				
D9220	Deep Sedation/General Anesthesia - First 30 Minutes				
D9221	Deep Sedation/General Anesthesia - Each Additional 15 Minutes				
D9230	Inhalation of Nitrous Oxide/anxiolysis, analgesia				
D9241	Intravenous Conscious Sedation/Analgesia - First 30 Minutes				
D9242	Intravenous Conscious Sedation/Analgesia - Each Additional 15 Minutes				
D9248	Non-intravenous Conscious Sedation				
Professional Consultation					
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician other than Requesting Dentist or Physician				
Professional Visits					
D9410	House/Extended Care Facility Call				
D9420	Hospital or Ambulatory Surgical Center Call				
D9430	Office Visit for Observation (During Regularly Scheduled Hours) - No other Services Performed				
D9440	Office Visit - After Regularly Scheduled Hours				
D9450	Case Presentation, Detailed and Extensive Treatment Planning				
	Broken Appointment without 24 hour notice - Per 15 Minutes				

City of Fort Lauderdale
DHMO Copay Comparison

Proposer's Name _____

CDT Code	Benefit	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*	*Enter DHMO Plan Name Here*
Drugs					
D9610	Therapeutic Parenteral Drug, Single Administration				
D9612	Therapeutic Parenteral Drugs, Two or More Administrations, Different Medications				
D9630	Other Drugs and/or Medicaments, By Report				
Miscellaneous Services					
D9910	Application of Desensitizing Medicament				
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, Per Tooth				
D9920	Behavior Management, By Report				
D9930	Treatment of Complications (Post-surgical) - Unusual Circumstances, By Report				
D9940	Occlusal Guard, By Report				
D9941	Fabrication of Athletic Mouthguard				
D9942	Repair and/or Reline of Occlusal Guard				
D9950	Occlusion Analysis - Mounted Case				
D9951	Occlusal Adjustment - Limited				
D9952	Occlusal Adjustment - Complete				
D9970	Enamel Micro abrasion				
D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections				
D9972	External Bleaching, Per Arch				
D9973	External Bleaching, Per Tooth				
D9974	Internal Bleaching, Per Tooth				
D9975	External bleaching for home application, per arch; includes materials and fabricaiton of custom trays				
D9999	Unspecified Adjunctive Procedure, By Report				

Additional lab and metal charges may apply for procedures in italics.

SECTION IV – SUBMITTAL REQUIREMENTS

4.2.5 Benefit Plans

Proposers must provide complete benefit descriptions of the plans being proposed, including the proposed DHMO schedule with CDT codes and brief explanation of service. These descriptions must include all exclusions and limitations. In addition, an Excel file is attached, *DHMO copays.xlsx*, which lists dental procedures. Please fill in the DHMO copay for each procedure for the plan or plans you are proposing. You must indicate which procedures are not covered. If your plan covers procedures that are not listed, please add them to the file and highlight your entry. Provide this in Excel format on a Flash Drive.

The DHMO Patient Charge Schedules are included in the Sample Contracts section of this proposal.

SECTION VI - COST PROPOSAL PAGE

Proposer Name: Cigna Health and Life Insurance Company (CHLIC), Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Florida, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Texas, Inc.

Proposer agrees to supply the products and services at the prices bid below in accordance with the terms, conditions and specifications contained in this RFP.

	Fully-Insured Cigna P5I0X DHMO for Management & Teamsters	Fully-Insured DPPO for Management & Teamsters	Fully-Insured DPPO for Firefighters
Employee Only	$16.77	$52.64	$30.88
Employee + Spouse	$29.35	$98.64	$56.45
Employee + Child or Children	$35.22	$101.40	$50.05
Employee + Family	$49.37	$127.81	$88.42

	Option 2: Fully-Insured Cigna P4I0X DHMO for Management & Teamsters	Option 3: Fully-Insured Cigna P2I0X DHMO for Management & Teamsters
Employee Only	$16.77	$23.09
Employee + Spouse	$29.35	$40.42
Employee + Child or Children	$35.22	$48.50
Employee + Family	$49.37	$67.99

The premiums listed above are guaranteed for

1 year _____ 2 years _____ 3 years __X__ 4 years _____ 5 years _____

Rate cap and details for any renewal not guaranteed:

Cigna is offering the City of Fort Lauderdale the choice of 3 different DHMO plans. That provide various levels of benefit richness. The P2I0X is richer than the current DHMO Plan and the P4I0X is a little bit richer overall and the P5I0X is what is the best match to current.

Multi-year guarantees (especially 3 years) are preferred and will be factored into the evaluation.

Submitted by:

Scott E. Evelyn	
Name (printed)	**Signature**
April 4th 2016	Vice President of CHLIC and Authorized Signatory.
Date	**Title**

City of Fort Lauderdale

Guaranteed Cost Funding
Non-Participating
January 01, 2018 - December 31, 2018

Tier	Expected Lives	Current Rates	36 Month Rates*
Dental PPO - City Plan			
Employee Only	396	$52.64	$52.64
Employee + Spouse	210	$98.64	$98.64
Employee + Child(ren)	95	$101.40	$101.40
Employee + Family	273	$127.81	$127.81
Annual Cost	974	$1,033,020	$1,033,017
Percent Change (Quoted vs Current)			**0.00%**

**The above quoted rates do not include any commissions.*
**The above quoted rates include 3.5% Health Insurance Assessment fees (PPACA).*

Tier	Expected Lives	Current Rates	36 Month Rates*
Dental PPO - Firefighters			
Employee Only	131	$30.88	$30.88
Employee + Spouse	49	$56.45	$56.45
Employee + Child(ren)	49	$50.05	$50.05
Employee + Family	143	$88.42	$88.42
Annual Cost	372	$262,894	$262,888
Percent Change (Quoted vs Current)			**0.00%**

**The above quoted rates do not include any commissions.*
**The above quoted rates include 3.5% Health Insurance Assessment fees (PPACA).*

Total	**1,346**	**$1,295,914**	**$1,295,905**
Percent Change (Quoted vs Current)			

Cigna Dental Care Proposed Rates

GROUP INFORMATION

Presale ID: **266061**

Group Name: **City of Fort Lauderdale (P2IOX)**

Eligible Employees: **2,120**

CHC Sales Person: **John Coolican South Florida - #362**

Medical UW: **. NONE**

PRODUCT INFORMATION

CDC Plan: **Cigna Dental Options**

CDC PCS: **P2I0X V&T, ER - VIRGIN & TAKEOVER/EMPLOYER PAID**

Product: **MULTI PRODUCT**

Funding: **TRADITIONAL**

RATE INFORMATION

	4 TIER SPECIAL			
	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
TOTAL BILLED RATE	$23.09	$40.42	$48.50	$67.99

UNDERWRITING CAVEATS:

- **Rates are valid for a 1/1/2018 effective date.**
- **Rates contain sufficient load for a 0.00% flat commission.**

•These rates are guaranteed for 36 months. The PCS is only guaranteed for 1 year.
• Rates include costs for standard eligibility, standard enrollment materials, and standard administration.
• Rates are valid only where there is an existing CDC network in place.•CDC copayments are subject to change on the anniversary date.
• Rates require an employer contribution of at least 50% for the employee, 0% for the dependent, or 25% overall.
• Rates are dependent upon eligibility being effective on the first of the month.
• Rates may be sold on a 4-tier special basis only.
• Rates assume ID cards will be mailed to employee homes.
• These rates are subject to regulatory approval.
• The dental insurance coverage shall be provided under a standalone group insurance policy and is an "excepted benefit" as defined in Public Health Service Act Section 2721(c) and (d) and not subject to the requirement of the Patient Protection and Affordable Care Act.
• The information contained in this Proposal by Cigna HealthCare is proprietary and highly confidential. It is being provided with the understanding that it will not be used by the employer, its representatives or consultants for any purpose other than the evaluation of the Proposal. Under no circumstances is any of the information contained herein (including excerpts, summaries, extracts, and evaluations thereof) to be used, disseminated, disclosed or otherwise communicated to any person or entity other than the employer, its representatives and consultants, and their respective employees who are directly involved in the evaluation process.
• Cigna HealthCare may have an agreement with your benefit advisor, under which the benefit advisor may be paid for providing marketplace intelligence or for the performance of administrative services. The qualification for and amount of this payment may be based upon overall business growth and/or retention levels. Any such payment is funded through Cigna HealthCare's general overhead.
• The benefit advisor may qualify for incentive payment (monetary or non-monetary) from Cigna HealthCare. For example, the benefit advisor may receive payment based upon new sales, new customer growth or retention. This incentive payment is funded from Cigna HealthCare's general overhead.
• Cigna HealthCare sponsors programs to inform benefit advisors about Cigna HealthCare's plan coverage and services (including producer advisory councils). The cost of these events is funded through Cigna HealthCare's general overhead.

STATE REGULATIONS

• For new business, employees residing in Idaho or New Mexico may not be offered Cigna Dental Care.
• AR law requires a carrier to offer a point of service option. CDC standalone is not available and must be sold as part of a dual choice option.

STATE CA, CO, FL, GA, NJ, NY, OH, TN, TX, WA

The quoted rates include the cost of the Health Insurance Assessment fees (PPACA) for 2016. Rates for 2017 do not include Health Insurance Assessment fees (PPACA). Rates for 2018 and later, will be adjusted to include applicable PPACA fees imposed for that time period. Cigna reserves the right to modify quoted rates, as necessary, consistent with any future change in regulation.

Prepared by CDC Underwriter: Howard Schachere

4/3/2017 2:25:31 PM

Cigna Dental Care Proposed Rates

GROUP INFORMATION

Presale ID: **266426**

Group Name: **City of Fort Lauderdale (P4IOX)**

Eligible Employees: **2,120**

CHC Sales Person: **John Coolican South Florida - #362**

Medical UW: **. NONE**

PRODUCT INFORMATION

CDC Plan: **Cigna Dental Options**

CDC PCS: **P4I0X V&T, ER - VIRGIN & TAKEOVER/EMPLOYER PAID**

Product: **MULTI PRODUCT**

Funding: **TRADITIONAL**

RATE INFORMATION

	4 TIER SPECIAL			
	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
TOTAL BILLED RATE	$16.77	$29.35	$35.22	$49.37

UNDERWRITING CAVEATS:

- **Rates are valid for a 1/1/2018 effective date.**
- **Rates contain sufficient load for a 0.00% flat commission.**

•These rates are guaranteed for 36 months. The PCS is only guaranteed for 1 year.
• Rates include costs for standard eligibility, standard enrollment materials, and standard administration.
• Rates are valid only where there is an existing CDC network in place.•CDC copayments are subject to change on the anniversary date.
• Rates require an employer contribution of at least 50% for the employee, 0% for the dependent, or 25% overall.
• Rates are dependent upon eligibility being effective on the first of the month.
• Rates may be sold on a 4-tier special basis only.
• Rates assume ID cards will be mailed to employee homes.
• These rates are subject to regulatory approval.
• The dental insurance coverage shall be provided under a standalone group insurance policy and is an "excepted benefit" as defined in Public Health Service Act Section 2721(c) and (d) and not subject to the requirement of the Patient Protection and Affordable Care Act.
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STATE REGULATIONS

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STATE CA, CO, FL, GA, NJ, NY, OH, TN, TX, WA

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Prepared by CDC Underwriter: Howard Schachere

4/7/2017 10:05:16 AM

Cigna Dental Care Proposed Rates

GROUP INFORMATION

Presale ID: **266055**

Group Name: **City of Fort Lauderdale (P5IOX)**

Eligible Employees: **2,120**

CHC Sales Person: **John Coolican South Florida - #362**

Medical UW: **. NONE**

PRODUCT INFORMATION

CDC Plan: **Cigna Dental Options**

CDC PCS: **P5I0X V&T, ER - VIRGIN & TAKEOVER/EMPLOYER PAID**

Product: **MULTI PRODUCT**

Funding: **TRADITIONAL**

RATE INFORMATION

	4 TIER SPECIAL			
	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
TOTAL BILLED RATE	$15.28	$26.73	$32.08	$44.97

UNDERWRITING CAVEATS:

- **Rates are valid for a 1/1/2018 effective date.**
- **Rates contain sufficient load for a 0.00% flat commission.**

•These rates are guaranteed for 36 months. The PCS is only guaranteed for 1 year.
• Rates include costs for standard eligibility, standard enrollment materials, and standard administration.
• Rates are valid only where there is an existing CDC network in place.•CDC copayments are subject to change on the anniversary date.
• Rates require an employer contribution of at least 50% for the employee, 0% for the dependent, or 25% overall.
• Rates are dependent upon eligibility being effective on the first of the month.
• Rates may be sold on a 4-tier special basis only.
• Rates assume ID cards will be mailed to employee homes.
• These rates are subject to regulatory approval.
• The dental insurance coverage shall be provided under a standalone group insurance policy and is an "excepted benefit" as defined in Public Health Service Act Section 2721(c) and (d) and not subject to the requirement of the Patient Protection and Affordable Care Act.
• The information contained in this Proposal by Cigna HealthCare is proprietary and highly confidential. It is being provided with the understanding that it will not be used by the employer, its representatives or consultants for any purpose other than the evaluation of the Proposal. Under no circumstances is any of the information contained herein (including excerpts, summaries, extracts, and evaluations thereof) to be used, disseminated, disclosed or otherwise communicated to any person or entity other than the employer, its representatives and consultants, and their respective employees who are directly involved in the evaluation process.
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STATE CA, CO, FL, GA, NJ, NY, OH, TN, TX, WA

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Prepared by CDC Underwriter: Howard Schachere

3/29/2017 12:57:51 PM

City of Fort Lauderdale
DENTAL NETWORK RECRUITMENT PERFORMANCE GUARANTEE

Network Utilized: DPPO Advantage, DHMO

Cigna will commit to $1,346 in Guarantees toward the implementation of the dental network recruitment plan outlined below. This recruitment effort has already begun and will be fully complete by 06/2018. The specific guarantee consists of the following:

1) Cigna will put $673 at risk to contact all dentists utilized by your employees that are not currently contracted with Cigna by 08/2017.*

4) Cigna will put $673 at risk to add a minimum of 20 DHMO dental offices in the Miami-Fort Lauderdale-Pompano Beach, FL CBSA by 06/2018.*

Cigna Dental has assigned Dawn Applewhite as the recruitment project manager to implement the plan, administrate specific provider recruitment requests, and provide consultation regarding future network expansion needs. Under the direction of the project manager, a team of highly-experienced expansion specialists will be assigned to this recruitment. The members of our network expansion team are skilled in negotiation techniques and have the authority to negotiate the best possible discounts, at the office level, to ensure provider participation.

Guarantee Assumptions:

The Dental Network Recruitment Guarantee is contingent upon the ability to use City of Fort Lauderdale name verbally and in writing for recruitment purposes and notification of sale by 06/01/2017. If notification date is later than originally stated the PG due dates will be adjusted accordingly.

The baseline recruitment number could change due to the validity of the data that may be identified.

**** This contract commitment is contingent upon receipt of a complete disruption report that includes TIN, dentist name, address, city, state and zip. Upon receipt of a full disruption this commitment could potentially change.***

This guarantee is based upon recruitment of a specific number of Dentists:

The contracts that will be eligible in order to meet the performance guarantee are:

Exact match to the disruption record
Associate dentist(s) or new owner dentist(s) in the same office of location listed
Associate dentist(s) or new owner dentist(s) in additional locations will be counted
Location listed is no longer valid and new location for same dentist is contracted (dentist moved)
Every listed location for each individual dentist will count separately

Any pay-out of the Performance Guarantee will be prorated per access point.

Cigna will provide progress reporting on a quarterly basis with final reconciliation reported out by third quarter of 2018.

Any matches within the criteria will be validated in the recruitment process and any non-valid matches will be included in the recruitment initiative.

Upon hitting the goal of 20 dentist access points, the Performance Guarantee will be considered complete and goals met.

3/31/2017

IMPLEMENTATION

Identification Card Delivery Implementation ID Card Timeliness. 98% of the ID cards will be mailed by the agreed upon commitment date in the Implementation Calendar. Results measured at Account Level.	Amount At Risk 0.25 % of annual premium
Claim Readiness Implementation Claim Readiness. Benefit Profile and eligibility information loaded on claims processing system as of the Commitment Date set forth in the approved Implementation Calendar. Results measured at Account Level.	Amount At Risk 0.25 % of annual premium
Call Readiness Implementation Call Readiness. Service Center(s) ready to respond to customer inquiries as of the Commitment Date set forth in the approved Implementation Calendar. Results measured at Account Level.	Amount At Risk 0.25 % of annual premium
Implementation Satisfaction Implementation Satisfaction. Score of no less than three (3) on Statement 1 of the Cigna HealthCare Implementation Survey. Results measured at Account Level.	Amount At Risk 0.25 % of annual premium

SERVICE

Claim Time-to-Process Dental Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 92% of Claims processed w/in 10 Business Days. Results measured at Account Level.	Amount At Risk 0.25 % of annual premium
Average Speed of Answer Dental ASA. Measured for the Term of the Agreement, results will not exceed: 30 seconds to answer a phone call. Results measured at Special Account Queue.	Amount At Risk 0.25 % of annual premium
Call Abandonment Rate Dental Call Abandonment Rate. Measured for the Term of the Agreement, results will not exceed: 2% of calls received by Call Center(s) terminated. Results measured at Special Account Queue.	Amount At Risk 0.25 % of annual premium
Automated Maintenance Eligibility Processing Auto Eligibility Discrepancy Report Delivery/Resolution. Reports will be available to view online 48 hours after we have updated a clean and accurate eligibility file. Measured at the Account Level.	Amount At Risk 0.25 % of annual premium
ID Card Maintenance OnGoing ID Card Timeliness/AL. I.D. Card Production (ongoing) - 98% of Identification Cards mailed within 10 business days of receipt of complete and accurate eligibility data (standard will be measured and reported to Employer quarterly).	Amount At Risk 0.25 % of annual premium
Account Management Dental - Account Management Custom/AL. Secure Internet Portals Commitment - Employer and member portals fully functional and available to City and participants as of open enrollment period.	Amount At Risk 0.25 % of annual premium

Performance Guarantees
City of Fort Lauderdale
Effective Start Date: January 1, 2018

SERVICE

Service	Amount At Risk
Service Manager Performance Standard - Response to telephone calls and email messages within 24 business hours	0.25 % of annual premium

Total % of Premium at Risk	**2.75 %**
Total $ Maximum Amount at Risk	**$38,811.46**

Provider	Amount At Risk
Dental - Provider Recruitment. Cigna will commit to $1,346 in Guarantees toward the implementation of the dental network recruitment plan outlined below. This recruitment effort has already begun and will be fully complete by 06/2018. The specific guarantee consists of the following: 1) Cigna will put $673 at risk to contact all dentists utilized by your employees that are not currently contracted with Cigna by 08/2017. 2) Cigna will put $673 at risk to add a minimum of 20 DHMO dental offices in the Miami-Fort Lauderdale-Pompano Beach, FL CBSA by 06/2018. (See Recruitment Guarantee Summar for details)	$1,346.00

Total $ Maximum Amount at Risk	**$1,346.00**

DENTAL HMO

Average Speed of Answer	At Risk $
Dental HMO ASA. Measured for the Term of the Agreement, results will not exceed: 30 seconds to answer a phone call. Results measured at the Special Account Queue.	0.50 % of annual premium

Call Abandonment Rate	At Risk $
Dental HMO Call Abandonment Rate. Measured for the Term of the Agreement, results will not exceed: 2% of calls received by Call Center(s) terminated. Results measured at Office Level.	0.50 % of annual premium

Post enrollment measure	At Risk $
DHMO ID Cards Maintenance. Measured for the Term of the Agreement, results will meet or exceed: 98.5% mailed within 10 business days after the release of, not receipt of, clean and accurate eligibility to the ID card vendor. Results measured at Account Level.	0.50 % of annual premium

Time to Process - Specialty Referral Claims Rate	At Risk $
Dental HMO Time to Process. Measured for the Term of the Agreement, result will meet or exceed: 95% within 10 Business Days. Results measured at Office Level.	0.50 % of annual premium

Total % of Premium at Risk	**2.00 %**
Total $ Maximum Amount at Risk	**$3,302.74**

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Network Summary

Please list the current number of DHMO dentists, not dental offices, by category by county. For general dentists, list only those currently accepting members. *If a provider has more than 1 office he or she should be counted only once.*

	Broward	Miami-Dade	Palm Beach	Martin
General Dentists	167	197	90	11
Pediatric Dentists	63	47	28	4
Oral Surgeons	55	46	37	4
Endodontists	57	31	35	5
Periodontists	60	43	28	4
Prosthodontists	0	0	0	0
Orthodontists	58	62	53	10

*Please note that DHMO providers are contracted by office. We are unable to provide individual dentists counts.

Please list the current number of PPO dentists, not dental offices, by category by county. *If a provider has more than 1 office he or she should be counted only once.*

Cigna Advantage DPPO

	Broward	Miami-Dade	Palm Beach	Martin
General Dentists	973	1030	570	91
Pediatric Dentists	82	71	52	9
Oral Surgeons	58	59	45	9
Endodontists	57	46	51	11
Periodontists	83	54	44	8
Prosthodontists	17	13	11	1
Orthodontists	80	86	56	11

Specific Dentist Network

We have attached and Excel file, *specific providers.xlsx,* with two lists of providers:

- **DHMO providers with members assigned**
- **DPPO providers utilized by City members. Please indicate which of these providers participate in your company's DPPO or DHMO network.**

Include the completed form in your proposal. Also provide the completed form in Excel format on a Flash Drive.

We have provided this form in our proposal and in Excel format on the flash drive.

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

Company Name: Cigna Health and Life Insurance Company, Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Florida, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of Ohio, Inc., and Cigna Dental Health of Texas, Inc.

Indicate which of the listed providers is included in your company's proposed DPPO network and include a hard copay as well as an Excel file in your response.

Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
1	461185149	Destefon, John J	30 NE 3rd St	Ft Lauderdale	FL	33301	Y
2	591389949	Rosenthal, Barry W	9200 NW 44th St	Sunrise	FL	33351	N
3	202058007	Leibowitz, Jayson R	10080 NW 1st Ct	Plantation	FL	33324	Y
4	650341505	Moore, Keith E	901 S Federal Hwy Ste 301	Fort Lauderdale	FL	33316	N
5	453626385	Young, Jared M	1930 Ne 34th Ct	Lighthouse Point	FL	33064	Y
6	592495753	Barr, Scott I	300 NW 70 Ave, #206	Plantation	FL	33317	N
7	203791829	Robinson, Sharon R	6738 W Sunrise Blvd, Ste 105	Plantation	FL	33313	Y
8	650666819	Bartlett, Jeffrey C	2440 E Sunrise Blvd	Fort Lauderdale	FL	33304	N
9	943420892	Horst, Nadja A	104 SE 1st St	Ft Lauderdale	FL	33301	Y
10	461919850	Douglass, Richard C	660 N State Road 7, Ste 12	Plantation	FL	33317	Y
11	461543139	Alexander, Allison	113 SW 11th Ct, Ste A	Ft Lauderdale	FL	33315	Y
12	412220291	Giraldo, Andrea	114 SW 10th St	Fort Lauderdale	FL	33315	N
13	591541047	Bennett, James G	1023 Atlantic Blvd	Atlantic Beach	FL	32233	Y
14	223703976	Mankame, Dipak M	300 NW 70th Ave, Ste 109	Plantation	FL	33317	N
15	650985810	Yang, James T	10189 Cleary Blvd, Ste 201	Plantation	FL	33324	N
16	421650718	Stanton, Robert B	1776 N Pine Island Rd, Ste 300	Plantation	FL	33322	Y
17	650700287	George, Ronald A	4100 S Hospital Dr, Ste 107	Plantation	FL	33317	Y
18	208195969	Polasky, Dawn L	6231 N Federal Hwy, Ste 109	Ft Lauderdale	FL	33308	Y
19	271200319	Riley, Marilyn P	3909 N Andrews Ave	Oakland Park	FL	33309	Y
20	591425149	Wilentz, Abby T	7400 NW 5th St	Plantation	FL	33317	Y
21	592208015	Zenga, William T	2500 N University Dr, Ste 9	Sunrise	FL	33322	Y
22	760741305	Johnson Leong, Charmaine	2717 E Oakland Park Blvd Ste 1	Fort Lauderdale	FL	33306	N
23	200185918	Lane, Thomas R	1831 NE 45th St, Suite B	Fort Lauderdale	FL	33308	Y
24	271835567	Toral, Armando	4811 Hollywood Blvd, Ste A	Hollywood	FL	33021	Y
25	900723233	Benedetti, Ana P	1535 Sunset Dr	Coral Gables	FL	33143	N
26	264305407	Tendler, Minelle M	199 W Palmetto Park Rd, Ste D	Boca Raton	FL	33432	Y
27	550881045	Freeman, Christopher S	8200 W Sunrise Blvd, Suite B-3	Plantation	FL	33322	Y
28	471820802	Rieger, Eric R	1200 Yamato Rd, Ste A4	Boca Raton	FL	33431	Y
29	202058007	Palenzuela, Mary A	10080 NW 1st Ct	Plantation	FL	33324	Y
30	650089306	Berger, Joel S	1890 N University Dr, Ste 210	Coral Springs	FL	33071	Y
31	202058007	Herbert, Brent	10080 NW 1st Ct	Plantation	FL	33324	Y
32	460771294	Naierman, Eric H	3333 Sheridan St	Hollywood	FL	33021	Y
33	650019957	Blitman, Robert	8430 W Broward Blvd, Ste 100	Plantation	FL	33324	Y
34	650075019	Boukzam, Mark A	4048 W Hillsboro Blvd	Deerfield Beach	FL	33442	N
35	650969035	Canizales, Jacqueline	10640 Griffin Rd, Ste 107	Davie	FL	33328	Y
36	471526151	Berley, Joel A	7110 Southgate Blvd	Margate	FL	33068	Y
37	650746314	Hernandez, Peter M	10051 Pines Blvd Ste C	Pembroke Pines	FL	33024	N
38	651100498	Mccawley, Daniel W	1625 E Las Olas Blvd	Fort Lauderdale	FL	33301	N
39	471755265	Sherman, Richard L	2249 N University Dr	Pembroke Pines	FL	33024	Y
40	203141319	Kerns, James M	2991 Myrtle Oak Cir	Davie	FL	33328	Y
41	452816684	Martin, Sidney S	660 N State Road 7, Ste 12	Plantation	FL	33317	Y
42	650000707	Chencin, Josef	3015 Bayview Dr, Ste D	Fort Lauderdale	FL	33306	Y
43	650461148	Zakko, Dalal	2826 E Oakland Park Blvd, Ste 300	Fort Lauderdale	FL	33306	Y
44	260849265	Hernandez, Roland A	1625 SE 3rd Avenue, Suite 802	Ft Lauderdale	FL	33316	Y
45	204587282	Dixon, Scott E	1620 SE 4th Ave	Ft Lauderdale	FL	33316	N
46	275197554	Joh, Julia H	4301 N Federal Hwy, Ste 5	Pompano Beach	FL	33064	Y
47	043589759	Castillo, Pedro L	1300 N Federal Hwy, Suite 1	Lake Worth	FL	33460	N
48	611734577	Bates, Barbara A	1096 W Indiantown Rd, Ste 200	Jupiter	FL	33458	Y
49	650914866	Fredrick, Jason W	10156 W Indiantown Rd	Jupiter	FL	33478	Y
50	591425149	Lustman, Craig	809 State Route 208	Monroe	NY	10950	Y
51	650980524	Jones, Ian C	6300 W Atlantic Blvd	Margate	FL	33063	Y
52	461543139	Arocha, Arianny	113 SW 11th Ct Ste A	Fort Lauderdale	FL	33315	Y
53	592603212	Heinsen, Gretchen	2480 E Commercial Blvd, Ste 2	Fort Lauderdale	FL	33308	Y
54	592681987	Barnard, Michael R	1209 W Broward Blvd	Ft Lauderdale	FL	33312	Y
55	471755265	Templeton, Patricia G	2249 N University Dr	Pembroke Pines	FL	33024	Y
56	650631864	Rozen, Henry	9154 Wiles Rd	Coral Springs	FL	33067	N
57	650863385	Colella, Candace R	4690 N State Rd 7 Ste 201	Coconut Creek	FL	33073	Y
58	161685076	Mazzei, Leanne	9387 W Sample Rd	Coral Springs	FL	33065	Y
59	592397569	Scharf, Blair	2801 N University Dr, Suite 101	Coral Springs	FL	33065	N
60	592211352	Behn, Jack W	8200 W Sunrise Blvd, Ste A1	Plantation	FL	33322	N
61	134205825	Khakhria, Milan L	104 NW 100th Ave	Plantation	FL	33324	Y
62	650161743	Bracco, Brent J	2467 E Commercial Blvd	Fort Lauderdale	FL	33308	Y
63	650947659	Simon, David G	10115 Forest Hill Blvd Ste 301	Wellington	FL	33414	N
64	205407398	Chen, Timothy P	12741 Miramar Pkwy, Ste 203	Miramar	FL	33027	Y
65	650246176	Spector, Lawrence A	9132 Wiles Rd	Coral Springs	FL	33067	N
66	900723233	Benedetti, Ana P	1535 Sunset Dr	Coral Gables	FL	33143	N
67	592661313	Schloss, Christopher M	2916 Bayview Dr	Fort Lauderdale	FL	33306	N
68	271499087	Forum, Richard B	320 SE 18th St	Fort Lauderdale	FL	33316	N
69	261365336	Shelling, Robert	19615 State Road 7, Ste 33	Boca Raton	FL	33498	Y
70	453626385	Young, Catherine R	1930 NE 34th Ct	Lighthouse Point	FL	33064	Y
71	651147593	Listopad, Howard D	10161 W Sample Rd, Ste A	Coral Springs	FL	33065	Y
72	010574562	Jarrett, Brent J	7312 W Atlantic Blvd	Margate	FL	33063	Y
73	753136614	Maye, Frank J	19615 33 S State Rd 7	Boca Raton	FL	33498	Y
74	650401664	Weiner, Seymour	8200 W Sunrise Blvd, Ste B2	Plantation	FL	33322	Y

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

Company Name: Cigna Health and Life Insurance Company, Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Florida, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of Ohio, Inc., and Cigna Dental Health of Texas, Inc.

Indicate which of the listed providers is included in your company's proposed DPPO network and include a hard copay as well as an Excel file in your response.

Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
75	591928451	Wiener, B H	800 E Broward Blvd, Ste 305	Ft Lauderdale	FL	33301	Y
76	203987895	Malpica, Omar A	14201 W Sunrise Blvd Ste 106	Sunrise	FL	33323	N
77	611734577	Bates, Barbara A	1096 W Indiantown Rd, Ste 200	Jupiter	FL	33458	Y
78	591425149	Trupkin, Denis P	7400 NW 5th St	Plantation	FL	33317	Y
79	461185149	Cook, Jonathan H	30 Ne 3Rd St	Ft Lauderdale	FL	33301	Y
80	112596095	Jaeger, Michael E	12012 S Shore Blvd, Ste 101	Wellington	FL	33414	Y
81	650937178	Fong, Ian S	1900 N University Dr, Ste 201	Pembroke Pines	FL	33024	Y
82	650766393	Rosenberg, Steven A	7500 NW 5th St, Ste 115	Plantation	FL	33317	N
83	463189195	Hernandez Rivera, Ricardo N	522 E 25Tth St	Hialeah	FL	33013	Y
84	452733082	Bouchard Lavenka, Cynthia R	14771 Biscayne Blvd	North Miami	FL	33181	Y
85	272813237	Rubensteen, Evan	2151 NW 2nd Ave, Ste 102	Boca Raton	FL	33431	Y
86	650807157	Douglas, Easton	2609 W Oakland Park Blvd	Fort Lauderdale	FL	33311	N
87	452382491	Olivera, Marisabel	4800 NE 20th Ter, Ste 301S	Ft Lauderdale	FL	33308	Y
88	043683245	Ferrer, Deborah A	1500 E Broward Blvd	Ft Lauderdale	FL	33301	N
89	650456698	Graff, Brad W	3107 Stirling Rd, Ste 108	Ft Lauderdale	FL	33312	Y
90	261147142	Ginzler, Bradley M	12651 W Sunrise Blvd, Ste 204	Sunrise	FL	33323	Y
91	592550069	Mandell, Charles S	3220 Stirling Rd	Hollywood	FL	33021	Y
92	592343174	Llera, Julio A	2607 Davie Blvd	Fort Lauderdale	FL	33312	N
93	760706979	Giol, Victor J	2474 SE Federal Hwy	Stuart	FL	34994	Y
94	592427954	Russo, Charles D	2801 N University Dr, Ste 102	Coral Springs	FL	33065	Y
95	208577828	Urrea Feldsberg, Helena	12301 Taft St Ste 300	Pembroke Pines	FL	33026	Y
96	651025280	Gomez, Luis F	4651 N State Road 7, Ste 4	Coconut Creek	FL	33073	Y
97	412132420	Warner, David K	1946 Wilton Dr	Wilton Manors	FL	33305	Y
98	454014601	Miresmaili, Mandana	3035 E Commercial Blvd	Fort Lauderdale	FL	33308	Y
99	592229420	Lipson, Frank D	333 NW 70th Ave, Ste 104	Plantation	FL	33317	Y
100	300012213	Quesada, Robert E	1500 E Broward Blvd	Fort Lauderdale	FL	33301	Y
101	263766926	Barbag, Adam C	9172 Glades Rd	Boca Raton	FL	33434	Y
102	591366609	Miller, Robert J	8903 Glades Rd Ste D6	Boca Raton	FL	33434	Y
103	264848166	Moore, Keith E	901 S Federal Hwy Ste 301	Fort Lauderdale	FL	33316	N
104	272119748	Wagner, Robert M	1275 York Ave	New York	NY	10065	Y
105	273006462	Finkelstein, Heidi R	333 NW 70th Ave	Fort Lauderdale	FL	33317	N
106	270812901	Caponera, Rinaldo	7420 NW 5th St, Ste 108	Plantation	FL	33317	Y
107	412139274	Schaumberg, Jennifer S	21150 Biscayne Blvd, Ste 401	Aventura	FL	33180	Y
108	591425149	Babyak, George R	7400 Nw 5th St	Plantation	FL	33317	Y
109	208445461	Shehadeh, Eyad	973 N Nob Hill Rd	Plantation	FL	33324	Y
110	650713391	Nudelberg, Michael E	550 SW 3rd St	Pompano Beach	FL	33060	Y
111	650792969	Montamarta, Francisco T	100 S Military Trl, Ste 4	Deerfield Beach	FL	33442	Y
112	591541047	Rothberg, Melanie R	5458 Town Center Rd, Ste 16	Boca Raton	FL	33486	Y
113	260829624	Briceno Crespi, Carmen	7615 SW 62nd Ave	South Miami	FL	33143	Y
114	473696720	Lepore, Krystina M	9109 Baymeadows Rd, Ste 1	Jacksonville	FL	32256	Y
115	264429924	Vultaggio, Francesco P	841 SE 8th Ave	Deerfield Bch	FL	33441	Y
116	650165775	Hosseini, Heather G	1040 Weston Rd, Ste 225	Weston	FL	33326	Y
117	464571377	Short, Steven T	5400 N Federal Hwy	Fort Lauderdale	FL	33308	Y
118	421598932	Roud, Taras	7015 Beracasa Way, Ste 101	Boca Raton	FL	33433	Y
119	650654799	Thomas, Christian M	3471 N Federal Hwy, Ste 501	Ft Lauderdale	FL	33306	Y
120	208036431	Marranzini Grosma, Maria G	4401 S Flamingo Rd, Ste 109	Davie	FL	33330	Y
121	651146878	Fuerst, Peter F	2706 N University Dr	Sunrise	FL	33322	Y
122	650184844	Marks, Lawrence H	5100 Hollywood Blvd Ste 2	Hollywood	FL	33021	N
123	650717556	Feuer, Mitchell R	900 S Federal Hwy	Hollywood	FL	33020	N
124	650688337	Simon, David S	7101 W McNab Rd, Ste 102	Tamarac	FL	33321	Y
125	010712049	Slatkoff, Joshua M	2151 NW Boca Raton Blvd, Ste 10	Boca Raton	FL	33431	Y
126	650668849	Wong, Albert G	300 NW 70th Ave, Suite 304	Plantation	FL	33317	N
127	201577593	Scerbo, Peter M	6600 W 12th Ave	Hialeah	FL	33012	N
128	542080841	Grandison, Nigel D	10117 Cleary Blvd	Plantation	FL	33324	Y
129	510446273	Najarian, Stephen	815 S University Dr, Ste 101	Plantation	FL	33324	Y
130	202996316	Bons, Brian K	1637 N Hiatus Rd	Pembroke Pines	FL	33026	N
131	464401786	Garg, Arun K	700 N Hiatus Rd, Ste 102	Pembroke Pines	FL	33026	Y
132	462882102	Deture, Christopher N	1500 E Hillsboro Blvd	Deerfield Beach	FL	33441	N
133	650132415	Blum, Michael R	648 NE 3rd Ave	Fort Lauderdale	FL	33304	Y
134	204399325	Smith, Austin F	10794 Pines Blvd, Ste 101	Pembroke Pines	FL	33026	Y
135	650787194	Taylor, Henderson P	3131 Inverrary Blvd W	Lauderhill	FL	33319	Y
136	263118748	Sainsbury, James W	2700 E Bay Dr, Ste 207	Largo	FL	33771	N
137	464114693	Selmic, Nadezda	401 E Las Olas Blvd, Ste 140	Fort Lauderdale	FL	33301	N
138	592756022	Fistel, Alan	7522 Wiles Rd, Ste 104	Coral Springs	FL	33067	Y
139	592724644	Mccauley, Mark C	3115 South Federal Highway	Delray Beach	FL	33483	Y
140	272813237	Gul, Yousaf A	4189 Southpoint Dr E	Jacksonville	FL	32216	Y
141	271509276	Taha, Ahmed A	1640 S Federal Hwy	Delray Beach	FL	33483	Y
142	275473032	Igualada Heine, Kristen N	8585 Sunset Dr, Ste 101	Miami	FL	33143	Y
143	582676964	Rosado, Itza M	12781 Miramar Pkwy, Ste 201	Miramar	FL	33027	Y
144	205614193	Benda, Natalia M	6361 N Andrews Ave	Fort Lauderdale	FL	33309	Y
145	270129674	Fox, Eric G	5551 N University Dr, Ste 203	Coral Springs	FL	33067	Y
146	650821596	Brady, Michael	4330 W Broward Blvd, Suit T	Plantation	FL	33317	N
147	650975638	Garcia, Kathy	1019 S University Dr	Plantation	FL	33324	Y
148	591693658	Bussell, Alan J	6269 N University Dr	Tamarac	FL	33321	Y

City of Fort Lauderdale
Top 250 DPPO Providers
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Indicate which of the listed providers is included in your company's proposed DPPO network and include a hard copay as well as an Excel file in your response.

Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
149	650121690	Garcia, Juan M	1490 W 49th Pl, Ste 450	Hialeah	FL	33012	Y
150	113697263	Most, Douglas S	544 NW University Blvd, Ste 105	Port Saint Lucie	FL	34986	Y
151	030576797	Sorroza, Jennifer P	435 E Sheridan St	Dania	FL	33004	Y
152	463455311	Israel, Elie	305 E Altamonte Springs Dr, Ste 1020	Altamonte Springs	FL	32701	Y
153	650559387	Pyle, Stephen J	2239 N Commerce Pkwy, Suite 1	Weston	FL	33326	N
154	650632466	Hernandez, Liliana J	4750 NW 7th St, Ste 10	Miami	FL	33126	Y
155	010718993	Nudel, Tatyana	7321 N State Road 7	Parkland	FL	33073	Y
156	650943768	Lichstrahl, Jared E	301 NW 84th Ave, Ste 203	Plantation	FL	33324	Y
157	261669042	Brilliant, Margo K	18851 NE 29th Ave, Ste 300	Aventura	FL	33180	Y
158	260353884	Cimand, Tami	7797 N University Dr, Ste 201	Tamarac	FL	33321	Y
159	650908498	Darojat, Zuhdiyah M	305 E Altamonte Springs Dr, Ste 1020	Altamonte Springs	FL	32701	Y
160	263394448	Hilali, Manal	10151 W Commercial Blvd	Sunrise	FL	33351	Y
161	208737121	Browne, Andrew M	9789 Glades Rd	Boca Raton	FL	33434	N
162	465601000	Casas, Silvia B	951 NE 167th St, Ste 104	North Miami Beach	FL	33162	Y
163	650043559	Arenas, Jorge A	10271 Pines Blvd	Pembroke Pines	FL	33026	Y
164	650387750	Fedele, Mark W	500 NW Dixie Hwy South	Stuart	FL	34994	N
165	651030631	Arnold, Patrick B	4800 NE 20th Ter, Ste 205	Ft Lauderdale	FL	33308	Y
166	591263751	Bluth, Barry A	4175 SW 64th Ave, Ste 103-104	Davie	FL	33314	Y
167	592582825	Kushner, Benn M	10031 Pines Blvd, Ste W101	Pembroke Pines	FL	33024	Y
168	593752296	Bender, Fara	6169 Jog Rd, Suite B-5	Lake Worth	FL	33467	Y
169	650976774	Ring, Christian D	1776 N Pine Island Rd, Ste 300	Plantation	FL	33322	Y
170	591944868	Parker, Stephen T	1003 N 35th Ave	Hollywood	FL	33021	Y
171	200185918	Plower, Katarzyna J	2275 20th St	Vero Beach	FL	32960	Y
172	260518079	Rezaie, Yeganeh	3801 Hollywood Blvd, Ste 225	Hollywood	FL	33021	Y
173	592459372	Spoont, E R	21301 Powerline Rd, Suite 208	Boca Raton	FL	33433	Y
174	391221409	Steinmetz, Mark J	W3132 Van Roy Rd	Appleton	WI	54915	N
175	592051908	Rosenthal, Allen H	3836 N University Dr	Sunrise	FL	33351	Y
176	453740998	Sevel, Dennis S	1350 SW 160th Ave	Weston	FL	33326	Y
177	650234930	Gittess, Laurie B	1625 N Commerce Pkwy, Ste 317	Weston	FL	33326	Y
178	562338791	Kawa, Larry B	20423 State Road 7, Ste F18	Boca Raton	FL	33498	Y
179	273533121	James, Kevin K	685 Royal Palm Beach Blvd, Ste 204	Royal Palm Beach	FL	33411	Y
180	650518576	Davis Iii, John M	19 NE 22nd Ave	Pompano Beach	FL	33062	N
181	651081473	Neuls, Julia W	2633 E Commercial Blvd Ste B	Fort Lauderdale	FL	33308	N
182	201677120	Shullman, Howard B	12634 Pines Blvd	Pembroke Pines	FL	33027	Y
183	592343174	Llera, Antonio J	2607 Davie Blvd	Fort Lauderdale	FL	33312	N
184	048949574	Ghodsi, Shayan	9375 W Sample Rd	Coral Springs	FL	33065	Y
185	451484825	Friedland, Bryan J	4800 NE 20th Ter, Ste 215	Ft Lauderdale	FL	33308	Y
186	592530483	Ongley, B Linda	1945 N Pine Island Rd	Sunrise	FL	33322	Y
187	651021909	Romasan, Oana	1700 NE 26th St, Ste 1	Wilton Manors	FL	33305	Y
188	454337609	Bautista, Enrico S	1776 N Pine Island Rd, Ste 300	Plantation	FL	33322	Y
189	200185918	Rodriguez, Jorge A	11130 N Kendall Dr, Ste 202	Miami	FL	33176	Y
190	471565474	Fallah, Rouhollah	7100 W Commercial Blvd, Ste 108	Lauderhill	FL	33319	Y
191	454640768	Elliot, Jeffrey F	9600 W Sample Rd, Ste 504	Coral Springs	FL	33065	Y
192	471601631	Mingel, Marc A	6702 N University Dr	Tamarac	FL	33321	Y
193	901032331	Ochoa, Luis H	5740 Hollywood Blvd	Hollywood	FL	33021	Y
194	650601646	Porras, Edgar J	12251 Taft St, Ste 404	Pembroke Pines	FL	33026	Y
195	263005908	Spencer, Scott B	210 Jupiter Lakes Blvd, Bldg 5000 Ste 204	Jupiter	FL	33458	Y
196	650286174	Gorfinkel, Michael S	111 N Pine Island Rd, Ste 101	Plantation	FL	33324	Y
197	650879389	Klein, Mitchell J	7228 W Oakland Park Blvd	Lauderhill	FL	33313	Y
198	591290474	Ozga, Gary F	1296 S Federal Hwy	Pompano Beach	FL	33062	N
199	208754293	Roseff, Michael J	8784 Boynton Beach Blvd, Ste 103	Boynton Beach	FL	33472	Y
200	810671550	Aron, Robert S	1874 W Hillsboro Blvd	Deerfield Beach	FL	33442	Y
201	911891746	Cirtaut, Linda M	Po Box 13828	Mill Creek	WA	98082	N
202	592289312	Berry, Bryan W	800 E Broward Blvd Ste 410	Ft Lauderdale	FL	33301	N
203	650908498	Proano Wise, Nancy L	2600 W Flagler St	Miami	FL	33135	Y
204	200185918	Waldee, Kerry G	817 S University Dr, Suite 103	Plantation	FL	33324	Y
205	582407716	Yates, David W	2474 SE Federal Hwy	Stuart	FL	34994	N
206	650731323	Krimsky, Peter K	7408 NW 5th St	Plantation	FL	33317	Y
207	651007689	Rothfield, Elizabeth A	4601 Hollywood Blvd	Hollywood	FL	33021	Y
208	591614126	Barogiannis, Constantinos	2440 E Commercial Blvd	Fort Lauderdale	FL	33308	N
209	223868692	Oklin, Richard S	6805 Pembroke Rd	Hollywood	FL	33023	Y
210	651077289	Bennett, David A	10305 NW 41st St, Ste 207	Doral	FL	33178	Y
211	273480873	Anand, Payal M	2410 N University Dr	Coral Springs	FL	33065	Y
212	593694196	Huhn, Clete F	1100 S Orange Ave	Orlando	FL	32806	Y
213	650349658	Ziadie, Elizabeth T	9720 Stirling Rd, Ste 211	Cooper City	FL	33024	Y
214	650006275	Shiffman, Harvey S	8200 S Jog Rd, Ste 201	Boynton Beach	FL	33472	Y
215	461139956	Lekkas, Nick	2870 Ne 8th St	Homestead	FL	33033	Y
216	200185918	Hohimer Jr, David M	817 S University Dr Su	Plantation	FL	33324	Y
217	542079759	Kaufman, Robert H	4665 W Atlantic Ave	Delray Beach	FL	33445	N
218	650144056	Cohen, Jeffrey	4324 Forest Hill Blvd	West Palm Beach	FL	33406	Y
219	650854084	Meier, Scott F	500 University Blvd, Ste 112	Jupiter	FL	33458	Y
220	200010251	Marchetto, John J	1600 Town Center Blvd Ste A	Weston	FL	33326	N
221	592714865	Lunsford, Joseph L	6736 Forest Hill Blvd	Greenacres	FL	33413	N
222	260042734	Morrow, Richard S	1881 N University Dr, Ste 2012	Coral Springs	FL	33071	Y

City of Fort Lauderdale
Top 250 DPPO Providers
Claims Paid 1/1/2016 - 12/31/2016

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Indicate which of the listed providers is included in your company's proposed DPPO network and include a hard copay as well as an Excel file in your response.

Rank	Federal Employer ID	Name	Address	City	State	Zip	In Network? Yes or No
223	582592630	Reilly, James W	1150 Hammond Dr Ste 200	Atlanta	GA	30328	N
224	650642600	Darling, Steven G	8190 S Jog Rd, Ste 200	Boynton Beach	FL	33472	Y
225	591273519	Sands, James D	5890 Hallandale Beach Blvd	West Hollywood	FL	33023	Y
226	650481999	Wasserman, Alan G	22053 State Road 7	Boca Raton	FL	33428	Y
227	204132428	Saidi, Ardavan	119 Washington Ave, Suite 601	Miami Beach	FL	33139	Y
228	650719035	Starkman, Jeffrey A	11682B US Highway 1, Ste 60	Palm Beach Gardens	FL	33408	Y
229	010924720	Kocher, Jennifer C	7593 Boynton Beach Blvd, Ste 200	Boynton Beach	FL	33437	Y
230	205495196	Gomez Trainor, Sandra P	1740 E Commercial Blvd	Fort Lauderdale	FL	33334	Y
231	650019957	Epstein, Mitchell R	8430 W Broward Blvd, Ste 100	Plantation	FL	33324	Y
232	650721202	Vallejo, Freddy A	600 S Pine Island Rd, Suit #201	Plantation	FL	33324	Y
233	592135962	Walsh, Joseph C	2600 N Military Trl Ste 3	Boca Raton	FL	33431	N
234	264306631	Shults, Randall C	1200 Corporate Center Way, Suite 100	Wellington	FL	33414	Y
235	592303705	Patel, Jitendra L	4651 NW 31st Ave	Tamarac	FL	33309	Y
236	451797933	Zombek, Steven J	Emerald Hills Medical Squ, 4480 Sheridan St	Hollywood	FL	33021	N
237	830401313	Winton, Adam J	1201 E Sample Rd, Ste 101	Pompano Beach	FL	33064	Y
238	650981758	Stokesberry, Douglas A	9204 NE 6th Ave	Miami Shores	FL	33138	N
239	591967618	Lev, Robert J	8383 Pines Blvd	Pembroke Pines	FL	33024	Y
240	900923182	Fendrich, Laurence E	18431 Miramar Pkwy	Miramar	FL	33029	Y
241	461424382	Friedel, Lee M	1605 Town Center Blvd, Ste B	Weston	FL	33326	Y
242	471526151	Krohn, Mel R	7500 NW 5th St, Ste 105	Plantation	FL	33317	Y
243	650795660	Baghdassarian, Rosemary	1608 E Commercial Blvd	Oakland Park	FL	33334	Y
244	203965948	Sajoo, Sameer	3471 N Federal Hwy Ste 200	Fort Lauderdale	FL	33306	N
245	264745380	Blanco, Yamilet	800 E Merritt Island Cswy, Ste 105	Merritt Island	FL	32952	N
246	650962928	Eggnatz, Michael D	17190 Royal Palm Blvd, Suite #4	Weston	FL	33326	N
247	650796764	Desenze, Philip S	540 E McNab Rd, Ste E	Pompano Beach	FL	33060	N
248	592655484	Malik, Sawan K	1027 SE 17th St	Fort Lauderdale	FL	33316	Y
249	203404121	Ardalan, Amir R	374 SW Prima Vista Blvd.	Port St. Lucie	FL	34983	N
250	651131832	Martinez, Mario J	6601 SW 80th St Ste 212	Miami	FL	33143	Y
							187
						Cigna	75%

City of Fort Lauderdale
DHMO Top Providers Chosen by Subscriber Count

Company Name: Cigna Health and Life Insurance Company, Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Florida, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of Ohio, Inc., and Cigna Dental Health of Texas, Inc.

Indicate which of the listed DHMO providers is included in your company's proposed DHMO network and include a hard copy as well as an Excel sheet in your proposal.

	Tax ID	Facility	Address	City	State	Zip	In Network? Yes or No
1	30576792	TLC Dental East	3001 E Commercial Blvd	Fort Lauderdale	FL	33308	Y
2	592681987	Barnard, DDS, Michael	1209 W Broward Blvd	Ft Lauderdale	FL	33312	Y
3	650461148	Bayview Dental Associates PA	2826 E Oklnd Prk Blvd Ste 300	Ft Lauderdale	FL	33306	Y
4	650908498	Sage Dental of Plantation PA	8440 W Broward Blvd	Plantation	FL	33324	Y
5	591399832	Emerald Hills Dental Center	3856 Sheridan St	Hollywood	FL	33021	Y
6	731723037	Jacardanda Dental Associates	600 S Pine Island Rd Ste 201	Plantation	FL	33324	Y
7	462896556	True Original Smiles Inc	5863 N University Dr	Tamarac	FL	33321	N
8	30576797	TLC Dental North	7110 Southgate Blvd	N Lauderdale	FL	33068	Y
9	562315803	The Dental Group	2609 W Oakland Park Blvd	Ft Lauderdale	FL	33311	Y
10	650924956	Sage Dental of Pompano Beach P	1650 N Federal Hwy Ste 105	Pompano Beach	FL	33062	Y
11	263699117	Dr. Max A Zaslavsky	6451 N Federal Hwy	Ft Lauderdale	FL	33308	N
12	592530483	Ongley/Jacaranda Square Dent	1945 N Pine Island Rd	Sunrise	FL	33322	Y
13	271436445	Sage Dental of Cooper City PLL	12129 Sheridan St	Hollywood	FL	33026	Y
14	203993947	Jeremy Gerber DMD PA	1332 SE 17th St	Fort Lauderdale	FL	33316	Y
15	421650718	Stanton Dental Excellence	5400 N Federal Hwy Ste 101	Ft Lauderdale	FL	33308	Y
16	272813237	Sage Dental of Coral Springs P	987 N University Dr	Coral Springs	FL	33071	Y
17	650132415	Centre for the Dental Arts	648 NE 3rd Ave	Fort Lauderdale	FL	33304	N
18	650076718	Karpel, DDS, Joel	7193 W Oakland Park Blvd	Lauderhill	FL	33313	Y
19	471565474	Fresh Dental Smiles	7100 W Commercial Blvd Ste 108	Lauderhill	FL	33319	Y
20	203175411	Veneto Dental Care	3600 Red Rd Ste 604	Miramar	FL	33025	Y
21	263005908	Sage Dental of Coconut Creek P	5463 Lyons Rd Ste C	Coconut Creek	FL	33073	Y
22	650234930	Family Dental Associates	6130 W Atlantic Blvd Ste 4	Margate	FL	33063	Y
23	650129699	Plantation Dental Services	314 S University Dr	Plantation	FL	33324	Y
24	650467002	Dallas, DDS, Michele	620 NE 3rd St	Fort Lauderdale	FL	33301	N
25	650509660	Sunrise Intracoastal Dtl Ctr	900 NE 26th Ave Ste 200	Fort Lauderdale	FL	33304	Y
26	650043559	G & G Dental Associates	7030 NW 57th St	Tamarac	FL	33319	Y
27	271168262	Healthy Family Dentistry	5350 W Hillsboro Blvd Ste 201	Coconut Creek	FL	33073	N
28	203141319	James Kerns Dmd Pllc	6905 W Broward Blvd Ste 101	Plantation	FL	33317	Y
29	592549495	L G James DMD Professional	4101 S Hospital Dr Ste 4	Plantation	FL	33317	Y
30	30576799	TLC Dental Dania	435 E Sheridan St	Dania	FL	33004	Y
31	273480873	Coral Springs Smiles PA	2929 N University Dr Ste 203	Coral Springs	FL	33065	Y
32	650719035	Dental Health Grp II Pem Pines	140 S University Dr	Pembroke Pines	FL	33025	Y
33	592655484	Gentle Family Dentistry	10167 W Sunrise Blvd Ste 101	Plantation	FL	33322	Y
34	650322438	Mehler, DDS, Eric	7800 W Oaklnd Pk Blvd Ste 114	Sunrise	FL	33351	Y
35	474657069	Sage Dental Of Tamarac Pllc	5779 N University Dr	Tamarac	FL	33321	Y
36	205495196	Gomez Trainor, DDS PA, Sandra	1831 NE 45th St Ste A	Ft Lauderdale	FL	33308	N
37	591788725	Deerfield Dental Services	1800 W Hillsboro Blvd Ste 210	Deerfield Beach	FL	33442	Y
38	200171638	Dental Care Ctr of Hollywood	3900 Hollywood Blvd Ste 304	Hollywood	FL	33021	Y
39	471035515	Optum Dental Care Llc	1854 N Nob Hill Rd	Plantation	FL	33322	N
40	272808186	Sage Dental of Deerfield Beach	2265 W Hillsboro Blvd	Deerfield Bch	FL	33442	Y
41	650411776	Premiere Dental Care Center	17901 NW 5th St Ste 206	Pembroke Pines	FL	33029	Y
42	273944632	BL Dental Associates LLC	3233 Palm Ave	Hialeah	FL	33012	N
43	592665788	Pine, DDS, Philip A.	1600 E Atlantic Blvd Fl 2	Pompano Beach	FL	33060	Y
44	223967347	Tamarac Dental Associates	7351 W Oaklnd Pk Blvd Ste 102	Lauderhill	FL	33319	Y
45	352163655	Howard Finnk DDS PA	10071 Sunset Strip	Sunrise	FL	33322	Y
46	473696720	Sage Dental Of Downtown Fort L	551 N Federal Hwy Ste 900	Fort Lauderdale	FL	33301	Y
47	593508140	Coast Dental - Sebring	901 US Highway 27 N Ste 60	Sebring	FL	33870	Y
48	263394448	Gentle Dentistry of Tamarac	10151 W Commercial Blvd	Sunrise	FL	33351	Y
49	650456698	Graff, DMD, PA, Brad W.	3107 Stirling Rd Ste 108	Ft Lauderdale	FL	33312	N

Strong Matches	Submitted Info	Cigna DHMO Results	
		Matched Info	% Match
# of Provider Access Points	49	40	82%

Strong Matches	Submitted Info	Humana DPPO		Cigna DPPO Advantage	
		Matched Info	% Match	Matched Info	% Matched
# of Provider Access Points	250	168	67%	188	75%
Service Units	10451	7886	75%	7975	76%
Amount Paid	739533	513966	69%	543097	73%

Note:

Cigna is matching 75% of all DPPO Providers used by the City of Fort Lauderdale.

Cigna Network Analysis

Cigna DHMO

Created for...

City of Fort Lauderdale

March 2017

Access Summary for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

[1] Provider counts represent:
#: Provider access points

Employees With Access

Employee		Provider		With Access		Counts[1]	Average Distance	
Name	#	Name	Standard	#	%	#	1	2
All Employees	282	Open General Dentists	2 in 5 miles	227	80.5	7,057	1.0	1.4
		All Specialists	2 in 5 miles	234	83.0	11,819	1.2	1.6

Key Geographic Areas

State Name	City	Employee	Provider		With Access		Counts[1]	Average Distance	
		#	Name	Standard	#	%	#	1	2
Florida	Fort Lauderdale	124	All Specialists	2 in 5 miles	124	100.0	125	1.2	1.5
			Open General Dentists	2 in 5 miles	124	100.0	80	0.9	1.2
	Pompano Beach	33	All Specialists	2 in 5 miles	33	100.0	72	1.0	1.2
			Open General Dentists	2 in 5 miles	33	100.0	37	0.7	1.1
	Hollywood	9	All Specialists	2 in 5 miles	9	100.0	70	1.1	1.2
			Open General Dentists	2 in 5 miles	9	100.0	39	0.7	0.9
	Dania	8	All Specialists	2 in 5 miles	8	100.0	2	1.0	1.0
			Open General Dentists	2 in 5 miles	8	100.0	1	0.5	1.2
	Port Saint Lucie	6	All Specialists	2 in 5 miles	6	100.0	16	1.7	2.6
	West Palm Beach	6	All Specialists	2 in 5 miles	6	100.0	25	1.8	1.8
			Open General Dentists	2 in 5 miles	6	100.0	24	1.6	2.1
	Port Saint Lucie	6	Open General Dentists	2 in 5 miles	5	83.3	8	1.9	3.2
	Miami	4	All Specialists	2 in 5 miles	4	100.0	169	0.7	1.1
			Open General Dentists	2 in 5 miles	4	100.0	140	0.5	1.0
	Deerfield Beach	3	All Specialists	2 in 5 miles	3	100.0	9	0.6	1.7
			Open General Dentists	2 in 5 miles	3	100.0	4	0.6	1.4
	Boynton Beach	2	All Specialists	2 in 5 miles	2	100.0	20	0.7	0.9
	Lake Worth	2	All Specialists	2 in 5 miles	2	100.0	17	2.1	2.3
	Tavares	2	All Specialists	2 in 5 miles	2	100.0	0	3.4	3.4
	Boynton Beach	2	Open General Dentists	2 in 5 miles	2	100.0	8	0.9	1.0
	Lake Worth	2	Open General Dentists	2 in 5 miles	2	100.0	10	1.8	2.0
	Jupiter	4	All Specialists	2 in 5 miles	1	25.0	26	0.8	1.0
			Open General Dentists	2 in 5 miles	1	25.0	9	0.8	1.0
	Lady Lake	2	All Specialists	2 in 5 miles	1	50.0	0	1.1	3.6
	Vero Beach	2	All Specialists	2 in 5 miles	1	50.0	4	0.5	1.4
	Inverness	2	Open General Dentists	2 in 5 miles	1	50.0	2	4.3	4.4
	Lady Lake	2	Open General Dentists	2 in 5 miles	1	50.0	1	0.7	3.6
	Tavares	2	Open General Dentists	2 in 5 miles	1	50.0	0	2.9	4.4
	Vero Beach	2	Open General Dentists	2 in 5 miles	1	50.0	2	3.0	3.1
	Boca Raton	1	All Specialists	2 in 5 miles	1	100.0	33	0.9	1.8
	Clermont	1	All Specialists	2 in 5 miles	1	100.0	13	0.9	0.9
	Daytona Beach	1	All Specialists	2 in 5 miles	1	100.0	8	1.9	2.1
	Deland	1	All Specialists	2 in 5 miles	1	100.0	5	2.0	3.8
	Delray Beach	1	All Specialists	2 in 5 miles	1	100.0	23	0.8	0.8

Access Summary for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

[1] Provider counts represent:
#: Provider access points

Employees Without Access

Employee		Provider		Without Access		Counts[1]	Average Distance	
Name	#	Name	Standard	#	%	#	1	2
All Employees	282	Open General Dentists	2 in 5 miles	55	19.5	7,057	15.0	20.7
		All Specialists	2 in 5 miles	48	17.0	11,819	18.0	24.2

Key Geographic Areas

State Name	City	Employee	Provider		Without Access		Counts[1]	Average Distance	
		#	Name	Standard	#	%	#	1	2
Florida	Jupiter	4	All Specialists	2 in 5 miles	3	75.0	26	6.5	6.6
			Open General Dentists	2 in 5 miles	3	75.0	9	6.6	7.3
	Lake Placid	3	All Specialists	2 in 5 miles	3	100.0	1	1.4	13.9
			Open General Dentists	2 in 5 miles	3	100.0	0	15.7	21.7
	Hobe Sound	2	All Specialists	2 in 5 miles	2	100.0	0	5.3	7.2
	Inverness	2	All Specialists	2 in 5 miles	2	100.0	0	10.7	15.8
	Live Oak	2	All Specialists	2 in 5 miles	2	100.0	0	30.9	59.1
Georgia	Sautee Nacoochee	2	All Specialists	2 in 5 miles	2	100.0	0	26.1	26.1
Florida	Hobe Sound	2	Open General Dentists	2 in 5 miles	2	100.0	0	5.3	7.2
	Live Oak	2	Open General Dentists	2 in 5 miles	2	100.0	0	31.0	40.7
Georgia	Sautee Nacoochee	2	Open General Dentists	2 in 5 miles	2	100.0	0	25.9	26.1
Florida	Port Saint Lucie	6	Open General Dentists	2 in 5 miles	1	16.7	8	3.4	5.8
	Lady Lake	2	All Specialists	2 in 5 miles	1	50.0	0	2.3	5.6
	Vero Beach	2	All Specialists	2 in 5 miles	1	50.0	4	5.1	5.1
	Inverness	2	Open General Dentists	2 in 5 miles	1	50.0	2	5.3	5.4
	Lady Lake	2	Open General Dentists	2 in 5 miles	1	50.0	1	2.1	5.6
	Tavares	2	Open General Dentists	2 in 5 miles	1	50.0	0	3.8	5.6
	Vero Beach	2	Open General Dentists	2 in 5 miles	1	50.0	2	4.9	5.9
Alabama	Albertville	1	All Specialists	2 in 5 miles	1	100.0	0	22.3	52.5
Arizona	Tucson	1	All Specialists	2 in 5 miles	1	100.0	71	6.3	6.3
Florida	Astor	1	All Specialists	2 in 5 miles	1	100.0	0	19.2	19.2
	Bronson	1	All Specialists	2 in 5 miles	1	100.0	0	15.0	18.2
	Chipley	1	All Specialists	2 in 5 miles	1	100.0	0	20.1	33.1
	Fernandina Beach	1	All Specialists	2 in 5 miles	1	100.0	1	0.2	17.8
	Hernando	1	All Specialists	2 in 5 miles	1	100.0	0	7.0	12.0
	Jacksonville	1	All Specialists	2 in 5 miles	1	100.0	62	5.6	5.6
	New Smyrna Beach	1	All Specialists	2 in 5 miles	1	100.0	0	9.9	10.0
	Okeechobee	1	All Specialists	2 in 5 miles	1	100.0	0	24.9	24.9
	Palm Bay	1	All Specialists	2 in 5 miles	1	100.0	4	5.1	5.1
	Summerfield	1	All Specialists	2 in 5 miles	1	100.0	0	5.2	5.3
	Tallahassee	1	All Specialists	2 in 5 miles	1	100.0	7	3.3	5.5
	Tavernier	1	All Specialists	2 in 5 miles	1	100.0	0	32.9	32.9
Georgia	Augusta	1	All Specialists	2 in 5 miles	1	100.0	1	6.7	10.6
	Blairsville	1	All Specialists	2 in 5 miles	1	100.0	0	35.1	35.5

Accessibility Overview

Access Overview for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Employees - Open General Dentists

Employee Group
All Employees

Office Group
Open General Dentists

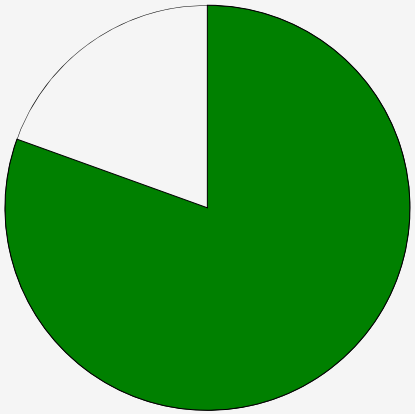
Comparison Graph
Percent of employees with access to a choice of offices over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (All Employees) employees accessing:
2 (Open General Dentists) offices in 5 miles

Overall Access[1]

282 Employees
7,057 offices at 6,942 locations (Open General Dentists)

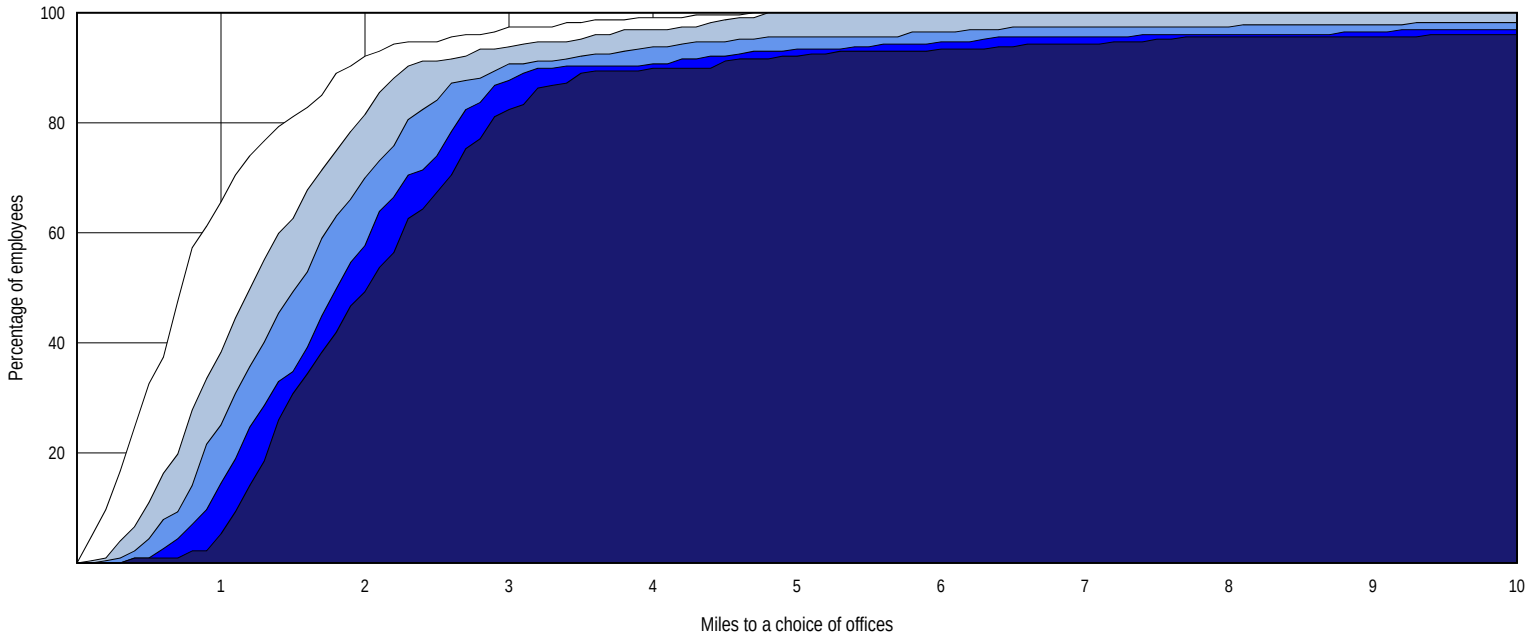
227 (80.5%) Employees with access



Distances

	Minimum	Average	Maximum
Distance to 1st closest office	0.0 mile	1.0 mile	4.7 miles
Distance to 2nd closest office	0.1 mile	1.4 miles	4.8 miles
Distance to 3rd closest office	0.2 mile	2.0 miles	19.1 miles
Distance to 4th closest office	0.4 mile	2.5 miles	19.9 miles
Distance to 5th closest office	0.4 mile	2.9 miles	24.6 miles

Access Standard Comparison



Access Overview for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Employees - Open General Dentists

Employee Group
All Employees

Office Group
Open General Dentists

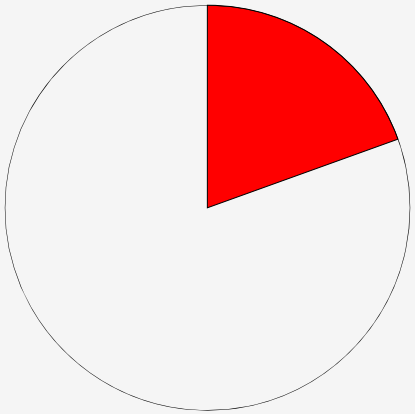
Comparison Graph
Percent of employees with access to a choice of offices over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (All Employees) employees accessing:
2 (Open General Dentists) offices in 5 miles

Overall Access[1]

282 Employees
7,057 offices at 6,942 locations (Open General Dentists)

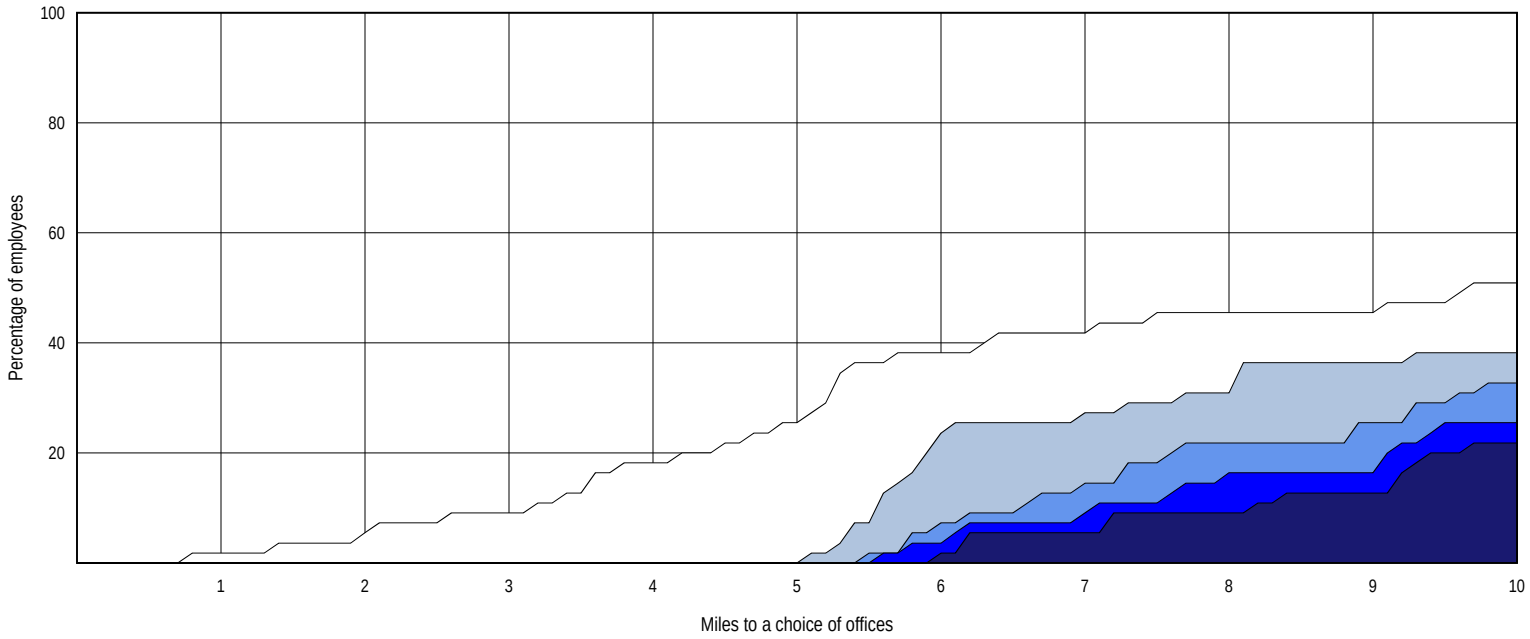
55 (19.5%) Employees without access



Distances

	Minimum	Average	Maximum
Distance to 1st closest office	0.8 mile	15.0 miles	62.0 miles
Distance to 2nd closest office	5.1 miles	20.7 miles	79.1 miles
Distance to 3rd closest office	5.5 miles	26.8 miles	81.6 miles
Distance to 4th closest office	5.6 miles	31.1 miles	93.0 miles
Distance to 5th closest office	6.0 miles	33.9 miles	107.6 miles

Access Standard Comparison



Access Overview for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Employees - All Specialists

Employee Group
All Employees

Office Group
All Specialists

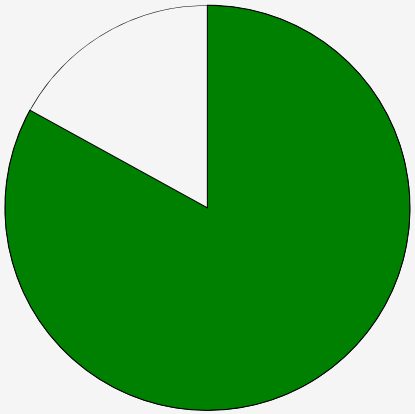
Comparison Graph
Percent of employees with access to a choice of offices over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (All Employees) employees accessing:
2 (All Specialists) offices in 5 miles

Overall Access[1]

282 Employees
11,819 offices at 7,123 locations (All Specialists)

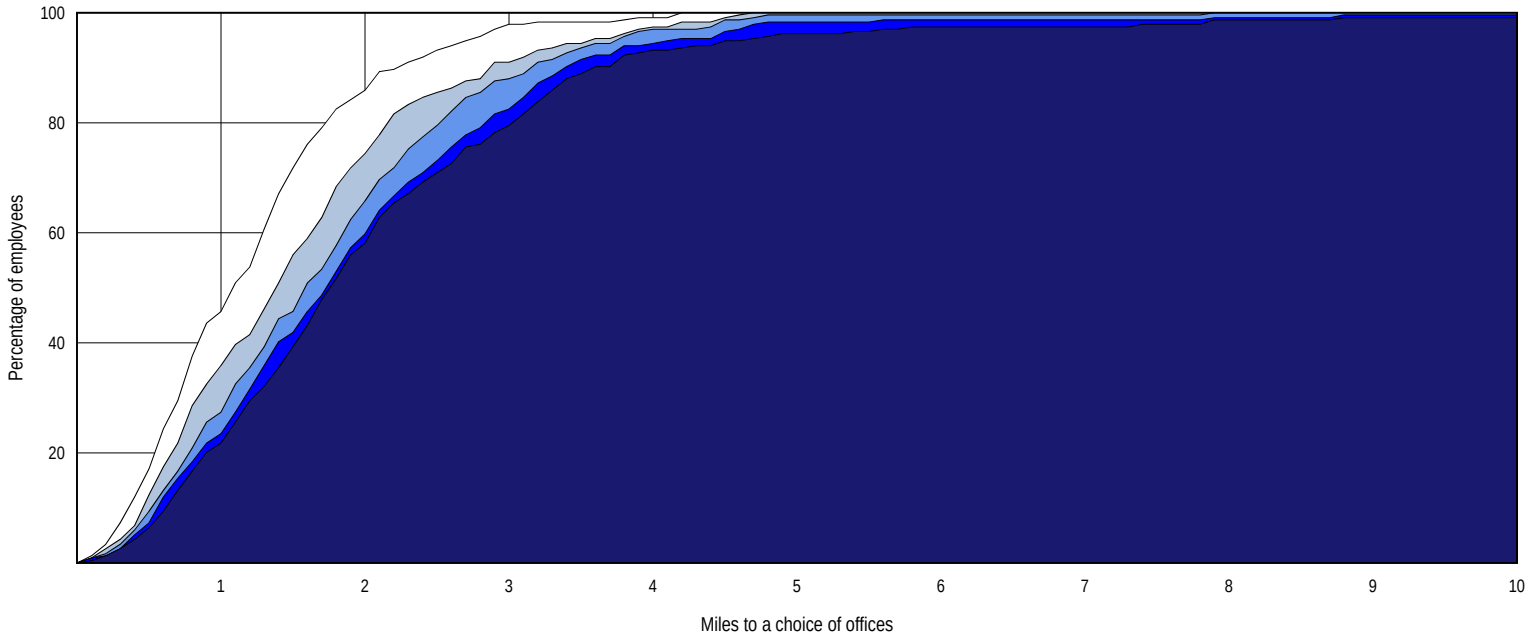
234 (83.0%) Employees with access



Distances

	Minimum	Average	Maximum
Distance to 1st closest office	0.1 mile	1.2 miles	4.2 miles
Distance to 2nd closest office	0.1 mile	1.6 miles	4.7 miles
Distance to 3rd closest office	0.1 mile	1.8 miles	7.9 miles
Distance to 4th closest office	0.1 mile	2.0 miles	13.6 miles
Distance to 5th closest office	0.1 mile	2.2 miles	13.7 miles

Access Standard Comparison



Access Overview for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Employees - All Specialists

Employee Group
All Employees

Office Group
All Specialists

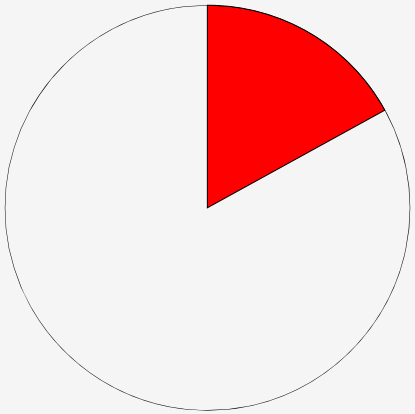
Comparison Graph
Percent of employees with access to a choice of offices over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (All Employees) employees accessing:
2 (All Specialists) offices in 5 miles

Overall Access[1]

282 Employees
11,819 offices at 7,123 locations (All Specialists)

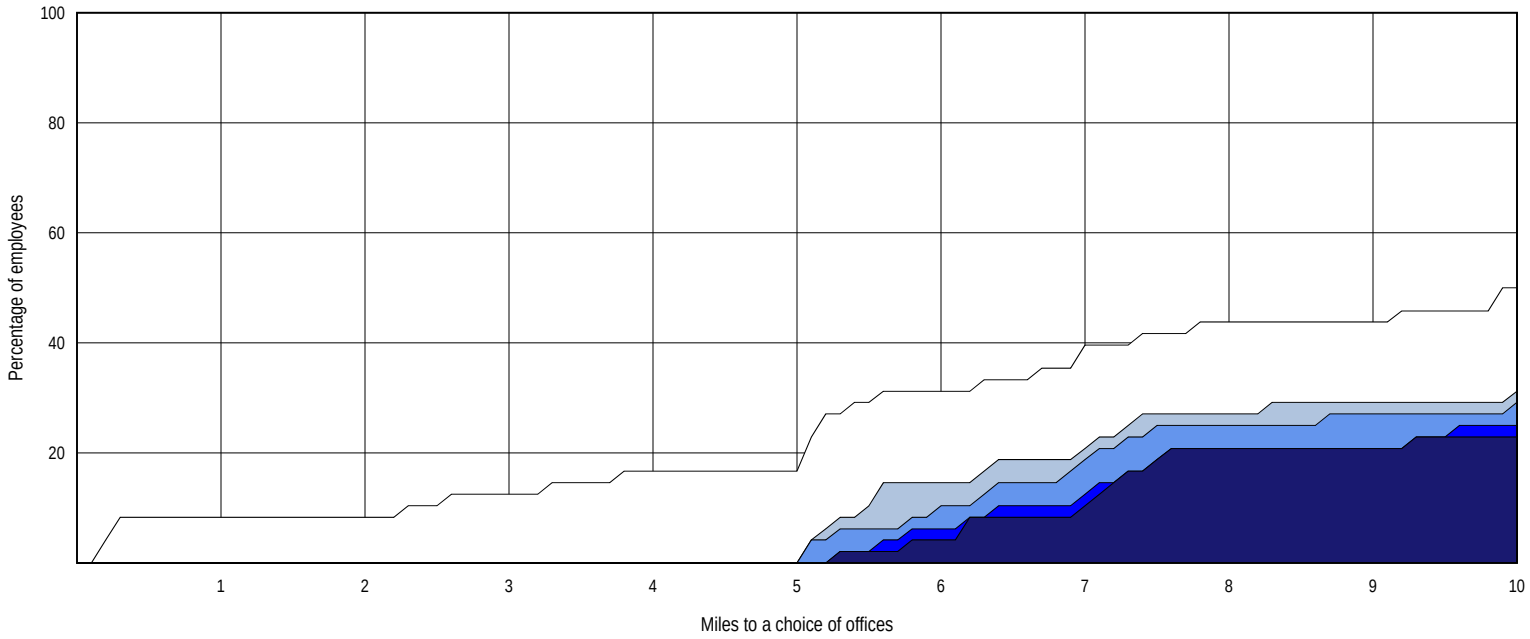
48 (17.0%) Employees without access



Distances

	Minimum	Average	Maximum
Distance to 1st closest office	0.2 mile	18.0 miles	72.9 miles
Distance to 2nd closest office	5.1 miles	24.2 miles	88.9 miles
Distance to 3rd closest office	5.1 miles	26.1 miles	89.6 miles
Distance to 4th closest office	5.3 miles	29.3 miles	90.7 miles
Distance to 5th closest office	5.3 miles	31.4 miles	93.0 miles

Access Standard Comparison



Accessibility Detail

Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee #	Provider Name	Provider Standard	Provider #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Boca Raton	33428	1	Open General Dentists	2 in 5 miles	2	1	100.0	0.3	1.4
				All Specialists	2 in 5 miles	1	1	100.0	0.9	1.8
	Boynton Beach	33435	1	Open General Dentists	2 in 5 miles	2	1	100.0	0.7	0.9
				All Specialists	2 in 5 miles	5	1	100.0	0.7	0.7
		33436	1	Open General Dentists	2 in 5 miles	0	1	100.0	1.0	1.1
				All Specialists	2 in 5 miles	3	1	100.0	0.6	1.0
	Clermont	34711	1	Open General Dentists	2 in 5 miles	3	1	100.0	0.2	1.1
				All Specialists	2 in 5 miles	13	1	100.0	0.9	0.9
	Dania	33004	8	Open General Dentists	2 in 5 miles	1	8	100.0	0.5	1.2
				All Specialists	2 in 5 miles	2	8	100.0	1.0	1.0
	Daytona Beach	32118	1	Open General Dentists	2 in 5 miles	0	1	100.0	1.7	2.7
				All Specialists	2 in 5 miles	1	1	100.0	1.9	2.1
	Deerfield Beach	33441	2	Open General Dentists	2 in 5 miles	2	2	100.0	0.6	1.7
				All Specialists	2 in 5 miles	1	2	100.0	0.6	2.3
		33442	1	Open General Dentists	2 in 5 miles	2	1	100.0	0.6	0.8
				All Specialists	2 in 5 miles	8	1	100.0	0.6	0.6
	Deland	32724	1	Open General Dentists	2 in 5 miles	1	1	100.0	2.0	3.8
				All Specialists	2 in 5 miles	1	1	100.0	2.0	3.8
	Delray Beach	33444	1	Open General Dentists	2 in 5 miles	1	1	100.0	0.8	0.9
				All Specialists	2 in 5 miles	3	1	100.0	0.8	0.8
	Estero	33928	1	Open General Dentists	2 in 5 miles	1	1	100.0	2.6	4.6
				All Specialists	2 in 5 miles	0	1	100.0	2.9	4.6
	Fleming Island	32003	1	Open General Dentists	2 in 5 miles	4	1	100.0	0.5	0.8
				All Specialists	2 in 5 miles	11	1	100.0	0.5	0.5
	Fort Lauderdale	33301	2	Open General Dentists	2 in 5 miles	1	2	100.0	0.3	0.9
				All Specialists	2 in 5 miles	8	2	100.0	0.3	0.3
		33304	4	Open General Dentists	2 in 5 miles	2	4	100.0	0.6	1.0
				All Specialists	2 in 5 miles	1	4	100.0	0.6	1.1
		33305	6	Open General Dentists	2 in 5 miles	0	6	100.0	1.3	1.6
				All Specialists	2 in 5 miles	2	6	100.0	0.7	0.8
		33306	3	Open General Dentists	2 in 5 miles	1	3	100.0	0.4	0.6
				All Specialists	2 in 5 miles	3	3	100.0	0.2	0.4
		33308	6	Open General Dentists	2 in 5 miles	8	6	100.0	0.3	0.4
				All Specialists	2 in 5 miles	18	6	100.0	0.4	0.4
		33309	7	Open General Dentists	2 in 5 miles	1	7	100.0	0.9	1.5
				All Specialists	2 in 5 miles	0	7	100.0	2.2	2.9
		33311	23	Open General Dentists	2 in 5 miles	2	23	100.0	1.0	1.4
				All Specialists	2 in 5 miles	0	23	100.0	1.4	1.6
		33312	10	Open General Dentists	2 in 5 miles	1	10	100.0	1.7	1.9
				All Specialists	2 in 5 miles	1	10	100.0	1.7	2.1

Continued on next page...

Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee #	Provider Name	Provider Standard	Provider #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Fort Lauderdale	33313	5	Open General Dentists	2 in 5 miles	8	5	100.0	0.7	0.8
				All Specialists	2 in 5 miles	1	5	100.0	1.2	1.7
		33314	1	Open General Dentists	2 in 5 miles	0	1	100.0	2.0	2.1
				All Specialists	2 in 5 miles	1	1	100.0	1.5	2.0
		33315	4	Open General Dentists	2 in 5 miles	0	4	100.0	1.6	1.8
				All Specialists	2 in 5 miles	0	4	100.0	2.7	2.9
		33316	2	Open General Dentists	2 in 5 miles	3	2	100.0	0.4	0.6
				All Specialists	2 in 5 miles	0	2	100.0	1.4	1.9
		33317	7	Open General Dentists	2 in 5 miles	6	7	100.0	1.1	1.2
				All Specialists	2 in 5 miles	12	7	100.0	1.2	1.3
		33319	5	Open General Dentists	2 in 5 miles	6	5	100.0	0.9	1.0
				All Specialists	2 in 5 miles	4	5	100.0	1.2	1.3
		33321	9	Open General Dentists	2 in 5 miles	3	9	100.0	0.6	1.3
				All Specialists	2 in 5 miles	9	9	100.0	1.0	1.0
		33322	2	Open General Dentists	2 in 5 miles	5	2	100.0	0.4	0.6
				All Specialists	2 in 5 miles	11	2	100.0	0.7	0.7
		33323	3	Open General Dentists	2 in 5 miles	5	3	100.0	0.7	1.0
				All Specialists	2 in 5 miles	9	3	100.0	1.1	1.1
		33324	4	Open General Dentists	2 in 5 miles	11	4	100.0	0.6	1.1
				All Specialists	2 in 5 miles	18	4	100.0	1.1	1.3
		33325	1	Open General Dentists	2 in 5 miles	1	1	100.0	1.0	1.8
				All Specialists	2 in 5 miles	1	1	100.0	1.1	2.2
		33326	2	Open General Dentists	2 in 5 miles	4	2	100.0	1.2	1.6
				All Specialists	2 in 5 miles	11	2	100.0	1.1	1.4
		33328	3	Open General Dentists	2 in 5 miles	4	3	100.0	0.8	1.0
				All Specialists	2 in 5 miles	7	3	100.0	0.8	0.9
		33334	8	Open General Dentists	2 in 5 miles	1	8	100.0	0.8	1.2
				All Specialists	2 in 5 miles	0	8	100.0	1.0	1.1
		33345	1	Open General Dentists	2 in 5 miles	0	1	100.0	0.7	1.1
				All Specialists	2 in 5 miles	0	1	100.0	1.4	1.9
		33351	6	Open General Dentists	2 in 5 miles	4	6	100.0	0.4	1.0
				All Specialists	2 in 5 miles	1	6	100.0	1.3	1.7
	Fort Myers	33901	1	Open General Dentists	2 in 5 miles	1	1	100.0	1.3	2.4
				All Specialists	2 in 5 miles	3	1	100.0	1.3	1.3
	Fort Pierce	34949	1	All Specialists	2 in 5 miles	0	1	100.0	4.2	4.5
	Gainesville	32606	1	Open General Dentists	2 in 5 miles	0	1	100.0	1.5	1.7
				All Specialists	2 in 5 miles	1	1	100.0	1.3	1.5
	Hallandale	33009	1	Open General Dentists	2 in 5 miles	3	1	100.0	0.1	0.9
				All Specialists	2 in 5 miles	9	1	100.0	0.9	0.9
	Hernando	34442	1	Open General Dentists	2 in 5 miles	0	1	100.0	4.7	4.8

Continued on next page...

Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee #	Provider Name	Provider Standard	Provider #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Hollywood	33019	1	Open General Dentists	2 in 5 miles	0	1	100.0	1.6	2.0
				All Specialists	2 in 5 miles	0	1	100.0	1.8	1.8
		33020	2	Open General Dentists	2 in 5 miles	5	2	100.0	0.2	0.4
				All Specialists	2 in 5 miles	3	2	100.0	1.4	1.7
		33021	3	Open General Dentists	2 in 5 miles	6	3	100.0	0.8	0.8
				All Specialists	2 in 5 miles	8	3	100.0	0.8	0.8
		33022	1	Open General Dentists	2 in 5 miles	0	1	100.0	0.2	0.5
				All Specialists	2 in 5 miles	0	1	100.0	1.4	1.4
		33029	1	Open General Dentists	2 in 5 miles	4	1	100.0	0.7	1.2
				All Specialists	2 in 5 miles	5	1	100.0	0.7	0.7
		33081	1	Open General Dentists	2 in 5 miles	0	1	100.0	1.3	1.3
				All Specialists	2 in 5 miles	0	1	100.0	0.8	1.3
	Indialantic	32903	1	All Specialists	2 in 5 miles	0	1	100.0	2.8	4.7
	Inverness	34452	1	Open General Dentists	2 in 5 miles	0	1	100.0	4.3	4.4
	Jupiter	33458	1	Open General Dentists	2 in 5 miles	5	1	100.0	0.8	1.0
				All Specialists	2 in 5 miles	22	1	100.0	0.8	1.0
	Lady Lake	32159	2	Open General Dentists	2 in 5 miles	1	1	50.0	0.7	3.6
				All Specialists	2 in 5 miles	0	1	50.0	1.1	3.6
	Lake Mary	32746	1	Open General Dentists	2 in 5 miles	4	1	100.0	0.2	1.0
				All Specialists	2 in 5 miles	7	1	100.0	0.2	0.2
	Lake Worth	33467	2	Open General Dentists	2 in 5 miles	2	2	100.0	1.8	2.0
				All Specialists	2 in 5 miles	6	2	100.0	2.1	2.3
	Lakeland	33809	1	All Specialists	2 in 5 miles	5	1	100.0	2.6	2.6
	Miami	33157	1	Open General Dentists	2 in 5 miles	5	1	100.0	0.7	1.6
				All Specialists	2 in 5 miles	3	1	100.0	0.7	1.5
		33169	1	Open General Dentists	2 in 5 miles	1	1	100.0	0.2	1.3
				All Specialists	2 in 5 miles	1	1	100.0	1.2	1.9
		33179	1	Open General Dentists	2 in 5 miles	4	1	100.0	0.5	0.6
				All Specialists	2 in 5 miles	8	1	100.0	0.6	0.6
		33189	1	Open General Dentists	2 in 5 miles	3	1	100.0	0.4	0.6
				All Specialists	2 in 5 miles	9	1	100.0	0.4	0.4
	Ocala	34478	1	Open General Dentists	2 in 5 miles	0	1	100.0	1.8	2.0
				All Specialists	2 in 5 miles	0	1	100.0	1.3	1.8
	Pensacola	32514	1	All Specialists	2 in 5 miles	0	1	100.0	3.9	3.9
	Pompano Beach	33060	3	Open General Dentists	2 in 5 miles	3	3	100.0	0.3	1.0
				All Specialists	2 in 5 miles	5	3	100.0	1.0	1.0
		33062	4	Open General Dentists	2 in 5 miles	3	4	100.0	0.4	0.5
				All Specialists	2 in 5 miles	5	4	100.0	0.9	0.9
		33063	8	Open General Dentists	2 in 5 miles	6	8	100.0	0.5	0.8
				All Specialists	2 in 5 miles	3	8	100.0	1.0	1.0

Continued on next page...

Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee #	Provider Name	Provider Standard	Provider #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Pompano Beach	33064	4	Open General Dentists	2 in 5 miles	1	4	100.0	1.4	2.0
				All Specialists	2 in 5 miles	1	4	100.0	1.1	2.0
		33065	2	Open General Dentists	2 in 5 miles	5	2	100.0	0.6	0.9
				All Specialists	2 in 5 miles	9	2	100.0	0.3	0.5
		33066	2	Open General Dentists	2 in 5 miles	1	2	100.0	0.7	1.2
				All Specialists	2 in 5 miles	0	2	100.0	1.7	1.8
		33067	1	Open General Dentists	2 in 5 miles	5	1	100.0	0.6	1.3
				All Specialists	2 in 5 miles	11	1	100.0	1.4	1.5
		33068	5	Open General Dentists	2 in 5 miles	1	5	100.0	0.9	1.3
				All Specialists	2 in 5 miles	2	5	100.0	1.0	1.0
		33069	2	Open General Dentists	2 in 5 miles	0	2	100.0	1.5	2.3
				All Specialists	2 in 5 miles	1	2	100.0	1.5	3.0
		33071	2	Open General Dentists	2 in 5 miles	5	2	100.0	0.4	0.6
				All Specialists	2 in 5 miles	16	2	100.0	0.6	0.6
	Port Saint Lucie	34953	3	Open General Dentists	2 in 5 miles	1	2	66.7	1.5	3.8
				All Specialists	2 in 5 miles	1	3	100.0	1.7	3.2
		34983	1	Open General Dentists	2 in 5 miles	0	1	100.0	2.1	2.1
				All Specialists	2 in 5 miles	0	1	100.0	1.6	1.9
		34984	1	Open General Dentists	2 in 5 miles	0	1	100.0	1.0	3.0
				All Specialists	2 in 5 miles	1	1	100.0	2.2	3.1
		34987	1	Open General Dentists	2 in 5 miles	0	1	100.0	3.4	3.5
				All Specialists	2 in 5 miles	2	1	100.0	1.3	1.3
	Saint Augustine	32086	1	Open General Dentists	2 in 5 miles	1	1	100.0	1.4	3.6
				All Specialists	2 in 5 miles	3	1	100.0	1.4	1.4
	Seminole	33776	1	Open General Dentists	2 in 5 miles	0	1	100.0	3.6	3.8
				All Specialists	2 in 5 miles	1	1	100.0	0.3	1.8
	Stuart	34994	1	Open General Dentists	2 in 5 miles	5	1	100.0	0.3	1.4
				All Specialists	2 in 5 miles	15	1	100.0	0.3	0.8
	Tavares	32778	2	Open General Dentists	2 in 5 miles	0	1	50.0	2.9	4.4
				All Specialists	2 in 5 miles	0	2	100.0	3.4	3.4
	Vero Beach	32964	1	Open General Dentists	2 in 5 miles	0	1	100.0	3.0	3.1
				All Specialists	2 in 5 miles	0	1	100.0	0.5	1.4
	Wellington	33414	1	Open General Dentists	2 in 5 miles	8	1	100.0	0.8	1.4
				All Specialists	2 in 5 miles	22	1	100.0	1.3	1.3
	West Palm Beach	33411	6	Open General Dentists	2 in 5 miles	4	6	100.0	1.6	2.1
				All Specialists	2 in 5 miles	7	6	100.0	1.8	1.8
Georgia	Atlanta	30342	1	Open General Dentists	2 in 5 miles	1	1	100.0	0.4	2.2
				All Specialists	2 in 5 miles	2	1	100.0	1.1	2.0
	Powder Springs	30127	1	All Specialists	2 in 5 miles	0	1	100.0	2.4	2.9
Kentucky	Georgetown	40324	1	All Specialists	2 in 5 miles	3	1	100.0	0.8	1.5

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Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee #	Provider Name	Provider Standard	Provider #	With Access #	With Access %	Average Distance 1	Average Distance 2
New Jersey	Bloomingdale	07403	1	All Specialists	2 in 5 miles	0	1	100.0	2.1	4.0
New York	Jamaica	11432	1	Open General Dentists	2 in 5 miles	10	1	100.0	0.1	0.3
				All Specialists	2 in 5 miles	6	1	100.0	0.4	0.4
Ohio	Painesville	44077	1	Open General Dentists	2 in 5 miles	0	1	100.0	3.9	4.5
				All Specialists	2 in 5 miles	1	1	100.0	3.2	4.5
Tennessee	Hermitage	37076	1	Open General Dentists	2 in 5 miles	1	1	100.0	1.7	2.1
				All Specialists	2 in 5 miles	3	1	100.0	0.4	1.7
	Knoxville	37918	1	Open General Dentists	2 in 5 miles	2	1	100.0	0.8	2.2
				All Specialists	2 in 5 miles	1	1	100.0	1.5	4.2
Texas	Arlington	76001	1	Open General Dentists	2 in 5 miles	0	1	100.0	2.2	2.6
				All Specialists	2 in 5 miles	1	1	100.0	1.1	1.8
	Austin	78730	1	Open General Dentists	2 in 5 miles	0	1	100.0	3.4	4.2
				All Specialists	2 in 5 miles	0	1	100.0	4.2	4.2
	Missouri City	77459	1	Open General Dentists	2 in 5 miles	4	1	100.0	0.4	0.8
				All Specialists	2 in 5 miles	16	1	100.0	0.4	0.4
Washington	Bothell	98012	1	Open General Dentists	2 in 5 miles	0	1	100.0	3.0	3.2
				All Specialists	2 in 5 miles	1	1	100.0	1.4	3.2
Grand Totals			230	Open General Dentists		207	227	98.7	1.0	1.5
			235	All Specialists		396	234	99.6	1.3	1.6

Access Detail for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

Employees Without Access

State Name	City	Zip Code	Employee	Provider			Without Access		Average Distance	
			#	Name	Standard	#	#	%	1	2
Alabama	Albertville	35951	1	Open General Dentists	2 in 5 miles	0	1	100.0	23.0	25.3
				All Specialists	2 in 5 miles	0	1	100.0	22.3	52.5
Arizona	Tucson	85739	1	Open General Dentists	2 in 5 miles	0	1	100.0	6.3	12.1
				All Specialists	2 in 5 miles	0	1	100.0	6.3	6.3
Florida	Astor	32102	1	Open General Dentists	2 in 5 miles	0	1	100.0	19.2	19.7
				All Specialists	2 in 5 miles	0	1	100.0	19.2	19.2
	Bronson	32621	1	Open General Dentists	2 in 5 miles	0	1	100.0	18.1	18.7
				All Specialists	2 in 5 miles	0	1	100.0	15.0	18.2
	Chipley	32428	1	Open General Dentists	2 in 5 miles	0	1	100.0	36.1	39.4
				All Specialists	2 in 5 miles	0	1	100.0	20.1	33.1
	Fernandina Beach	32034	1	Open General Dentists	2 in 5 miles	0	1	100.0	14.3	14.7
				All Specialists	2 in 5 miles	1	1	100.0	0.2	17.8
	Fort Pierce	34949	1	Open General Dentists	2 in 5 miles	0	1	100.0	4.5	10.8
	Hernando	34442	1	All Specialists	2 in 5 miles	0	1	100.0	7.0	12.0
	Hobe Sound	33455	2	Open General Dentists	2 in 5 miles	0	2	100.0	5.3	7.2
				All Specialists	2 in 5 miles	0	2	100.0	5.3	7.2
	Indialantic	32903	1	Open General Dentists	2 in 5 miles	0	1	100.0	4.7	6.0
	Inverness	34450	1	Open General Dentists	2 in 5 miles	0	1	100.0	5.3	5.4
				All Specialists	2 in 5 miles	0	1	100.0	11.5	16.4
		34452	1	All Specialists	2 in 5 miles	0	1	100.0	9.9	15.1
	Jacksonville	32221	1	Open General Dentists	2 in 5 miles	1	1	100.0	3.2	5.6
				All Specialists	2 in 5 miles	0	1	100.0	5.6	5.6
	Jupiter	33478	3	Open General Dentists	2 in 5 miles	0	3	100.0	6.6	7.3
				All Specialists	2 in 5 miles	0	3	100.0	6.5	6.6
	Lady Lake	32159	2	Open General Dentists	2 in 5 miles	1	1	50.0	2.1	5.6
				All Specialists	2 in 5 miles	0	1	50.0	2.3	5.6
	Lake Placid	33852	3	Open General Dentists	2 in 5 miles	0	3	100.0	15.7	21.7
				All Specialists	2 in 5 miles	1	3	100.0	1.4	13.9
	Lakeland	33809	1	Open General Dentists	2 in 5 miles	1	1	100.0	2.6	8.1
	Live Oak	32060	2	Open General Dentists	2 in 5 miles	0	2	100.0	31.0	40.7
				All Specialists	2 in 5 miles	0	2	100.0	30.9	59.1
	New Smyrna Beac	32169	1	Open General Dentists	2 in 5 miles	0	1	100.0	10.9	10.9
				All Specialists	2 in 5 miles	0	1	100.0	9.9	10.0
	Okeechobee	34974	1	Open General Dentists	2 in 5 miles	0	1	100.0	27.2	27.3
				All Specialists	2 in 5 miles	0	1	100.0	24.9	24.9
	Palm Bay	32909	1	Open General Dentists	2 in 5 miles	1	1	100.0	0.8	5.1
				All Specialists	2 in 5 miles	0	1	100.0	5.1	5.1
	Pensacola	32514	1	Open General Dentists	2 in 5 miles	0	1	100.0	3.6	5.7
	Port Saint Lucie	34953	3	Open General Dentists	2 in 5 miles	1	1	33.3	3.4	5.8
	Summerfield	34491	1	Open General Dentists	2 in 5 miles	0	1	100.0	5.2	5.3

Continued on next page...

Access Detail for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

Employees Without Access

State Name	City	Zip Code	Employee	Provider			Without Access		Average Distance	
			#	Name	Standard	#	#	%	1	2
Florida	Summerfield	34491	1	All Specialists	2 in 5 miles	0	1	100.0	5.2	5.3
	Tallahassee	32312	1	Open General Dentists	2 in 5 miles	0	1	100.0	4.2	6.1
				All Specialists	2 in 5 miles	1	1	100.0	3.3	5.5
	Tavares	32778	2	Open General Dentists	2 in 5 miles	0	1	50.0	3.8	5.6
	Tavernier	33070	1	Open General Dentists	2 in 5 miles	0	1	100.0	11.9	32.8
				All Specialists	2 in 5 miles	0	1	100.0	32.9	32.9
	Vero Beach	32967	1	Open General Dentists	2 in 5 miles	0	1	100.0	4.9	5.9
				All Specialists	2 in 5 miles	0	1	100.0	5.1	5.1
Georgia	Augusta	30906	1	Open General Dentists	2 in 5 miles	0	1	100.0	5.3	20.0
				All Specialists	2 in 5 miles	0	1	100.0	6.7	10.6
	Blairsville	30512	1	Open General Dentists	2 in 5 miles	0	1	100.0	40.0	40.2
				All Specialists	2 in 5 miles	0	1	100.0	35.1	35.5
	Hephzibah	30815	1	Open General Dentists	2 in 5 miles	0	1	100.0	10.5	25.9
				All Specialists	2 in 5 miles	0	1	100.0	12.3	15.2
	McDonough	30252	1	Open General Dentists	2 in 5 miles	0	1	100.0	9.1	9.3
				All Specialists	2 in 5 miles	0	1	100.0	7.8	8.3
	Powder Springs	30127	1	Open General Dentists	2 in 5 miles	0	1	100.0	3.6	5.4
	Sautee Nacooche	30571	2	Open General Dentists	2 in 5 miles	0	2	100.0	25.9	26.1
				All Specialists	2 in 5 miles	0	2	100.0	26.1	26.1
Kentucky	Georgetown	40324	1	Open General Dentists	2 in 5 miles	1	1	100.0	1.4	10.9
Mississippi	Purvis	39475	1	Open General Dentists	2 in 5 miles	0	1	100.0	58.5	62.5
				All Specialists	2 in 5 miles	0	1	100.0	44.9	58.0
New Hampshire	Center Tuftonboro	03816	1	Open General Dentists	2 in 5 miles	0	1	100.0	62.0	79.1
				All Specialists	2 in 5 miles	0	1	100.0	62.0	62.9
New Jersey	Bloomingdale	07403	1	Open General Dentists	2 in 5 miles	0	1	100.0	2.0	5.9
New York	Clifton Park	12065	1	Open General Dentists	2 in 5 miles	0	1	100.0	6.4	8.1
				All Specialists	2 in 5 miles	1	1	100.0	2.6	6.4
North Carolina	Advance	27006	1	Open General Dentists	2 in 5 miles	0	1	100.0	9.7	37.0
				All Specialists	2 in 5 miles	0	1	100.0	10.3	34.0
	Flat Rock	28731	1	Open General Dentists	2 in 5 miles	0	1	100.0	20.2	25.2
				All Specialists	2 in 5 miles	0	1	100.0	30.5	31.0
	Hickory	28602	1	Open General Dentists	2 in 5 miles	0	1	100.0	31.7	34.5
				All Specialists	2 in 5 miles	0	1	100.0	19.2	28.4
Ohio	Navarre	44662	1	Open General Dentists	2 in 5 miles	0	1	100.0	5.7	10.6
				All Specialists	2 in 5 miles	0	1	100.0	9.2	10.6
Pennsylvania	Bellefonte	16823	1	Open General Dentists	2 in 5 miles	0	1	100.0	9.6	44.2
				All Specialists	2 in 5 miles	0	1	100.0	44.2	54.2
	Greenville	16125	1	Open General Dentists	2 in 5 miles	0	1	100.0	12.1	15.1
				All Specialists	2 in 5 miles	1	1	100.0	0.3	12.1
South Carolina	Landrum	29356	1	Open General Dentists	2 in 5 miles	0	1	100.0	15.8	20.9

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Access Detail for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - Open General Dentists & All Specialists

Employee Group
All Employees

Provider Group
Open General Dentists
All Specialists

Employees Without Access

State Name	City	Zip Code	Employee	Provider			Without Access		Average Distance	
			#	Name	Standard	#	#	%	1	2
South Carolina	Landrum	29356	1	All Specialists	2 in 5 miles	0	1	100.0	21.2	22.4
	Westminster	29693	1	Open General Dentists	2 in 5 miles	0	1	100.0	26.2	26.3
				All Specialists	2 in 5 miles	0	1	100.0	45.3	45.3
Washington	Anacortes	98221	1	Open General Dentists	2 in 5 miles	0	1	100.0	41.8	47.7
				All Specialists	2 in 5 miles	0	1	100.0	21.9	21.9
West Virginia	Huntington	25705	1	Open General Dentists	2 in 5 miles	0	1	100.0	16.3	63.1
				All Specialists	2 in 5 miles	0	1	100.0	72.9	88.9
Wisconsin	Wrightstown	54180	1	Open General Dentists	2 in 5 miles	0	1	100.0	29.2	29.4
				All Specialists	2 in 5 miles	0	1	100.0	63.0	78.2
Grand Totals			59	Open General Dentists		6	55	93.2	15.0	20.7
			49	All Specialists		5	48	98.0	18.0	24.2

Cigna Network Analysis

Cigna DPPO Advantage

Created for...

City of Fort Lauderdale

March 2017

Access Summary for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

[1] Provider counts represent:
#: Provider access points
L: Unique provider locations

Employees With Access

Employee		Provider		With Access		Counts[1]		Average Distance	
Name	#	Name	Standard	#	%	#	L	1	2
All Employees	282	General Dentists	2 in 5 miles	263	93.3	145,816	49,593	0.8	0.9
		All Specialists	2 in 5 miles	248	87.9	47,051	17,999	1.1	1.3

Key Geographic Areas

State Name	City	Employee	Provider		With Access		Counts[1]	Average Distance	
		#	Name	Standard	#	%	#	1	2
Florida	Fort Lauderdale	124	All Specialists	2 in 5 miles	124	100.0	377	0.9	1.1
			General Dentists	2 in 5 miles	124	100.0	863	0.6	0.7
	Pompano Beach	33	All Specialists	2 in 5 miles	33	100.0	184	0.8	1.0
			General Dentists	2 in 5 miles	33	100.0	419	0.5	0.6
	Hollywood	9	All Specialists	2 in 5 miles	9	100.0	220	0.8	1.0
			General Dentists	2 in 5 miles	9	100.0	411	0.5	0.5
	Dania	8	All Specialists	2 in 5 miles	8	100.0	3	1.0	1.0
			General Dentists	2 in 5 miles	8	100.0	24	0.3	0.4
	Port Saint Lucie	6	All Specialists	2 in 5 miles	6	100.0	87	1.4	1.5
	West Palm Beach	6	All Specialists	2 in 5 miles	6	100.0	81	1.8	1.8
	Port Saint Lucie	6	General Dentists	2 in 5 miles	6	100.0	226	0.9	0.9
	West Palm Beach	6	General Dentists	2 in 5 miles	6	100.0	210	1.2	1.3
	Miami	4	All Specialists	2 in 5 miles	4	100.0	544	0.5	0.5
	Jupiter	4	General Dentists	2 in 5 miles	4	100.0	131	2.0	2.0
	Miami	4	General Dentists	2 in 5 miles	4	100.0	1,320	0.4	0.4
	Deerfield Beach	3	All Specialists	2 in 5 miles	3	100.0	30	0.5	0.5
			General Dentists	2 in 5 miles	3	100.0	61	0.4	0.4
	Jupiter	4	All Specialists	2 in 5 miles	2	50.0	67	2.7	2.8
	Boynton Beach	2	All Specialists	2 in 5 miles	2	100.0	66	0.6	0.6
	Lady Lake	2	All Specialists	2 in 5 miles	2	100.0	4	1.3	1.3
	Lake Worth	2	All Specialists	2 in 5 miles	2	100.0	52	1.2	1.2
	Tavares	2	All Specialists	2 in 5 miles	2	100.0	1	1.5	3.4
	Vero Beach	2	All Specialists	2 in 5 miles	2	100.0	10	2.5	2.5
	Boynton Beach	2	General Dentists	2 in 5 miles	2	100.0	150	0.3	0.5
	Hobe Sound	2	General Dentists	2 in 5 miles	2	100.0	2	2.5	3.5
	Inverness	2	General Dentists	2 in 5 miles	2	100.0	4	1.8	1.8
	Lady Lake	2	General Dentists	2 in 5 miles	2	100.0	19	0.7	0.7
	Lake Worth	2	General Dentists	2 in 5 miles	2	100.0	168	0.7	0.8
	Tavares	2	General Dentists	2 in 5 miles	2	100.0	4	1.6	1.9
	Vero Beach	2	General Dentists	2 in 5 miles	2	100.0	39	2.3	2.5
	Live Oak	2	General Dentists	2 in 5 miles	1	50.0	5	1.5	1.5
	Boca Raton	1	All Specialists	2 in 5 miles	1	100.0	151	0.3	0.9
	Clermont	1	All Specialists	2 in 5 miles	1	100.0	32	0.9	0.9
	Daytona Beach	1	All Specialists	2 in 5 miles	1	100.0	11	1.9	2.7

Access Summary for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

[1] Provider counts represent:
#: Provider access points
L: Unique provider locations

Employees Without Access

Employee		Provider		Without Access		Counts[1]		Average Distance	
Name	#	Name	Standard	#	%	#	L	1	2
All Employees	282	General Dentists	2 in 5 miles	19	6.7	145,816	49,593	7.8	11.5
		All Specialists	2 in 5 miles	34	12.1	47,051	17,999	13.6	15.8

Key Geographic Areas

State Name	City	Employee	Provider		Without Access		Counts[1]	Average Distance	
		#	Name	Standard	#	%	#	1	2
Florida	Lake Placid	3	All Specialists	2 in 5 miles	3	100.0	0	17.9	18.4
			General Dentists	2 in 5 miles	3	100.0	1	1.6	13.1
	Jupiter	4	All Specialists	2 in 5 miles	2	50.0	67	6.7	6.8
	Hobe Sound	2	All Specialists	2 in 5 miles	2	100.0	0	5.3	7.2
	Inverness	2	All Specialists	2 in 5 miles	2	100.0	0	10.7	10.7
	Live Oak	2	All Specialists	2 in 5 miles	2	100.0	0	31.0	41.5
Georgia	Sautee Nacoochee	2	All Specialists	2 in 5 miles	2	100.0	0	23.3	23.3
			General Dentists	2 in 5 miles	2	100.0	0	7.3	8.3
Florida	Live Oak	2	General Dentists	2 in 5 miles	1	50.0	5	5.4	5.5
Alabama	Albertville	1	All Specialists	2 in 5 miles	1	100.0	0	20.2	21.8
Arizona	Tucson	1	All Specialists	2 in 5 miles	1	100.0	262	2.1	5.6
Florida	Astor	1	All Specialists	2 in 5 miles	1	100.0	0	19.2	19.2
	Bronson	1	All Specialists	2 in 5 miles	1	100.0	0	10.6	15.0
	Chipley	1	All Specialists	2 in 5 miles	1	100.0	0	20.1	20.1
	Hernando	1	All Specialists	2 in 5 miles	1	100.0	0	7.0	7.0
	Summerfield	1	All Specialists	2 in 5 miles	1	100.0	0	4.7	5.6
	Tavernier	1	All Specialists	2 in 5 miles	1	100.0	1	0.4	9.2
Georgia	Blairsville	1	All Specialists	2 in 5 miles	1	100.0	0	17.0	17.0
	Hephzibah	1	All Specialists	2 in 5 miles	1	100.0	0	9.7	9.7
	McDonough	1	All Specialists	2 in 5 miles	1	100.0	31	5.8	5.8
Mississippi	Purvis	1	All Specialists	2 in 5 miles	1	100.0	0	11.3	36.7
New Hampshire	Center Tuftonboro	1	All Specialists	2 in 5 miles	1	100.0	0	14.0	14.0
North Carolina	Advance	1	All Specialists	2 in 5 miles	1	100.0	0	5.1	5.1
	Flat Rock	1	All Specialists	2 in 5 miles	1	100.0	0	20.1	22.4
Ohio	Navarre	1	All Specialists	2 in 5 miles	1	100.0	0	6.7	6.7
Pennsylvania	Bellefonte	1	All Specialists	2 in 5 miles	1	100.0	0	11.4	11.4
South Carolina	Landrum	1	All Specialists	2 in 5 miles	1	100.0	0	15.8	17.2
	Westminster	1	All Specialists	2 in 5 miles	1	100.0	0	27.1	27.8
West Virginia	Huntington	1	All Specialists	2 in 5 miles	1	100.0	0	14.6	15.3
Wisconsin	Wrightstown	1	All Specialists	2 in 5 miles	1	100.0	0	12.3	12.3
Florida	Astor	1	General Dentists	2 in 5 miles	1	100.0	0	12.7	12.7
	Bronson	1	General Dentists	2 in 5 miles	1	100.0	0	10.4	10.4
	Chipley	1	General Dentists	2 in 5 miles	1	100.0	0	11.7	20.1
	Tavernier	1	General Dentists	2 in 5 miles	1	100.0	0	8.6	9.2

Accessibility Overview

Access Overview for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Employees - General Dentists

Employee Group
All Employees

Dentist Group
General Dentists

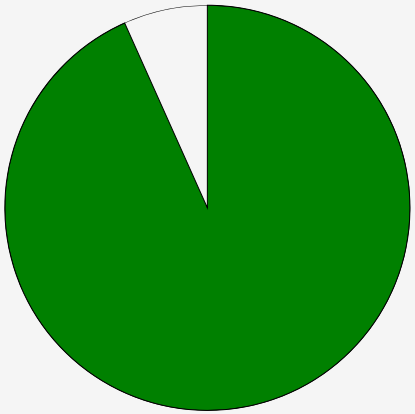
Comparison Graph
Percent of employees with access to a choice of dentists over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (All Employees) employees accessing:
2 (General Dentists) dentists in 5 miles

Overall Access[1]

282 Employees
145,816 dentists at 49,593 locations (General Dentists)

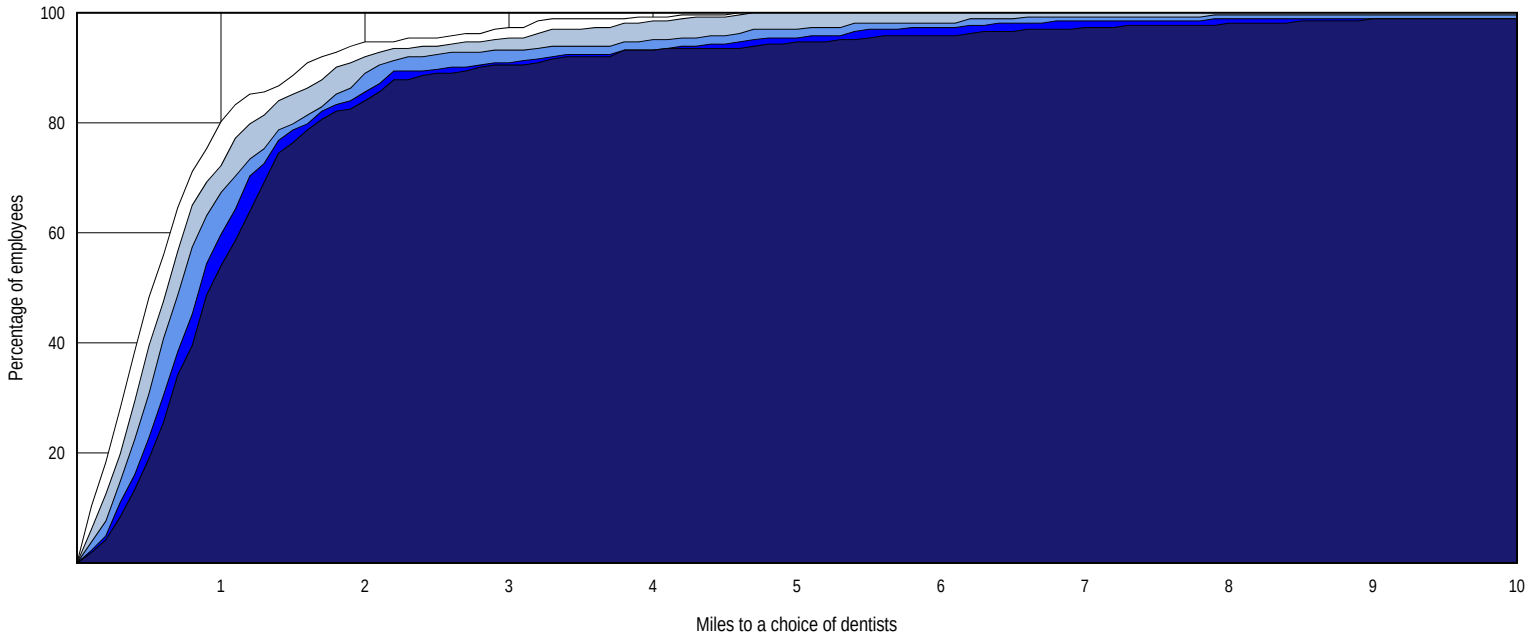
263 (93.3%) Employees with access



Distances

	Minimum	Average	Maximum
Distance to 1st closest dentist	0.0 mile	0.8 mile	4.6 miles
Distance to 2nd closest dentist	0.0 mile	0.9 mile	4.7 miles
Distance to 3rd closest dentist	0.0 mile	1.2 miles	14.1 miles
Distance to 4th closest dentist	0.0 mile	1.4 miles	15.7 miles
Distance to 5th closest dentist	0.0 mile	1.5 miles	15.7 miles

Access Standard Comparison



Access Overview for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Employees - General Dentists

Employee Group
All Employees

Dentist Group
General Dentists

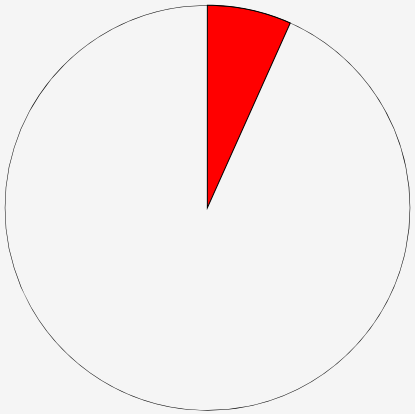
Comparison Graph
Percent of employees with access to a choice of dentists over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (All Employees) employees accessing:
2 (General Dentists) dentists in 5 miles

Overall Access[1]

282 Employees
145,816 dentists at 49,593 locations (General Dentists)

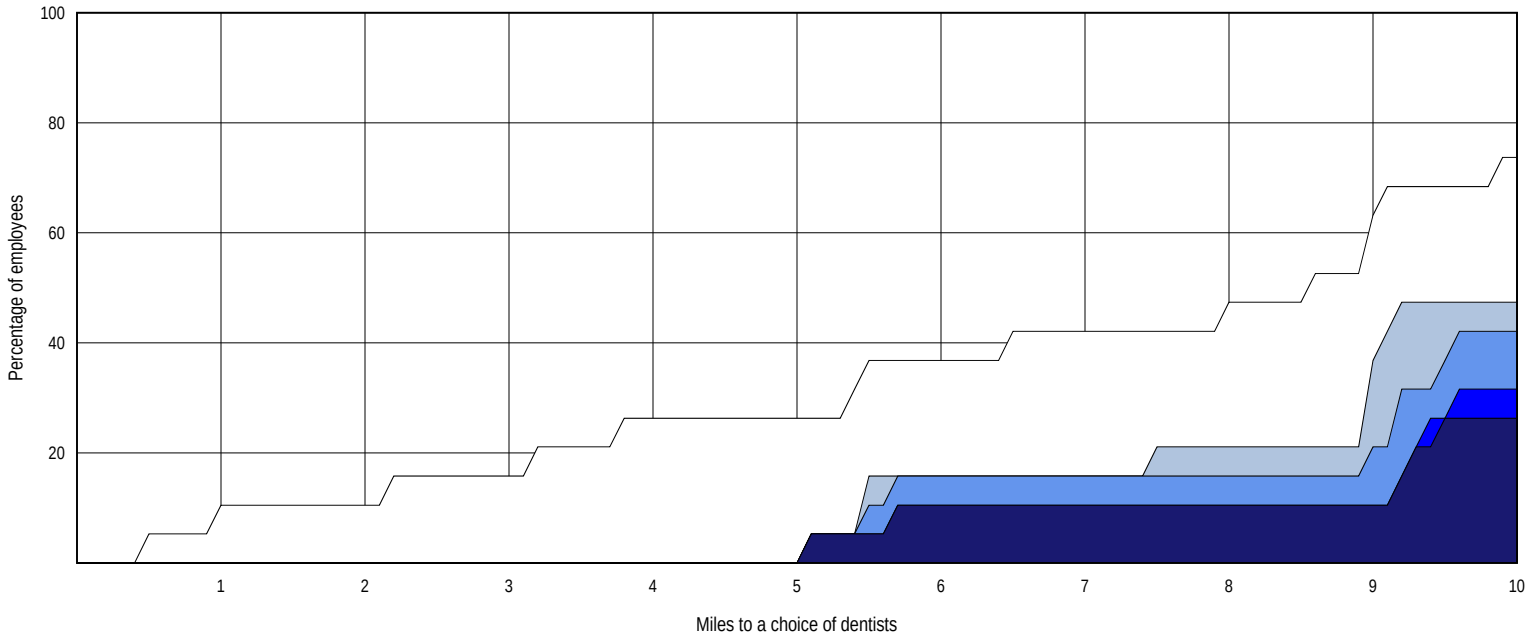
19 (6.7%) Employees without access



Distances

	Minimum	Average	Maximum
Distance to 1st closest dentist	0.5 mile	7.8 miles	20.7 miles
Distance to 2nd closest dentist	5.1 miles	11.5 miles	22.9 miles
Distance to 3rd closest dentist	5.1 miles	11.8 miles	22.9 miles
Distance to 4th closest dentist	5.1 miles	13.1 miles	22.9 miles
Distance to 5th closest dentist	5.1 miles	14.9 miles	24.5 miles

Access Standard Comparison



Access Overview for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Employees - All Specialists

Employee Group
All Employees

Dentist Group
All Specialists

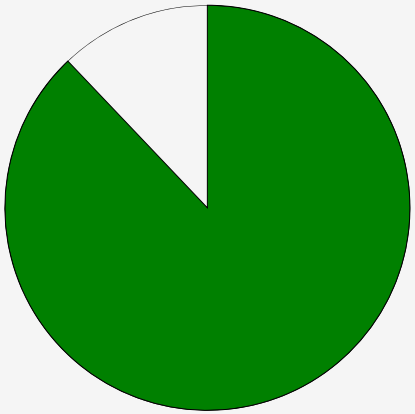
Comparison Graph
Percent of employees with access to a choice of dentists over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (All Employees) employees accessing:
2 (All Specialists) dentists in 5 miles

Overall Access[1]

282 Employees
47,051 dentists at 17,999 locations (All Specialists)

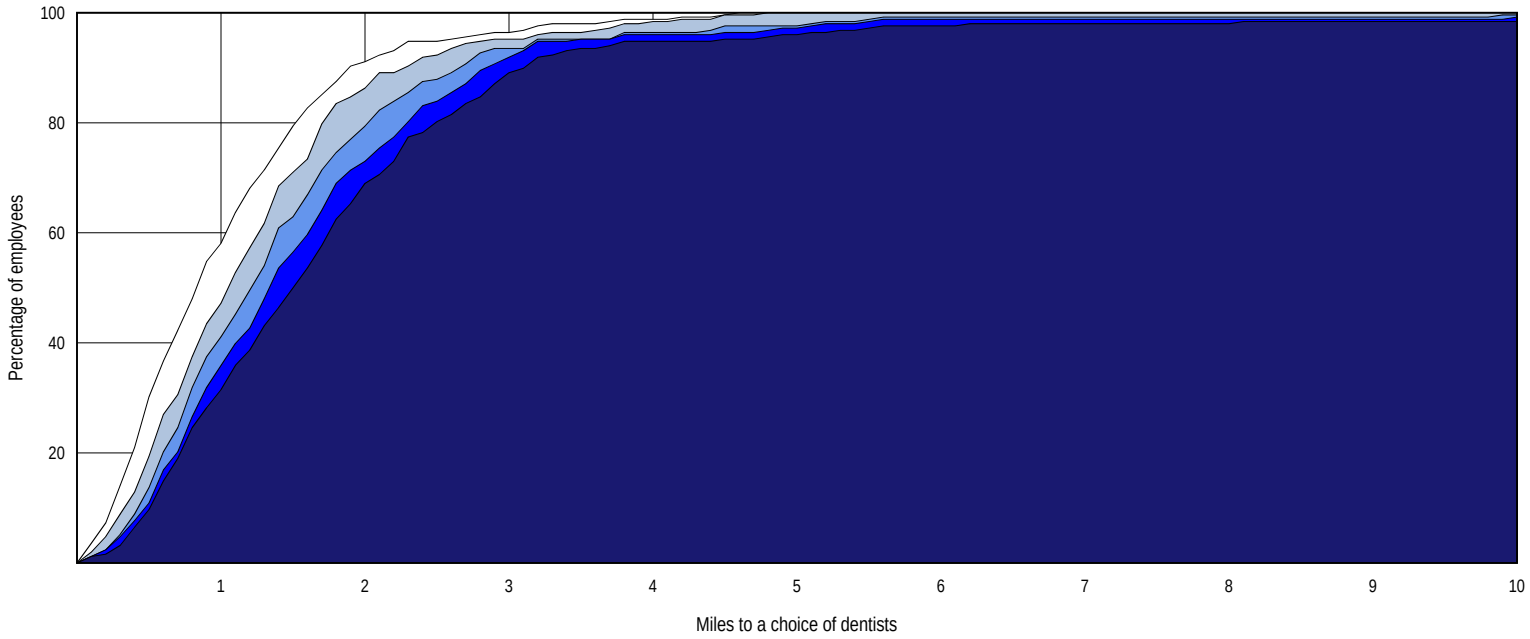
248 (87.9%) Employees with access



Distances

	Minimum	Average	Maximum
Distance to 1st closest dentist	0.1 mile	1.1 miles	4.6 miles
Distance to 2nd closest dentist	0.1 mile	1.3 miles	4.8 miles
Distance to 3rd closest dentist	0.1 mile	1.5 miles	14.0 miles
Distance to 4th closest dentist	0.1 mile	1.7 miles	24.9 miles
Distance to 5th closest dentist	0.1 mile	1.9 miles	24.9 miles

Access Standard Comparison



Access Overview for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Employees - All Specialists

Employee Group
All Employees

Dentist Group
All Specialists

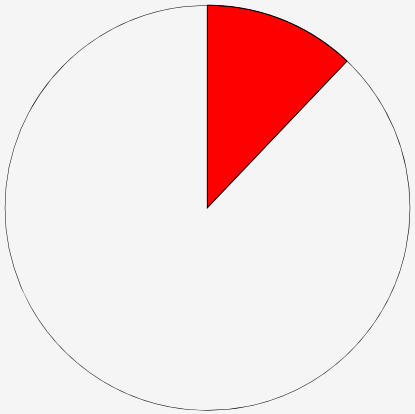
Comparison Graph
Percent of employees with access to a choice of dentists over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (All Employees) employees accessing:
2 (All Specialists) dentists in 5 miles

Overall Access[1]

282 Employees
47,051 dentists at 17,999 locations (All Specialists)

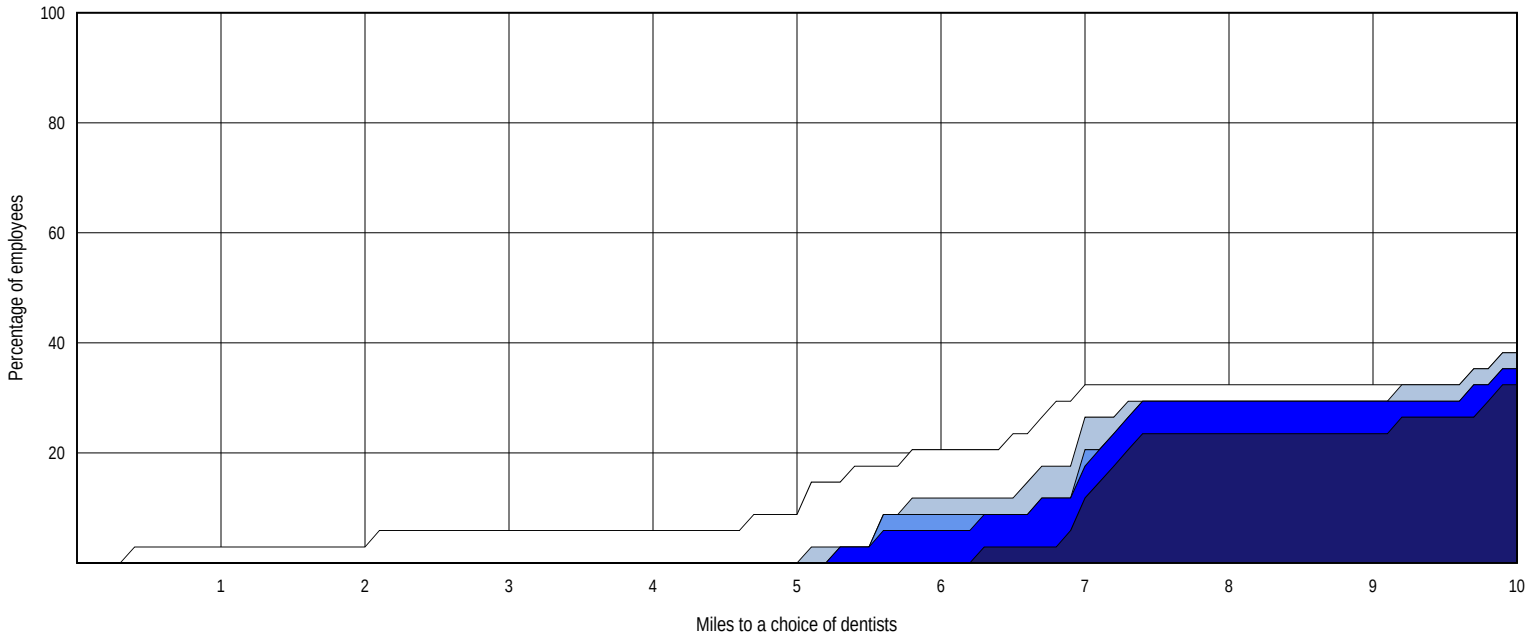
34 (12.1%) Employees without access



Distances

	Minimum	Average	Maximum
Distance to 1st closest dentist	0.4 mile	13.6 miles	35.4 miles
Distance to 2nd closest dentist	5.1 miles	15.8 miles	42.6 miles
Distance to 3rd closest dentist	5.3 miles	18.9 miles	44.4 miles
Distance to 4th closest dentist	5.3 miles	21.0 miles	61.4 miles
Distance to 5th closest dentist	6.3 miles	21.7 miles	61.7 miles

Access Standard Comparison



Accessibility Detail

Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee	Provider			With Access		Average Distance	
			#	Name	Standard	#	#	%	1	2
Alabama	Albertville	35951	1	General Dentists	2 in 5 miles	2	1	100.0	3.0	3.0
Arizona	Tucson	85739	1	General Dentists	2 in 5 miles	5	1	100.0	1.9	1.9
Florida	Boca Raton	33428	1	General Dentists	2 in 5 miles	5	1	100.0	0.3	0.7
				All Specialists	2 in 5 miles	2	1	100.0	0.3	0.9
	Boynton Beach	33435	1	General Dentists	2 in 5 miles	49	1	100.0	0.3	0.5
				All Specialists	2 in 5 miles	17	1	100.0	0.7	0.7
		33436	1	General Dentists	2 in 5 miles	8	1	100.0	0.2	0.5
				All Specialists	2 in 5 miles	10	1	100.0	0.4	0.4
	Clermont	34711	1	General Dentists	2 in 5 miles	34	1	100.0	0.2	0.2
				All Specialists	2 in 5 miles	32	1	100.0	0.9	0.9
	Dania	33004	8	General Dentists	2 in 5 miles	24	8	100.0	0.3	0.4
				All Specialists	2 in 5 miles	3	8	100.0	1.0	1.0
	Daytona Beach	32118	1	General Dentists	2 in 5 miles	2	1	100.0	1.0	1.1
				All Specialists	2 in 5 miles	1	1	100.0	1.9	2.7
	Deerfield Beach	33441	2	General Dentists	2 in 5 miles	11	2	100.0	0.4	0.4
				All Specialists	2 in 5 miles	5	2	100.0	0.5	0.5
		33442	1	General Dentists	2 in 5 miles	50	1	100.0	0.6	0.6
				All Specialists	2 in 5 miles	25	1	100.0	0.6	0.6
	Deland	32724	1	General Dentists	2 in 5 miles	1	1	100.0	2.9	3.8
				All Specialists	2 in 5 miles	0	1	100.0	3.8	3.8
	Delray Beach	33444	1	General Dentists	2 in 5 miles	28	1	100.0	0.8	0.8
				All Specialists	2 in 5 miles	8	1	100.0	0.8	0.8
	Estero	33928	1	General Dentists	2 in 5 miles	9	1	100.0	0.6	0.6
				All Specialists	2 in 5 miles	4	1	100.0	0.5	0.5
	Fernandina Beach	32034	1	General Dentists	2 in 5 miles	8	1	100.0	0.4	0.4
				All Specialists	2 in 5 miles	7	1	100.0	0.2	0.2
	Fleming Island	32003	1	General Dentists	2 in 5 miles	30	1	100.0	0.3	0.3
				All Specialists	2 in 5 miles	19	1	100.0	0.3	0.5
	Fort Lauderdale	33301	2	General Dentists	2 in 5 miles	89	2	100.0	0.1	0.1
				All Specialists	2 in 5 miles	33	2	100.0	0.1	0.1
		33304	4	General Dentists	2 in 5 miles	9	4	100.0	0.5	0.5
				All Specialists	2 in 5 miles	1	4	100.0	0.6	1.0
		33305	6	General Dentists	2 in 5 miles	10	6	100.0	0.2	0.4
				All Specialists	2 in 5 miles	3	6	100.0	0.5	0.8
		33306	3	General Dentists	2 in 5 miles	13	3	100.0	0.2	0.2
				All Specialists	2 in 5 miles	6	3	100.0	0.2	0.2
		33308	6	General Dentists	2 in 5 miles	110	6	100.0	0.3	0.3
				All Specialists	2 in 5 miles	52	6	100.0	0.3	0.4
		33309	7	General Dentists	2 in 5 miles	4	7	100.0	0.8	0.9
				All Specialists	2 in 5 miles	0	7	100.0	1.6	1.8

Continued on next page...

Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee	Provider			With Access		Average Distance	
			#	Name	Standard	#	#	%	1	2
Florida	Fort Lauderdale	33311	23	General Dentists	2 in 5 miles	12	23	100.0	0.7	0.8
				All Specialists	2 in 5 miles	0	23	100.0	1.2	1.6
		33312	10	General Dentists	2 in 5 miles	10	10	100.0	0.8	1.1
				All Specialists	2 in 5 miles	4	10	100.0	1.5	1.7
		33313	5	General Dentists	2 in 5 miles	22	5	100.0	0.4	0.5
				All Specialists	2 in 5 miles	3	5	100.0	0.7	1.1
		33314	1	General Dentists	2 in 5 miles	6	1	100.0	0.4	0.4
				All Specialists	2 in 5 miles	2	1	100.0	1.5	1.5
		33315	4	General Dentists	2 in 5 miles	5	4	100.0	1.1	1.1
				All Specialists	2 in 5 miles	1	4	100.0	1.2	1.4
		33316	2	General Dentists	2 in 5 miles	5	2	100.0	0.3	0.6
				All Specialists	2 in 5 miles	2	2	100.0	0.6	0.6
		33317	7	General Dentists	2 in 5 miles	29	7	100.0	1.0	1.1
				All Specialists	2 in 5 miles	24	7	100.0	1.3	1.3
		33319	5	General Dentists	2 in 5 miles	21	5	100.0	0.7	0.7
				All Specialists	2 in 5 miles	5	5	100.0	1.0	1.2
		33321	9	General Dentists	2 in 5 miles	133	9	100.0	0.5	0.7
				All Specialists	2 in 5 miles	36	9	100.0	0.8	0.9
		33322	2	General Dentists	2 in 5 miles	21	2	100.0	0.4	0.5
				All Specialists	2 in 5 miles	28	2	100.0	0.5	0.7
		33323	3	General Dentists	2 in 5 miles	66	3	100.0	0.7	0.7
				All Specialists	2 in 5 miles	25	3	100.0	0.9	0.9
		33324	4	General Dentists	2 in 5 miles	85	4	100.0	0.4	0.9
				All Specialists	2 in 5 miles	51	4	100.0	0.7	1.1
		33325	1	General Dentists	2 in 5 miles	1	1	100.0	1.0	1.8
				All Specialists	2 in 5 miles	2	1	100.0	1.1	1.1
		33326	2	General Dentists	2 in 5 miles	87	2	100.0	0.5	0.7
				All Specialists	2 in 5 miles	36	2	100.0	1.1	1.3
		33328	3	General Dentists	2 in 5 miles	57	3	100.0	0.5	0.7
				All Specialists	2 in 5 miles	32	3	100.0	0.7	0.8
		33334	8	General Dentists	2 in 5 miles	10	8	100.0	0.4	0.6
				All Specialists	2 in 5 miles	4	8	100.0	0.6	0.7
		33345	1	General Dentists	2 in 5 miles	0	1	100.0	0.6	0.7
				All Specialists	2 in 5 miles	0	1	100.0	1.1	1.4
		33351	6	General Dentists	2 in 5 miles	33	6	100.0	0.4	0.4
				All Specialists	2 in 5 miles	5	6	100.0	0.7	0.8
	Fort Myers	33901	1	General Dentists	2 in 5 miles	38	1	100.0	0.4	0.4
				All Specialists	2 in 5 miles	8	1	100.0	1.3	1.3
	Fort Pierce	34949	1	General Dentists	2 in 5 miles	0	1	100.0	3.2	3.8
				All Specialists	2 in 5 miles	0	1	100.0	4.2	4.5

Continued on next page...

Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee #	Provider Name	Provider Standard	Provider #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Gainesville	32606	1	General Dentists	2 in 5 miles	15	1	100.0	0.9	0.9
				All Specialists	2 in 5 miles	6	1	100.0	1.7	1.7
	Hallandale	33009	1	General Dentists	2 in 5 miles	101	1	100.0	0.1	0.2
				All Specialists	2 in 5 miles	37	1	100.0	0.9	0.9
	Hernando	34442	1	General Dentists	2 in 5 miles	2	1	100.0	3.2	3.2
	Hobe Sound	33455	2	General Dentists	2 in 5 miles	2	2	100.0	2.5	3.5
	Hollywood	33019	1	General Dentists	2 in 5 miles	4	1	100.0	1.6	1.7
				All Specialists	2 in 5 miles	0	1	100.0	1.8	1.8
		33020	2	General Dentists	2 in 5 miles	21	2	100.0	0.2	0.2
				All Specialists	2 in 5 miles	3	2	100.0	0.4	1.4
		33021	3	General Dentists	2 in 5 miles	115	3	100.0	0.6	0.6
				All Specialists	2 in 5 miles	40	3	100.0	0.8	0.8
		33022	1	General Dentists	2 in 5 miles	0	1	100.0	0.0	0.2
				All Specialists	2 in 5 miles	0	1	100.0	1.0	1.4
		33029	1	General Dentists	2 in 5 miles	30	1	100.0	0.7	0.7
				All Specialists	2 in 5 miles	13	1	100.0	0.7	0.7
		33081	1	General Dentists	2 in 5 miles	0	1	100.0	0.3	0.3
				All Specialists	2 in 5 miles	0	1	100.0	0.5	0.5
	Indialantic	32903	1	General Dentists	2 in 5 miles	1	1	100.0	1.3	2.2
				All Specialists	2 in 5 miles	0	1	100.0	2.3	2.4
	Inverness	34450	1	General Dentists	2 in 5 miles	0	1	100.0	1.6	1.6
		34452	1	General Dentists	2 in 5 miles	3	1	100.0	2.0	2.0
	Jacksonville	32221	1	General Dentists	2 in 5 miles	7	1	100.0	3.2	3.2
				All Specialists	2 in 5 miles	1	1	100.0	3.2	4.2
	Jupiter	33458	1	General Dentists	2 in 5 miles	113	1	100.0	0.8	0.8
				All Specialists	2 in 5 miles	59	1	100.0	0.8	0.8
		33478	3	General Dentists	2 in 5 miles	2	3	100.0	2.4	2.4
				All Specialists	2 in 5 miles	0	1	33.3	4.6	4.8
	Lady Lake	32159	2	General Dentists	2 in 5 miles	19	2	100.0	0.7	0.7
				All Specialists	2 in 5 miles	4	2	100.0	1.3	1.3
	Lake Mary	32746	1	General Dentists	2 in 5 miles	72	1	100.0	0.2	0.2
				All Specialists	2 in 5 miles	16	1	100.0	0.2	0.2
	Lake Worth	33467	2	General Dentists	2 in 5 miles	71	2	100.0	0.7	0.8
				All Specialists	2 in 5 miles	24	2	100.0	1.2	1.2
	Lakeland	33809	1	General Dentists	2 in 5 miles	9	1	100.0	0.9	2.6
				All Specialists	2 in 5 miles	4	1	100.0	1.9	2.6
	Live Oak	32060	2	General Dentists	2 in 5 miles	0	1	50.0	1.5	1.5
	Miami	33157	1	General Dentists	2 in 5 miles	21	1	100.0	0.3	0.3
				All Specialists	2 in 5 miles	5	1	100.0	0.7	0.7
		33169	1	General Dentists	2 in 5 miles	17	1	100.0	0.2	0.2

Continued on next page...

Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee #	Provider Name	Provider Standard	Provider #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Miami	33169	1	All Specialists	2 in 5 miles	3	1	100.0	0.2	0.2
		33179	1	General Dentists	2 in 5 miles	49	1	100.0	0.5	0.5
				All Specialists	2 in 5 miles	20	1	100.0	0.6	0.6
		33189	1	General Dentists	2 in 5 miles	58	1	100.0	0.4	0.4
				All Specialists	2 in 5 miles	19	1	100.0	0.4	0.4
	New Smyrna Beac	32169	1	General Dentists	2 in 5 miles	1	1	100.0	2.3	2.4
				All Specialists	2 in 5 miles	0	1	100.0	2.9	4.0
	Ocala	34478	1	General Dentists	2 in 5 miles	0	1	100.0	1.1	1.3
				All Specialists	2 in 5 miles	0	1	100.0	1.1	1.1
	Okeechobee	34974	1	General Dentists	2 in 5 miles	0	1	100.0	2.9	2.9
				All Specialists	2 in 5 miles	0	1	100.0	3.7	3.7
	Palm Bay	32909	1	General Dentists	2 in 5 miles	16	1	100.0	0.8	0.9
				All Specialists	2 in 5 miles	1	1	100.0	0.9	3.6
	Pensacola	32514	1	General Dentists	2 in 5 miles	2	1	100.0	1.1	1.7
				All Specialists	2 in 5 miles	0	1	100.0	3.1	3.2
	Pompano Beach	33060	3	General Dentists	2 in 5 miles	8	3	100.0	0.3	0.5
				All Specialists	2 in 5 miles	4	3	100.0	0.8	0.9
		33062	4	General Dentists	2 in 5 miles	84	4	100.0	0.4	0.4
				All Specialists	2 in 5 miles	28	4	100.0	0.5	0.5
		33063	8	General Dentists	2 in 5 miles	33	8	100.0	0.4	0.4
				All Specialists	2 in 5 miles	9	8	100.0	0.7	1.0
		33064	4	General Dentists	2 in 5 miles	13	4	100.0	0.7	0.7
				All Specialists	2 in 5 miles	7	4	100.0	0.8	1.1
		33065	2	General Dentists	2 in 5 miles	35	2	100.0	0.4	0.4
				All Specialists	2 in 5 miles	26	2	100.0	0.3	0.4
		33066	2	General Dentists	2 in 5 miles	2	2	100.0	0.5	0.6
				All Specialists	2 in 5 miles	0	2	100.0	1.4	1.7
		33067	1	General Dentists	2 in 5 miles	39	1	100.0	0.6	0.6
				All Specialists	2 in 5 miles	19	1	100.0	1.4	1.4
		33068	5	General Dentists	2 in 5 miles	3	5	100.0	1.0	1.0
				All Specialists	2 in 5 miles	0	5	100.0	1.2	1.3
		33069	2	General Dentists	2 in 5 miles	11	2	100.0	0.1	0.1
				All Specialists	2 in 5 miles	2	2	100.0	1.5	1.5
		33071	2	General Dentists	2 in 5 miles	84	2	100.0	0.4	0.6
				All Specialists	2 in 5 miles	46	2	100.0	0.6	0.6
	Port Saint Lucie	34953	3	General Dentists	2 in 5 miles	13	3	100.0	0.8	0.8
				All Specialists	2 in 5 miles	8	3	100.0	1.7	1.7
		34983	1	General Dentists	2 in 5 miles	15	1	100.0	0.9	0.9
				All Specialists	2 in 5 miles	1	1	100.0	0.9	1.6
		34984	1	General Dentists	2 in 5 miles	4	1	100.0	1.0	1.0

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Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee #	Provider Name	Provider Standard	Provider #	With Access #	With Access %	Average Distance 1	Average Distance 2
Florida	Port Saint Lucie	34984	1	All Specialists	2 in 5 miles	1	1	100.0	1.0	1.0
		34987	1	General Dentists	2 in 5 miles	13	1	100.0	1.2	1.2
				All Specialists	2 in 5 miles	4	1	100.0	1.3	1.3
	Saint Augustine	32086	1	General Dentists	2 in 5 miles	9	1	100.0	1.4	1.4
				All Specialists	2 in 5 miles	6	1	100.0	1.4	1.4
	Seminole	33776	1	General Dentists	2 in 5 miles	2	1	100.0	0.7	0.7
				All Specialists	2 in 5 miles	1	1	100.0	0.3	1.8
	Stuart	34994	1	General Dentists	2 in 5 miles	68	1	100.0	0.1	0.3
				All Specialists	2 in 5 miles	37	1	100.0	0.3	0.3
	Summerfield	34491	1	General Dentists	2 in 5 miles	17	1	100.0	1.7	4.0
	Tallahassee	32312	1	General Dentists	2 in 5 miles	1	1	100.0	1.6	1.8
				All Specialists	2 in 5 miles	1	1	100.0	3.3	3.3
	Tavares	32778	2	General Dentists	2 in 5 miles	4	2	100.0	1.6	1.9
				All Specialists	2 in 5 miles	1	2	100.0	1.5	3.4
	Vero Beach	32964	1	General Dentists	2 in 5 miles	0	1	100.0	0.6	0.6
				All Specialists	2 in 5 miles	0	1	100.0	0.5	0.5
		32967	1	General Dentists	2 in 5 miles	0	1	100.0	3.9	4.3
				All Specialists	2 in 5 miles	0	1	100.0	4.5	4.5
	Wellington	33414	1	General Dentists	2 in 5 miles	110	1	100.0	0.8	1.4
				All Specialists	2 in 5 miles	47	1	100.0	0.6	1.2
	West Palm Beach	33411	6	General Dentists	2 in 5 miles	33	6	100.0	1.2	1.3
				All Specialists	2 in 5 miles	18	6	100.0	1.8	1.8
Georgia	Atlanta	30342	1	General Dentists	2 in 5 miles	14	1	100.0	0.4	0.4
				All Specialists	2 in 5 miles	39	1	100.0	0.6	0.6
	Augusta	30906	1	General Dentists	2 in 5 miles	19	1	100.0	1.4	1.4
				All Specialists	2 in 5 miles	4	1	100.0	2.8	2.8
	Hephzibah	30815	1	General Dentists	2 in 5 miles	2	1	100.0	0.1	4.6
	McDonough	30252	1	General Dentists	2 in 5 miles	0	1	100.0	4.2	4.2
	Powder Springs	30127	1	General Dentists	2 in 5 miles	3	1	100.0	1.6	2.1
				All Specialists	2 in 5 miles	8	1	100.0	2.0	2.1
Kentucky	Georgetown	40324	1	General Dentists	2 in 5 miles	43	1	100.0	0.6	0.6
				All Specialists	2 in 5 miles	16	1	100.0	0.8	0.8
New Jersey	Bloomingdale	07403	1	General Dentists	2 in 5 miles	2	1	100.0	0.8	0.8
				All Specialists	2 in 5 miles	0	1	100.0	1.8	1.8
New York	Clifton Park	12065	1	General Dentists	2 in 5 miles	30	1	100.0	1.2	1.2
				All Specialists	2 in 5 miles	21	1	100.0	1.3	1.3
	Jamaica	11432	1	General Dentists	2 in 5 miles	47	1	100.0	0.0	0.1
				All Specialists	2 in 5 miles	10	1	100.0	0.3	0.4
North Carolina	Flat Rock	28731	1	General Dentists	2 in 5 miles	0	1	100.0	4.6	4.7
	Hickory	28602	1	General Dentists	2 in 5 miles	9	1	100.0	1.7	1.7

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Access Detail for All Employees With Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

Employees With Access

State Name	City	Zip Code	Employee	Provider			With Access		Average Distance	
			#	Name	Standard	#	#	%	1	2
North Carolina	Hickory	28602	1	All Specialists	2 in 5 miles	3	1	100.0	1.7	2.4
Ohio	Painesville	44077	1	General Dentists	2 in 5 miles	11	1	100.0	0.9	0.9
				All Specialists	2 in 5 miles	3	1	100.0	3.2	3.2
Pennsylvania	Greenville	16125	1	General Dentists	2 in 5 miles	10	1	100.0	0.2	1.1
				All Specialists	2 in 5 miles	4	1	100.0	0.3	0.3
Tennessee	Hermitage	37076	1	General Dentists	2 in 5 miles	24	1	100.0	0.3	0.3
				All Specialists	2 in 5 miles	13	1	100.0	0.4	1.7
	Knoxville	37918	1	General Dentists	2 in 5 miles	21	1	100.0	0.8	0.8
				All Specialists	2 in 5 miles	11	1	100.0	1.2	1.2
Texas	Arlington	76001	1	General Dentists	2 in 5 miles	5	1	100.0	1.1	1.2
				All Specialists	2 in 5 miles	2	1	100.0	1.1	1.2
	Austin	78730	1	General Dentists	2 in 5 miles	3	1	100.0	1.9	1.9
				All Specialists	2 in 5 miles	4	1	100.0	1.9	1.9
	Missouri City	77459	1	General Dentists	2 in 5 miles	96	1	100.0	0.4	0.4
				All Specialists	2 in 5 miles	39	1	100.0	0.4	0.4
Washington	Anacortes	98221	1	General Dentists	2 in 5 miles	3	1	100.0	1.7	1.8
				All Specialists	2 in 5 miles	2	1	100.0	1.2	1.2
	Bothell	98012	1	General Dentists	2 in 5 miles	27	1	100.0	0.5	0.5
				All Specialists	2 in 5 miles	11	1	100.0	0.5	0.5
West Virginia	Huntington	25705	1	General Dentists	2 in 5 miles	8	1	100.0	0.4	0.4
Grand Totals			264	General Dentists		2,871	263	99.6	0.8	0.9
			250	All Specialists		1,207	248	99.2	1.1	1.3

Access Detail for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

Employees Without Access

State Name	City	Zip Code	Employee	Provider			Without Access		Average Distance	
			#	Name	Standard	#	#	%	1	2
Alabama	Albertville	35951	1	All Specialists	2 in 5 miles	0	1	100.0	20.2	21.8
Arizona	Tucson	85739	1	All Specialists	2 in 5 miles	1	1	100.0	2.1	5.6
Florida	Astor	32102	1	General Dentists	2 in 5 miles	0	1	100.0	12.7	12.7
				All Specialists	2 in 5 miles	0	1	100.0	19.2	19.2
	Bronson	32621	1	General Dentists	2 in 5 miles	0	1	100.0	10.4	10.4
				All Specialists	2 in 5 miles	0	1	100.0	10.6	15.0
	Chipley	32428	1	General Dentists	2 in 5 miles	0	1	100.0	11.7	20.1
				All Specialists	2 in 5 miles	0	1	100.0	20.1	20.1
	Hernando	34442	1	All Specialists	2 in 5 miles	0	1	100.0	7.0	7.0
	Hobe Sound	33455	2	All Specialists	2 in 5 miles	0	2	100.0	5.3	7.2
	Inverness	34450	1	All Specialists	2 in 5 miles	0	1	100.0	11.5	11.5
		34452	1	All Specialists	2 in 5 miles	0	1	100.0	9.9	9.9
	Jupiter	33478	3	All Specialists	2 in 5 miles	0	2	66.7	6.7	6.8
	Lake Placid	33852	3	General Dentists	2 in 5 miles	1	3	100.0	1.6	13.1
				All Specialists	2 in 5 miles	0	3	100.0	17.9	18.4
	Live Oak	32060	2	General Dentists	2 in 5 miles	0	1	50.0	5.4	5.5
				All Specialists	2 in 5 miles	0	2	100.0	31.0	41.5
	Summerfield	34491	1	All Specialists	2 in 5 miles	0	1	100.0	4.7	5.6
	Tavernier	33070	1	General Dentists	2 in 5 miles	0	1	100.0	8.6	9.2
				All Specialists	2 in 5 miles	1	1	100.0	0.4	9.2
Georgia	Blairsville	30512	1	General Dentists	2 in 5 miles	1	1	100.0	3.8	22.9
				All Specialists	2 in 5 miles	0	1	100.0	17.0	17.0
	Hephzibah	30815	1	All Specialists	2 in 5 miles	0	1	100.0	9.7	9.7
	McDonough	30252	1	All Specialists	2 in 5 miles	0	1	100.0	5.8	5.8
	Sautee Nacooche	30571	2	General Dentists	2 in 5 miles	0	2	100.0	7.3	8.3
				All Specialists	2 in 5 miles	0	2	100.0	23.3	23.3
Mississippi	Purvis	39475	1	General Dentists	2 in 5 miles	0	1	100.0	9.0	9.0
				All Specialists	2 in 5 miles	0	1	100.0	11.3	36.7
New Hampshire	Center Tuftonboro	03816	1	General Dentists	2 in 5 miles	0	1	100.0	20.7	22.5
				All Specialists	2 in 5 miles	0	1	100.0	14.0	14.0
North Carolina	Advance	27006	1	General Dentists	2 in 5 miles	1	1	100.0	2.2	5.1
				All Specialists	2 in 5 miles	0	1	100.0	5.1	5.1
	Flat Rock	28731	1	All Specialists	2 in 5 miles	0	1	100.0	20.1	22.4
Ohio	Navarre	44662	1	General Dentists	2 in 5 miles	0	1	100.0	5.5	5.5
				All Specialists	2 in 5 miles	0	1	100.0	6.7	6.7
Pennsylvania	Bellefonte	16823	1	General Dentists	2 in 5 miles	0	1	100.0	9.0	9.0
				All Specialists	2 in 5 miles	0	1	100.0	11.4	11.4
South Carolina	Landrum	29356	1	General Dentists	2 in 5 miles	0	1	100.0	11.4	11.4
				All Specialists	2 in 5 miles	0	1	100.0	15.8	17.2
	Westminster	29693	1	General Dentists	2 in 5 miles	0	1	100.0	9.1	9.1

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Access Detail for All Employees Without Access

March 2017

Created for...
City of Fort Lauderdale

Access Analysis
All Accessibility - All Employees - General Dentists & All Specialists

Employee Group
All Employees

Provider Group
General Dentists
All Specialists

Employees Without Access

State Name	City	Zip Code	Employee	Provider			Without Access		Average Distance	
			#	Name	Standard	#	#	%	1	2
South Carolina	Westminster	29693	1	All Specialists	2 in 5 miles	0	1	100.0	27.1	27.8
West Virginia	Huntington	25705	1	All Specialists	2 in 5 miles	0	1	100.0	14.6	15.3
Wisconsin	Wrightstown	54180	1	General Dentists	2 in 5 miles	0	1	100.0	9.9	10.2
				All Specialists	2 in 5 miles	0	1	100.0	12.3	12.3
Grand Totals			35	All Specialists		2	34	97.1	13.6	15.9
			20	General Dentists		3	19	95.0	7.8	11.5

SECTION IV – SUBMITTAL REQUIREMENTS

4.2.8 National DHMO and DPPO Networks / Geo Access Reports

Please provide a complete listing of all national markets in which you have DHMO and DPPO networks that would be available to City retirees. Include a Geo Access report based on the census provided which includes zip codes. The geo access reports are required only for retirees living outside of the South Florida area.

The Cigna DHMO plan is operational in 37 states, and the Cigna DPPO plan is operational in 50 states. We are one of only two carriers to offer DPPO and DHMO plans nationwide. Our DHMO network is one of the largest in the nation, with more than 19,800 unique dentists and more than 95,600 access points. Our DPPO network has the largest network of dentists contracted to discounted fee arrangements, with over 142,700 unique dentists and 365,200 access points.

We have included Geo Access Reports on the flash drive.

Proposal Questionnaire

Responses to the following questions are to be included in your proposal and also in an electronic format (CD) as a Word document.
Confirmed. We have also included a copy in electronic format on CD.

General

1. **Where are your company's claims and customer service offices located that will be servicing this account? Are there any plans to locate those member call centers out of the country? If so, please elaborate.**

   Customer Service Locations
   Customer service for the City's employees will be provided by customer service advocates (CSAs) located in our Denison, Texas; Moosic, Pennsylvania; and Visalia, California, customer service centers.

   Claim Processing Centers

   DHMO
   We process specialty referrals in the Visalia, California, customer service center, located at: 5300 West Tulare Avenue, Visalia, CA 93277

   DPPO
   Our dental claim service model leverages our technology to support a highly efficient virtual network of experienced claim processors. To ensure an optimal level of accuracy, we pay claims across the network based on processor expertise within specific claim categories. Our claim processors are located in Denison, Texas; Visalia, California; Moosic, Pennsylvania; and work-at-home locations.

   Call Center Relocation
   At this time, Cigna does not plan to relocate any of our member call centers out of the country

2. **Is your company willing to provide a dedicated toll free number (and dedicated staff) for servicing this account?**

   Yes, we provide local account teams which consist of John Coolican, Client Manager; Malena Maya, Client Engagement Manager; and Kerri Holden, Onsite Representative; to service the needs of the dental product.

   Cigna's 1.800.Cigna24 number will provide 24/7/365 service and support with no need to transfer. Simply select the option for dental and receive dental support.

   New and current members will continue to call their designated toll free number on the back of their ID cards. Customer service advocates are available to help members 24 hours a day, 7 days a week, 365 days a year—including weekends and holidays.

3. Is your company capable of providing the following reports on a monthly basis? If not, please provide a description of reports the company is capable of providing and their frequency. Please list the reports you are not able to provide in the deviation section of your proposal.

DPPO Plans

Monthly paid claims separated by plan option, by network, non-network, by employee, by dependent

Yes

Quarterly Utilization reports by category of services and CDT code

Yes

Monthly Paid Claims and Premium by Plan (by Firefighters & All other groups)

Yes

Quarterly Summary Reports of customer service calls providing the number of calls and categorizing the reasons for the calls such as benefit inquiries, claim issues, provider issues, network assistance.

Yes

DHMO Plans

Monthly total revenue and expenses including capitation, fee for service and administration.

Yes, we do report on administration fees in revenue. However, capitation and fee for service does not apply to the DHMO plan.

Number of encounters by CDT code and description, by month

Yes

Denied claim report indicating the reasons for denial

The Cigna Dental Care plan is a capitated plan and does not require the filing of claims; therefore, this question does not apply.

Quarterly Utilization reports by category of services

Yes

Quarterly Summary Reports of customer service calls for the City providing the number of calls and categorizing the reasons for the calls such as benefit inquiries, claim issues, provider issues, network assistance.

Yes

4. **Please provide your website address and a description of the services and capabilities for employers and members available at that site.**

myCigna
Our member website, myCigna, will provide an easy and convenient way for the City of Fort Lauderdale's members to manage their dental health and dental-related finances. Members can also access personalized information on myCigna through our free myCigna mobile app.
The following member information and self-service functions are available through myCigna:

- coverage details lookup
- DPPO claim status inquiry capabilities
- DPPO electronic EOB and explanation of payment (EOP) display
- DPPO deductible, out-of-pocket, and lifetime maximum accumulation presentment
- DPPO network dentist search with ability to book appointments for selected dentists and find maps and directions
- DPPO claim forms and submission information
- dental prevention and wellness information, including WebMD articles
- glossary of dental terms
- DHMO ID card requests
- ability to request replacement and print temporary dental ID cards
- dental provider profiles, with pictures, videos
- dental provider customer reviews
- DPPO Dental Dashboard
- dental claim office phone numbers and addresses and customer service contact information
- FAQ
- dental treatment cost estimator *(pulls directly from provider contracts for 400 procedures)*
- information about our Healthy Rewards® discount program

CignaAccess.com
CignaAccess.com provides tools and information to support the City of Fort Lauderdale in the following key areas:

- **Claim Inquiry** – The City can view DPPO paid claim information at the member level and view deductible and lifetime maximum accumulation data at the member level.
- **Eligibility and Coverage Inquiry** – The City can view DPPO eligibility and coverage information at the member level. Clients can also print temporary ID cards.
- **Automated Eligibility Management and Reporting Tool** – Clients that submit eligibility via our automated eligibility process can access and download fallout reports. Clients can review key file processing metrics that provide a historical

view of file processing results, including file processing timeliness, member defect rates, and error resolution cycle times.

- **Employee Enrollment and Maintenance** – The City can enroll and maintain coverage elections and demographics for their employees and dependents. Transactions post immediately to the internal eligibility system. The City can
  - add and delete dependents;
  - end employee coverage;
  - reinstate employees and dependents; and
  - process life status changes.
- **Eligibility Reports and Statistics** – The City can create and download eligibility reports that include member listings and census reports. The City can tailor the reports to meet their needs. Data is available in real time as it appears in our eligibility system at the time of the request. If the City submit electronic eligibility files, they can also use the automated eligibility management and reporting tool to access and download user-friendly fallout reports and key file processing metrics.
- **Premium/Fee Invoices and Online Bill Payment** - Electronic versions (PDF) of the premium/fee invoices are available. Additionally, the City can
  - receive a system-generated notification when the invoice is ready;
  - retrieve, view, save, or print the invoices at their convenience; and
  - pay their bills online.
- **Financial Reports** – The City can review standard DPPO financial reports, which include monthly experience reports (excluding premium) and lag reports. We post reports to the website by the 10th calendar day of the month.
- **Banking Reports and Statistics** - Clients can view current DPPO, ASO funded banking reports based on a preselected request (daily, weekly, or monthly depending on the report type). Reports include worksheets, issued check registers, cleared check registers, and claim refunds.

Monthly reports are available by the 10th business day of the following month; weekly reports are available the 1st business day of the following week; daily issued reports are available the next business day. Daily cleared reports are available two business days later.

To tour the website, go to CignaAccess.com and click on the demo located on the upper right hand side or go to http://www.maier.com/cigna/cigna-access/. A user ID and password are not needed.

5. How often is your online directory of providers updated for terminations and additions?

Our online provider directory is updated daily. Members can access our provider directories through www.cigna.com, myCigna (available through a computer or smartphone app), our automated phone system, or by calling customer service.

6. Does your company have the ability to take automatic weekly eligibility updates from the City's payroll system, Cyborg, and/or Cigna Guided Solutions?

Yes. As the incumbent, there will be no changes to the automatic weekly eligibility updates in place.

7. Are the DPPO and DHMO plans both serviced through the same toll-free number and website?

Yes. Members can utilize the same toll free number and member website, myCigna, for both plans.

8. Is your organization currently in compliance with Florida Department of Financial Services statutes and requirements? If no, describe why not.

Yes, to the best of our knowledge and belief, our organization is currently in compliance with Florida Department of Financial Services statutes and requirements.

9. Is member satisfaction information linked to provider compensation? If so, how?

There are no financial incentives, monetary bonuses, or withholds built into our network payment agreements.

10. How many verbal and written complaints were received per 1,000 members during 2015 and 2016?

DHMO

In 2015 there were 0.057 verbal and written complaints per 1,000 members.

In 2016 there were 0.063 verbal and written complaints per 1,000 members.

DPPO

In 2015 there were 0.031 verbal and written complaints per 1,000 members.

In 2016 there were 0.012 verbal and written complaints per 1,000 members.

11. Are claim forms ever required of patients? If so, under what circumstances?

Yes, for non-contracted providers on the DPPO plan or when a member decides to pay the dentist for the services provided. The member then completes a claim form attaching an itemized bill and takes assignment for the payment. The member submits the form to Cigna and we process the claim and send the payment to the member.

For your Cigna Dental Care (DHMO) plan, no submission of claim forms, processing, or member payment is necessary.

12. What percentage of your primary care providers are capitated? Specialty providers?

DHMO

For general dentists, 96 percent are paid on a capitation basis and 4 percent are paid on a fee schedule. For specialists, 100 percent are paid on a fee schedule.

DPPO

The Cigna DPPO plans are not capitation-based programs. We pay network dentists according to a contracted discounted fee-for-service (FFS) schedule based on average charges in a given geographic area. Like network general dentists, we contract with network specialists on a discounted fee-for-service (FFS) schedule based on average charges in a geographic area. We pay out-of-network dentists according to maximum reimbursable charge (MRC) levels or fixed schedules, depending on the plan design.

13. What percentage of orthodontists, maxillofacial surgeons, endodontists and periodontists have certification in their specialty from an accredited program?

Every network dentist that we contract with to provide specialty care has successfully completed postgraduate dental specialty programs in his or her field. Our networks include specialists in orthodontics, endodontics, periodontics, pediatric dentistry, and oral surgery.
It is important to note that in dentistry, board-certification is not necessarily the norm. As a result, we do not require board-certification or board-eligibility for credentialing. We accept dentists who are recognized specialists, including those that are board-certified or board-eligible.

Of Cigna's network dentists, 3.1 percent are board-certified.

14. What process is in place for members to nominate dentists to the DHMO and/or DPPO network? Include the estimated timeframe in which the process will be completed.

The City and your members are welcome to call our customer service department to refer specific dental offices to be included in the Cigna dental networks.
Once we receive the dentist's information, we contact them to discuss participation in the Cigna dental networks. We make every effort to contract with any dentist referred to us.
Cigna is happy to offer a recruitment guarantee to the City. A detailed exhibit regarding this guarantee is included within the Rate and Premium Form Section of this proposal.

DHMO

1. What is the current average waiting time for setting appointments for

	Broward	Miami-Dade	Palm Beach	Martin
General Dentists	*	*	*	*
Specialists	*	*	*	*

*We do not report on wait time at county or city levels. We have provided this information at a state level for general dentists in 2016.

- 97.9 percent of DHMO members set an appointment within 4 weeks

2. Does your proposed DHMO plan require the member to select a general dentist and what are the requirements for changing DHMO dentists?

Yes. When a member decides to change dental offices, they can contact customer service advocates (CSAs) by calling our toll-free number, 800.Cigna24. CSAs are available to answer questions about network dentists and make changes to member's dental offices. The transfer will begin the first of the following month. We suggest that members finish any dental procedure in progress before transferring to another dental office. In addition, the member must ensure that they have cleared their balance with the current office.

Members can also submit an electronic request to change dental offices at either www.cigna.com or myCigna.

3. Can each family member select his or her own dentist when using the DHMO?

Yes, each family member can select a different dentist.

4. How often are members permitted to change their selection of a dentist?

Members may transfer to a new dental office once a month and for any reason, as long as the member has paid his/her account, in full, at the current office. Members can call customer service to speak with a representative, or use our automated transfer option which can process transfers 24 hours a day. Transfers are effective the first of the following month. We suggest that members complete any dental treatment-in-progress before transferring to another dental office.

5. Does your plan require a referral to a specialist dentist? If yes, please explain the process and turn-around time for the referral.

Yes. Network general dentists initiate patient referrals for endodontic, oral surgery, and periodontal treatment. Referrals are confirmed for 90 days from the approval date. Specialty referrals are not required for orthodontic treatment or pediatric care for children up to seven years old as long as members visit network specialists. The network specialist may submit a request for preauthorization to Cigna for oral surgery and periodontal services. Members are responsible for the applicable patient charges listed on the patient charge schedule (PCS) for covered procedures. After specialty treatment is finished, the member should return to the network general dentist for care.

If a network specialist is not available, the general dentist will refer the member to an out-of-network specialist, and the member will only be responsible for charges listed on the PCS; however, Cigna Dental Care (DHMO) network general dentists render the range of services that are required for graduation from dental school, including diagnostic treatment, preventive treatment, operative dentistry, crowns and bridges, partial and complete dentures, root canal therapy, minor oral surgery, preliminary periodontal therapy, and pediatric dentistry.

6. Please provide a description of the process and estimated timeline to add DPPO Dentists and DPPO dentists to your network.

To ensure appropriate and convenient access, we focus our expansion efforts on the dentists and in the areas that are important to you. Depending upon the dentists

credentialing application and any variances, this process can take anywhere from 10-45 days.

DHMO
We generally use direct phone outreach to contact dentists in target markets or identified by the City's employees, to gauge their interest. Follow-up discussions, generally by phone or electronic capabilities, include qualifications and payment negotiations. The dentist is provided the appropriate documentation, including application and contract, to complete. The documentation can be completed and submitted via paper or electronically.
A network management or clinical personnel will visit an office to perform an initial quality assessment review as part of our credentialing requirements. The assessment is an onsite review to confirm key requirements are met including, but not limited to, accessibility, sterilization and infection contract, and emergency procedures.
Upon receipt of the completed application, signed contract, initial quality assessment and other documentation, the dentist will be reviewed for acceptance into our Cigna Dental Care network.

Cigna is happy to offer a recruitment guarantee to the City. A detailed exhibit regarding this guarantee is included within the Rates and Premiums Forms section.

7. **Does your plan include a copay for each dentist office visit in addition to the copay for each defined service provided?**

   No, the DHMO plan has no $5 office visit copay for each visit.

8. **Please describe any plans for future DHMO network growth in Broward, Miami-Dade, Palm Beach and Martin Counties. Be specific and include number and type of dentists targeted by county. If no growth is planned, please say so.**

   We develop our network expansion plans annually after carefully assessing and reviewing client and geographic market needs. An extensive management process oversees expansion plan execution and achievement, with visibility and accountability from our frontline recruiters to senior management.

   Our projected DHMO targets include a combination of General Dentists and Specialists are as follows: Broward County: 15; Miami-Dade: 25, and Palm Beach: 5. Martin County is pending expansion through client need.

9. **What is the maximum number of members that may be assigned to a specific dentist before a practice is closed to new members? Include a description of how often this is measured and if the calculation includes other DHMO plan members.**

   Cigna DHMO specialists do not cap or close their offices.

Network capacity for DHMO general dentists is determined by available dentists' chair hours. A single dentist working 40 hours per week, 50 weeks per year, with two operatories and one hygienist would have 6,000 available chair hours (40 x 50 x 3 = 6,000). An average patient will require approximately two chair-hours per year. This calculation occurs on a monthly basis. There is no maximum number of members that may be assigned to specific dentist since the figure depends on the following factors:

- How many chairs an office has
- Current office wait times for members
- Capacity based on providers feedback

Our systems track dental office capacity and current and projected patient loads. This calculation includes DHMO members. Our contracting and professional relations team regularly monitors capacity and projected growth.

10. How many participating general dentists in Broward, Miami-Dade, Palm Beach and Martin Counties left your DHMO network in 2016? How many were added in 2016?

General Dentists Termed in 2016

Broward	39
Martin	15
Miami-Dade	53
Palm Beach	29

General Dentists Added in 2016

Broward	75
Martin	37
Miami-Dade	82
Palm Beach	60

11. How many participating specialist dentists in Broward, Miami-Dade, Palm Beach and Martin Counties left your DHMO network in 2016? How many were added in 2016?

Specialist Providers Termed in 2016

Broward	16
Martin	13
Miami-Dade	27
Palm Beach	15

Specialist Providers Added in 2016

Broward	28

Martin	11
Miami-Dade	36
Palm Beach	18

12. Please describe your credentialing criteria and process for DHMO providers.

Modeled after recognized national standards, dentists must meet the following credentialing requirements to participate in the Cigna Dental Care (DHMO).

Credentialing Requirements	Primary/Secondary Source Verification
State license	State Dental Licensing Board
DEA certificate (if applicable)	National Technology Information Services website, State Dental Licensing Board, applicable state agency, or copy of certificates
Graduation from accredited dental school	State Dental Licensing Board, copy of certificate from a school accredited by the American Dental Association (ADA) or directly from the graduating school
Specialty training verification (if applicable)	ADA master file or copy of certificate
Professional liability insurance	Copy of declaration page or binder
Controlled substance certificate (if applicable)	State Dental Licensing Board, applicable state agency or copy of certificate
Application and contract	Both must be signed by the dentist

Additionally, as part of our comprehensive quality management program, Cigna also verifies the following during the initial credentialing process.

Additional Credentialing Requirements	Checked
Malpractice coverage information	✓
Detailed malpractice history	✓
Detailed history of disciplinary action or litigation	✓
Detailed history of conviction for fraud or felony	✓
Current cardiopulmonary resuscitation certification	✓
Adherence to accept and treat patients in accordance with the Americans with Disabilities Act and professionally recognized standards of dental practice	✓
A recall system for ongoing appointments	✓
An emergency system including 24-hour telephone service	✓
Emergency treatment within 24 hours	✓
Available appointment times (initial appointment within four weeks)	✓
Performance of the following procedures): Restorative - amalgam and/or composite restorations Endodontics - anterior, bicuspid and first molar root canal Periodontics - scaling and root planing Oral surgery - surgical removal of erupted tooth Pediatric dentistry - routine care for children	 ✓ ✓ ✓ ✓ ✓

Additional Credentialing Requirements	Checked
Convenient office hours (at least 24 hours a week)	✓
Full-time hours at one dental office only	✓
Ability to administer nitrous oxide	✓
Submission of complete encounter data	✓

The credentialing department credentials the dentists and presents the information to the credentialing subcommittee for approval or denial. A dentist who does not meet these standards will not be included in our network. Exceptions require authorization from the dental director. The credentialing department reviews denials of prospective dentists based on quality of care issues for appropriate reporting to the regulatory agency, as required by state and federal law.
Cigna's online credentialing website automates the credentialing process. It allows dentists to complete, sign, and submit all required documents electronically, including uploading of required credentials to participate in the Cigna network. This tool drives efficiencies for network professional practices by eliminating the manual paper process and getting dentists up and running quicker.
We recredential all dentists at least every three years.

13. How many general dentists are not accepting new patients? Please provide this information separately for Broward, Miami-Dade, Palm Beach Counties and Monroe counties.

Broward	6
Miami-Dade	10
Palm Beach	6
Martin	0

14. What is the 2016 turnover percentage for your DHMO network of general dentists?

In 2016, the DHMO general dentists turnover percentage in Broward, Martin, Miami-Dade, and Palm Beach county was 11.62 percent.

15. What is the process for a newly-added DHMO member to receive services if he does not yet appear in the provider's eligibility file?

Providers can call Cigna to verify coverage for any member. Coverage can be verified by the City's eligibility system which makes real-time changes to eligibility information including newly-added DHMO members.

16. How are emergency dental services provided and/or reimbursed for members who may be out of area at time of service?

In-Network
Our agreements with dentists require them to provide or arrange for emergency care 24 hours a day, 7 days a week, 365 days a year, and to provide emergency

attention within 24 hours of requests. Members should refer to the charges listed on their patient charge schedule (PCS) for the cost of emergency treatment provided by their network general dentist. There may be a separate charge for services rendered during and after regularly scheduled office hours.

Out-of-Network
If a member is more than 50 miles away from home, or is unable to contact his/her primary care dentist, he/she may receive emergency care from any licensed dentist. We will pay the cost of diagnostic and for Texas members who are more than 50 miles away from home, are unable to contact their network general dentist, and require emergency care, Cigna will pay the difference between the dentist's usual fee for emergency covered services, and the patient charge listed on the PCS. For New York members who are unable to contact their network general dentist, and require emergency care, Cigna will pay the cost of diagnostic and therapeutic dental procedures up to a maximum of $50, less applicable patient charges listed on the PCS.
For reimbursement, members should submit to us a statement with copies of the bills and dental records relating to treatment.

17. Provide a description of benefits available for TMJ. Include details regarding any required authorization processes.

Treatment for temporomandibular joint (TMJ) disorder is usually rendered in response to non-dental factors, such as musculoskeletal, psychological, and neurophysiological conditions. Since symptoms of these disorders are usually related to a medical condition, patients may wish to consult their medical plan about this type of treatment.

Cigna plans cover a detailed and extensive oral evaluation problem focused, by report (D0160) and an occlusal orthotic device, by report (D7880) when performed in conjunction with the treatment of TMJ disorder.

18. Does your proposed DHMO plan include coverage for implants? If yes, please explain the coverage.

Yes, the DHMO plan includes coverage for implants.

19. Does your proposed DHMO plan include coverage for resin-based composite fillings on posterior teeth? If so, please specify any price differences in filling materials.

Yes, coverage for resin-based composite fillings on posterior teeth are covered. Cigna is offering the option of 3 different DHMOs and the price differences are charted below.

Procedure	Cigna P2IOX	Cigna P4I0X	Cigna P5I0X
Resin-based composite – 1 surface, posterior	-$5	$15	$25
Resin-based composite – 2 surfaces, posterior	Same as Current	$25	$35

Resin-based composite – 3 surfaces, posterior	-$10	$20	$30

20. What benefits, if any, are included for the detection of oral cancer?

Recognizing the importance of early detection and intervention, Cigna provides coverage for the oral cancer screening procedure known as a brush biopsy for members enrolled in Cigna dental plans.

During a regular checkup, dentists can check for oral cancer. If the dentist identifies any suspicious oral spots or sores during a visual assessment, the dentist can perform a brush biopsy to detect potentially dangerous cells. The dentist can use this painless service as a frontline procedure, possibly avoiding the need for more invasive oral surgical procedures, which typically require excision and anesthesia, unless the dentist shows otherwise. Brush biopsy may help detect unhealthy cells before they can cause any harm.

21. For services that are limited to a certain number of occurrences within a plan year, such as prophylaxis, periodontal maintenance, bitewings and periodic exams, please specify how the frequency is monitored (i.e. days, months, etc.). What limitations and guidelines does your company use to determine when a member is eligible for subsequent occurrences?

The limitations vary by procedure and are outlined in the DHMO Schedule of Benefits. However, most of the limitations are per calendar year. For example, Prophylaxis are 2 free per calendar year or Periodontal scaling (Limit 4 quadrants per consecutive 12 months). Bitewings do not have a limit on the DHMO plan.

DPPO

1. Are members required to select a dentist when enrolled in the PPO?

No, since Cigna DPPO is a nongatekeeper plan, members are not required to select a primary care dentist or seek a referral by a gatekeeper for the services of a specialist. Members may choose to seek services from an in- or out-of-network specialist or general dentist.

2. What is the average turn around for a clean non-network claim submission?

For 2016, the average turnaround for DPPO claims was 98.87 percent in 10 business days, 99.28 percent in 15 business days, and 99.31 percent in 20 business days.

When measuring turnaround time we do not distinguish between types of claims (i.e., clean claims, COB claims).

3. Please describe the credentialing criteria for PPO dentists.

Modeled after recognized national standards, dentists must meet the following credentialing requirements to participate in the Cigna DPPO networks.

Credentialing Requirements	Primary/Secondary Source Verification
State license	State Dental Licensing Board

Credentialing Requirements	Primary/Secondary Source Verification
DEA certificate (if applicable)	National Technology Information Services website, State Dental Licensing Board, applicable state agency, or copy of certificates
Graduation from accredited dental school	State Dental Licensing Board, copy of certificate from a school accredited by the American Dental Association (ADA) or directly from the graduating school
Specialty training verification (if applicable)	ADA master file or copy of certificate
Professional liability insurance	Copy of declaration page or binder
Controlled substance certificate (if applicable)	State Dental Licensing Board, applicable state agency or copy of certificate
Application and contract	Both must be signed by the dentist

Additionally, as part of our comprehensive quality management program, Cigna also verifies the following during the initial credentialing process.

Additional Credentialing Requirements	Checked
Malpractice coverage information	✓
Detailed malpractice history	✓
Detailed history of disciplinary action or litigation	✓
Detailed history of conviction for fraud or felony	✓
Current cardiopulmonary resuscitation certification	✓
Adherence to accept and treat patients in accordance with the Americans with Disabilities Act and professionally recognized standards of dental practice	✓
A recall system for ongoing appointments	✓
An emergency system including 24-hour telephone service	✓
Emergency treatment within 24 hours	✓
Available appointment times (initial appointment within four weeks)	✓
Convenient office hours (at least 24 hours a week)	✓
Submission of complete encounter data (DHMO) and acceptance of assignment (DPPO)	✓

The credentialing department credentials the dentists and presents the information to the credentialing subcommittee for approval or denial. A dentist who does not meet these standards will not be included in our network. Exceptions require authorization from the dental director. The credentialing department reviews denials of prospective dentists based on quality of care issues for appropriate reporting to the regulatory agency, as required by state and federal law.

4. Are non-network claims paid subject to usual, customary and reasonable allowances or a schedule of allowances?

Non-network claims are paid on a schedule of allowance or Maximum Allowable Charge. Cigna has the capability of implementing usual, customary and reasonable allowances that range from 50th to 90th percentile but it will result in an increase in premium.

5. Describe your company's method of determining usual, customary and reasonable charges.

Cigna claim payment systems maintain the fee schedules based on FAIR Health® data. Cigna schedules are updated twice a year within 90 days of FAIR Health published updates.

6. What database does your company use for reasonable and customary profiles? How often is it updated?

Cigna's claim payment system maintains the fee schedules based on FAIR Health data. We update Cigna schedules bi-annually within 90 days of FAIR Health's published updates. Cigna does not track the percentage of increases or decreases to the maximum reimbursable charge.

7. What percentile is typically used for dental R&C? What are the options?

The options for R&C range from a MAC schedule or 50th to the 95th percentile, depending on the client's specific needs and cost savings goals. A change in the R&C may have an impact to the overall premium. The percentile we have determined is a match to the Humana's plans is the maximum allowable charge fee schedule.

8. Can your system allow certain tolerance ranges to be applied to reasonable and customary limits? Describe.

Yes, the claim system can apply a maximum reasonable and customary tolerance range based on a specified dollar amount ($5, $10,$15).

There is a minimal programming cost to implement the tolerance or 'slide' functionality.

9. Are participating dentist offices required to file claims on behalf of their members as part of the provider contract?

Yes, under the DPPO plan, an in-network dentist will submit a claim form to us for processing. Once the claim form is processed, we pay the amount owed to the dentist, and we send an EOB to the member showing his or her required payment to the dentist, if any.

For out-of-network services, two approaches are possible. One option is for the dentist to complete a claim form and accept assignment for the payment. The dentist then submits the form to us for processing and we send the payment to the professional. We send an EOB to the member, detailing the remaining balance because of the dentist, if any.

The second option is for the member to pay the dentist for the services provided. The member then completes a claim form attaching an itemized bill and takes assignment for the payment. The member submits the form to us and we process the claim and send the payment to the member.

10. Do your proposed DPPO plans include coverage for resin-based composite fillings on posterior teeth? If so, please specify any price differences in filling materials.

Yes, Cigna will match the current benefit and cover resin-based composite fillings on posterior teeth.

11. What benefits, if any, are included for the detection of oral cancer?

Recognizing the importance of early detection and intervention, Cigna provides coverage for the oral cancer screening procedure known as a brush biopsy for members enrolled in Cigna dental plans.

During a regular checkup, dentists can check for oral cancer. If the dentist identifies any suspicious oral spots or sores during a visual assessment, the dentist can perform a brush biopsy to detect potentially dangerous cells. The dentist can use this painless service as a frontline procedure, possibly avoiding the need for more invasive oral surgical procedures, which typically require excision and anesthesia, unless the dentist shows otherwise. Brush biopsy may help detect unhealthy cells before they can cause any harm.

12. For services that are limited to a certain number of occurrences within a plan year, such as prophylaxis, periodontal maintenance, bitewings and periodic exams, please specify how the frequency is monitored (i.e. days, months, etc.). What limitations and guidelines does your company use to determine when a member is eligible for subsequent occurrences?

The frequency & limitations are disclosed on the second page of the benefit summary. For example, Cigna's limitations for cleanings are X number per calendar year.

DHMO Deviations – Cigna P5I0X, P4IOX, or P2IOX Patient Charge Schedule

Listed below are deviations on Cigna's DHMO services when compared to your Humana Plan. Plan enhancements are not listed below.

- Pediatric Dentistry - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday.
- Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months.
- Implant Coverage- Coverage for implants has not lifetime limit, it is covered with specific copays per procedure codes as listed in the Implant coverage section of the Patient.
- Orthodontia - Coverage for orthodontia is listed differently on Cigna's plans. All orthodontia claims are processed as manual claims and will be reviewed carefully prior to being processed. Below is a breakout of how Orthodontia would be covered on Cigna vs the Current Plan. Below is an example of the P5I0X and the P4I0X

Procedure	Cigna P5I0X	Cigna P4I0X	Humana 195
Child Orthodontia	$2414	$2234	$2685
Consultation, Evaluation D8660 Pre-Orthodontic visit	$125	$85	$285
Treatment and Retention D8050 Banding, D8670 Treatment, D8680 Retention, D8999 Records	$2289 $400 + $1344 + $275 + $270	$2149 $390 + $1224 + $270 + $265	$2400 $250 + $1850 + $300
Procedure	**Cigna P5I0X**	**Cigna P4I0X**	**Humana 195**
Adult Orthodontia	$2889	$2653	$2435
Consultation, Evaluation D8660 Pre-Orthodontic visit	$85	$85	$285
Treatment and Retention D8050 Banding, D8670 Treatment, D8680 Retention, D8999 Records	$2149 $400 + $1944 + $275 + $270	$2653 $390 + $1728 + $270 + $265	$2150

The following ADA codes are covered by Humana but not covered by Cigna. Please note that utilization numbers were pulled from Exhibit 3 received from the City of Fort Lauderdale.

ADA	ADA Description	Utilization: Number of Procedures	HS195 Copay
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	1	$0
D9230	INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS	41	$15
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	3	$15
D3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM	2	$19
D3950	CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST	1	$15
D4320	PROVISIONAL SPLINTING - INTRACORONAL	1	$95
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	3	$85
D2955	POST REMOVAL	1	$10
D6980	FIXED PARTIAL DENTURE REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE	1	$45
D9972	EXTERNAL BLEACHING - PER ARCH, PERFORMED IN OFFICE	3	$125
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT	10	$10

SERVICES NOT COVERED UNDER YOUR DENTAL PLAN
There is no coverage for:

- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)

- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.

- infection control and/or sterilization. CIGNA dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.

- services to correct congenital malformations, including the replacement of congenitally missing teeth.

- resin bonded retainers and associated pontics.

Product	Requested Benefit	CIGNA Alternative & Recommendation
Dental PPO	Exclusions, definitions, terms, administration including claims, subro, COB, appeals, any protocols including how procedure allowances are calculated, etc.	Our review has attempted to identify the chief differences between the substantive provisions of your current plan and Cigna's standard insurance policy terms. However, Cigna's group insurance policy terms are typically subject to regulatory approval in the state where the policy is issued to the policyholder. Therefore, Cigna's standard insurance policy language (definitions, eligibility and coverage terms, exclusions, limitations and general provisions) will in all cases apply replacing any existing insurance policy or plan terms and Cigna will administer its insurance policy according to those terms and Cigna's then current administrative practices.
Dental PPO	Class I-Harmful habits and thumb-sucking appliances; Services are payable only for dependents age 15 and younger for the installation of the initial appliance.	Cigna considers services Orthodontic in nature and will be covered in class 4, subject to class 4 age/frequency limits.
Dental PPO	For members age 40 and older, oral cancer screening – one per year.	Service is Medical in nature. Covering under Dental plan will prematurely exhaust dental benefits.
Dental PPO	Denture relines or rebases – once in a one-year period.	Cigna covers if more than 6 months after installation of the full or partial denture and then no more than 1 time in 36 calendar months.
Dental PPO	Coverage for such newborn child consists of benefits for services which are a dental necessity for the treatment of a bodily injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, or premature birth; and transportation costs, not to exceed $1,000 to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. The transportation must be certified by the attending physician as necessary to protect the health and safety of the newborn child, and is subject to the reimbursement limit.	Service is Medical in nature. Covering under Dental plan will prematurely exhaust dental benefits.

SECTION IV – SUBMITTAL REQUIREMENTS

4.2.11 Grievance and Appeal Procedures

Proposers should provide a description of the grievance and appeal procedure for DHMO and DPPO plan participants. Be specific in terms of timelines and expected turnarounds.

Grievance

If a member has a complaint or concern, he or she are able to contact our customer service by phone or in writing. Our goal is to resolve the matter during the initial outreach; however, if we need more time to review or investigate the concern, we will communicate the outcome to the member within 30 days. The majority of issues are resolved within one business day.

If members are not satisfied with the results of the review, they may start the appeals procedure. Members can submit an appeal in writing or contact customer service and initiate the process verbally (some state-specific requirements may apply).

Level One Appeal

Someone not involved in the initial claims process reviews appeals. A dental professional reviews appeals involving dental necessity or clinical appropriateness.

As required by state regulations, we will follow state requirements when responding to concerns about preservice or postservice denial requests.

Cigna notifies the member of the decision in writing, including the specific contractual or clinical reasons for the decision, as applicable.

Only preservice reviews are eligible for expedited processing. A member may request an expedited review if our standard time frames to respond would seriously jeopardize his or her life, health, or ability to regain the dental functionality that existed before the onset of the condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary, and communicate an oral response within 72 hours, he or she then follow up in writing.

If a member is not satisfied with our level one appeal decision, he or she may request a level two appeal.

The time frames or requirements may vary depending on state-specific law.

Level Two Appeal

An appeals committee or someone not involved in the level one appeal may conduct appeals. If specialty care is in dispute, we may involve a dentist in the same or similar specialty.

As required by state regulations, we will follow state requirements when responding to concerns about preservice or postservice denial requests.

Cigna notifies the member of the decision in writing, including the specific contractual or clinical reasons for the decision, as applicable.

Only preservice reviews are eligible for expedited processing. A member may request an expedited review if our standard time frames to respond would seriously jeopardize his or her life, health, or ability to regain the dental functionality that existed before the onset of the condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary, and communicate an oral response within 72 hours, and then follow up in writing.

The time frames or requirements may vary depending on state- specific law.

SECTION IV – SUBMITTAL REQUIREMENTS

4.2.12 DHMO Quality Assurance

Provide a detailed description of your DHMO and DPPO provider Quality Assurance program.

We developed Cigna's quality management program to reinforce our commitment to excellence, and to continuously improve the delivery of dental care and services to our clients and members. Our quality management program helps ensure that members achieve better oral health and ultimate satisfaction with their dental plan.

The quality management program is under the direction and management of the national governing body, composed of the Cigna dental president and CEO, national dental director, as well as representatives from other business units. The national governing body establishes standards by which the quality of care and services are measured, and appoints regional quality management committees and subcommittees to implement the program on a regional level.

The program's four main objectives include:

- promote and maintain consistent networks that meet Cigna Dental's credentialing requirements
- improve member's oral health through the effective guidance, monitoring, and evaluation of treatment
- identify opportunities for improvement and take appropriate steps to implement corrective actions
- maintain compliance with local, state, and federal regulatory requirements and standards

These objectives are realized through set quality management program activities including:

Initial Credentialing - Dentists must meet stringent credentialing requirements to participate in Cigna Dental networks.

Recredentialing - We regularly reverify the credentials of every dentist to ensure the standards of initial credentialing continue to meet accepted industry standards.

Dentist Accessibility Monitoring - We conduct ongoing dentist accessibility monitoring in several different ways including but not limited to periodic dental office phone calls, onsite visits, member satisfaction surveys, review of complaint and grievance data, and geographic access analysis.

Health Promotion and Preventive Care - Prevention is the way to achieve optimal oral health, as well as reduce the long-term costs of dental care for both the patient and the plan sponsor. In keeping with this philosophy, most of our plans provide preventive services with no patient charge, eliminating the barrier to obtaining preventive care. We promote preventive services through employee communications and client health fairs. The Cigna dental Internet site also offers members a wealth of educational and preventive facts and tips, as well as other important information about Cigna.

Network Dentist Performance Monitoring - Through our performance monitoring program, we have a process that includes ongoing analyses and other focused activities

to affect continuous improvement in the care and services provided by network dentists. The performance measurement tools include, but are not limited to, dentist profiling, grievance tracking, and member satisfaction reports. Corrective action plans are implemented as needed. We maintain a system to track dentist-based corrective actions, used under the direction of the regional dental director and maintained by network management, customer service, and the quality department.

Performance Monitoring Studies - Performance monitoring studies are designed to monitor, evaluate and improve the delivery of services by our network dentists. The national governing body approves the topics for these special studies, which are then conducted under the direction of the national quality management committee.

Complaint and Grievance Review - The purpose of the complaint and grievance review process is to identify and to help resolve member concerns quickly and efficiently, and to identify corrective actions for improvement in the delivery of dental services. Inquiries relating to quality of care are referred to the regional dental directors and network management for investigation. Follow-up actions are under the direction of the regional dental director.

Member and Dentist Satisfaction Surveys - Member satisfaction is assessed through evaluation of member surveys (conducted by a third-party research firm) and member complaints. Dentist satisfaction surveys are performed yearly. Results are reviewed to identify areas of improvement and subsequent action plans.

Setting Administrative Standards for Accuracy and Response - We provide members, clients, and dentists with cost-effective, caring, and responsive claim and inquiry services through one consistent national service delivery model. The model includes uniform standards and state of the art systems capabilities, achieving fast, accurate, and responsive service.

Oversight of Reporting Results and Implementing Corrective Actions - The national quality management committee reports the results of quality management program activities bi-annually to the national governing body.
To measure the effectiveness of the quality management program, we conduct an annual evaluation. This evaluation includes every aspect of the program with an emphasis on determining whether there have been demonstrated improvements in the delivery of services by our network dentists. We use the results to develop the work plan for the following year, in our continuous efforts to keep members satisfied.

CERTIFICATE OF REDOMESTICATION

INSURANCE COMPANY REDOMESTICATION TO CONNECTICUT

Office of the Secretary of the State

MAILING ADDRESS:
Commercial Recording Division
Connecticut Secretary of the State
P.O. Box 150470
Hartford, CT 06115-0470
860-509-6003

DELIVERY ADDRESS:
Commercial Recording Division
Connecticut Secretary of the State
30 Trinity Street
Hartford, CT 06106
860-509-6003

Certificate of Authorization from Insurance Commissioner and a certified copy of the original Articles of Incorporation must be filed with this certificate.

FEE: $100.00 *(plus franchise tax)*

Space For Office Use Only | **Make Checks Payable To "Secretary of the State"**

FILING #0004114403 PG 01 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02807
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. NAME OF INSURANCE COMPANY:

Alta Health & Life Insurance Company

2. CHARTER HISTORY OF CORPORATION (including date and place of incorporation, name change information and information regarding change of domicile state):

The corporation was originally incorporated on May 2, 1963 as "Orange State Life Insurance Company" under the laws of the State of Florida. On June 15, 1982, the corporation's name was changed to "Home Life Financial Assurance Corporation." On August 1, 1994, the corporation transferred its state of domicile from the State of Florida to the State of Ohio. On March 21, 1996, the corporation changed its corporate name to "Anthem Health & Life Insurance Company" and it transferred its state of domicile from the State of Ohio to the State of Indiana. On July 19, 1999, the corporation's name was changed to "Alta Health & Life Insurance Company."

3. APPROVALS:

The corporation's redomestication to Connecticut was approved by the Insurance Commissioner of the State of

Indiana
(State from which corporation is redomesticating)

The corporation's redomestication was approved by the Insurance Commissioner of the State of Connecticut as demonstrated by such Commissioner's Certificate of Approval included herewith.

(Please reference an 8 1/2 X 11 attachment if additional space is needed)

Space For Office Use Only

FILING #0004114403 PG 02 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02808
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

4. VOTE INFORMATION (check and complete A. or B.):

X **A.** The insurance company has authority to issue capital stock. The resolution of redomestication was adopted by its board of directors and approved by its shareholders as follows (provide at minimum the total number of shareholder votes cast in favor of the resolution and the total number of votes cast against the resolution or if no shareholder approval was required, provide a statement to that effect):

The board of directors of the corporation, acting by unanimous written consent, duly adopted resolutions approving the redomestication. The sole shareholder of the corporation, also acting by unanimous written consent, duly approved the redomestication.

____ **B.** The corporation is a mutual insurance company. The resolution of redomestication was adopted by its board of directors and approved by its members as follows (provide at minimum the total number of member votes cast in favor of the resolution and the total number of votes cast against the resolution or if no membership approval was required, provide a statement to that effect):

5. CERTIFICATE OF INCORPORATION:

The corporation's amended and restated Certificate of Incorporation is attached hereto.

6. EXECUTION:

Signed this 4th day of March, 2010.

Shermona Mapp	Corporate Secretary	
Print or type name of signatory	Capacity of signatory	Signature

Rev. 12/07/09

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FILED 03/05/2010 12:30 PM PAGE 02809
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

AMENDED AND RESTATED ARTICLES OF INCORPORATION

OF

ALTA HEALTH AND LIFE INSURANCE COMPANY

SECTION 1. The new name of the corporation shall be CIGNA Health and Life Insurance Company.

SECTION 2. In accordance with Connecticut General Statutes Section 38a-58a, the corporation shall adopt the State of Connecticut as its corporate domicile and shall be subject to the authority and jurisdiction of the State of Connecticut, with all the powers granted by the general statutes, as now enacted or hereafter amended, to corporations formed under the Connecticut Business Corporation Act. The corporation shall be a continuation of the body corporate incorporated in the State of Florida on May 2, 1963. The corporation shall continue to use May 2, 1963 as the date of incorporation.

SECTION 3. The business of the corporation shall be life insurance, endowments, annuities, accident insurance, health insurance and any other business or type of business which any other corporation now or hereafter chartered by Connecticut and empowered to do a health or life insurance business may now or hereafter lawfully do. The corporation is specifically empowered to accept and to cede reinsurance and retrocession of any such risks or hazards. The corporation may exercise such powers outside of Connecticut to the extent permitted by the laws of the particular jurisdiction. Policies or other contracts may be issued stipulated to be with or without participation in profits and with or without a seal.

SECTION 4. The corporation shall be authorized to issue 2,000,000 shares of common stock with a par value of two dollars ($2) per share. The capital stock of the corporation shall be transferable in accordance with the bylaws and a transfer agent may be employed.

SECTION 5. The annual meeting of the shareholders of the corporation shall be held at such time and place as may be determined from time to time either by or in accordance with the bylaws. If the corporation shall fail to hold its annual meeting at the time specified for the meeting in any year or shall fail to elect directors thereat, the corporation shall not be dissolved nor shall its rights be impaired thereby, but a special meeting of the shareholders shall he called; and at such meeting directors to fill the places of the directors whose terms shall have expired may be elected and any other proper business may be transacted. At all meetings of the shareholders each shareholder shall be entitled to vote in person or by an attorney duly authorized by a written proxy, and each share of stock represented at the meeting shall be entitled to one vote.

SECTION 6. The corporation's principal place of business shall be at 900 Cottage Grove Road, Bloomfield, Connecticut 06152, or at some other place within the State of Connecticut, and the corporation may establish and maintain other offices and agencies in other locations within or without the State. The property and affairs of the corporation shall be managed under the direction of a board of directors. The directors shall have concurrent power with the stockholders to make, alter, amend, change, add to or repeal the bylaws of the corporation. The number of directors of the corporation shall be as from time to time fixed by, or in the manner provided in, the by-laws of the corporation. Directors will be elected by a plurality of the votes cast at each annual meeting of shareholders of the corporation and each director so elected shall hold office until the next annual meeting of shareholders of the corporation or until such director's successor is duly elected and qualified, or until such director's earlier death, resignation or removal. If any vacancy occurs in the board of directors, such vacancy may be filled by a majority of the remaining directors, whether or not such directors constitute a quorum, for the unexpired portion of the term, and if the number of directors is increased by vote of the board of directors between meetings of shareholders, the additional directors may be chosen by the board of directors for terms expiring with the next annual meeting thereafter. Unless the bylaws provide for a lesser or greater quorum as may be permitted by law, a majority of the authorized number of directors, as fixed by the board of directors from time to time, shall constitute a quorum.

SECTION 7. Connecticut General Life Insurance Company shall be the corporation's registered agent. The registered agent's address is 900 Cottage Grove Road, Bloomfield, Connecticut 06152.

SECTION 8. The personal liability of a person who is or was a director of the corporation to the corporation or its shareholders for monetary damages for breach of duty as a director shall be limited to the amount of compensation received by the director for serving the corporation during the year of the violation if such breach did not (a) involve a knowing and culpable violation of law by the director, (b) enable the director or an associate, as defined in Section 33-840 of the Connecticut Business Corporation Act as in effect on the effective date hereof or as it may be amended from time to time (the "Act"), to receive an improper personal economic gain, (c) show a lack of good faith and a conscious disregard for the duty of the director to the corporation under circumstances in which the director was aware that his conduct or omission created an unjustifiable risk of serious injury to the corporation, (d) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the director's duty to the corporation, or (e) create liability under Section 33-757 of the Act. Any lawful repeal or modification of this Section 8 or the adoption of any provision inconsistent herewith by the board of directors and the shareholders of the corporation shall not, with respect to a person who is or was a director, adversely affect any limitation of liability, right or protection existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a director provided for in this Section 8 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any such person under, Connecticut law as in effect on the effective date hereof or as thereafter amended.

SECTION 9. The corporation may indemnify or advance expenses to a person who is or was a director, officer, employee or agent of the corporation, or who is or was serving at the corporation's request as a director, officer, partner, trustee, employee or agent of another corporation, a partnership, joint venture, trust, an employee benefit plan or other entity, to the extent permitted under Connecticut law as in effect on the effective date hereof or as thereafter amended, including, without limitation, pursuant to Section 33-636(b)(5) of the Act, for liability of any such person for any actions taken, or any failure to take any actions, except for conduct as set out in items (a) through (e) of Section 8, above. The corporation shall indemnify or advance expenses to any such person to the extent required by the bylaws of the corporation, as amended from time to time.

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FILED 03/05/2010 12:30 PM PAGE 02812
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

State of Connecticut

Insurance Department

This is to Certify, that

- the redomestication of Alta Health & Life Insurance Company, a Indiana Company, pursuant to Section 38a-58a Connecticut General Statutes, is approved, and

- the attached Certificate of Redomestication and Amended and Restated Articles of Incorporation effecting and name are change of domicile is approved.

Witness my hand and official seal, at HARTFORD,

this 3rd day of March, 2010

Insurance Commissioner

INDIANA SECRETARY OF STATE
BUSINESS SERVICES DIVISION
CORPORATIONS CERTIFIED COPIES

INDIANA SECRETARY OF STATE
BUSINESS SERVICES DIVISION
302 West Washington Street, Room E018
Indianapolis, IN 46204

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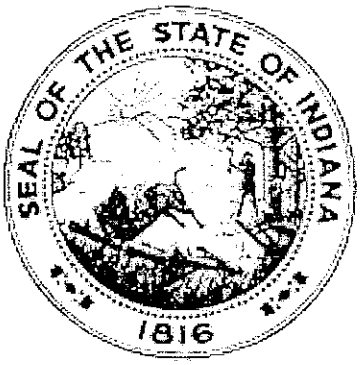
FILED 03/05/2010 12:30 PM PAGE 02813
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

http://www.sos.in.gov

January 13, 2010

Company Requested: ALTA HEALTH & LIFE INSURANCE COMPANY
Control Number: 1996031230

Date	Transaction	# Pages
03/21/1996	Articles of Incorporation	6
03/10/1999	Miscellaneous	1
04/19/1999	Notice of Change of Registered Office or Registered Agent	2
07/19/1999	Restatement of Articles of Incorporation	6
02/13/2001	Change of Officer	1
02/13/2001	Change of Principal Address	1
02/08/2002	Administrative Dissolution	1
05/21/2002	Application of Reinstatement	3
05/22/2009	Change of Principal Address	1



State of Indiana
Office of the Secretary of State

I hereby certify that this is a true and complete copy of this 22 page document filed in this office.

Dated: January 13, 2010
Certification Number: 2010011365565

Secretary of State

Certification Number: 2010011365565

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/21/1996
Effective Date: 03/21/1996

STATE OF INDIANA
OFFICE OF THE SECRETARY OF STATE

CERTIFICATE OF INCORPORATION

OF

ANTHEM HEALTH & LIFE INSURANCE COMPANY

I, SUE ANNE GILROY, Secretary of State of Indiana, hereby certify that Articles of Incorporation of the above corporation have been presented to me at my office accompanied by the fees prescribed by law; that I have found such Articles conform to law; all as prescribed by the provisions of the Indiana Business Corporation Law, as amended.

NOW, THEREFORE, I hereby issue to such corporation this Certificate of Incorporation, and further certify that its corporate existence will begin March 21, 1996.

In Witness Whereof, I have hereunto set my hand and affixed the seal of the State of Indiana, at the City of Indianapolis, this Twenty-first day of March, 1996.

Deputy

Certification Number: 2010011365565

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/21/1996
Effective Date: 03/21/1996

1996031230

APPROVED
DEPARTMENT OF INSURANCE
MAR 19 1996
STATE OF INDIANA
INSURANCE COMMISSIONER

APPROVED
AND
FILED
IND. SECRETARY OF STATE

ARTICLES OF INCORPORATION AND REDOMESTICATION

OF

ANTHEM HEALTH & LIFE INSURANCE COMPANY

PREAMBLE

The undersigned corporation desires to transfer its corporate domicile from the State of Ohio to the State of Indiana pursuant to the approval of the Indiana Commissioner of Insurance and to be recognized as a corporation from its original date of incorporation of May 2, 1963 in the State of Florida.

The undersigned corporation was incorporated on May 2, 1963 under the laws of the State of Florida under the name Orange State Life Insurance Company. On June 15, 1982, the corporation's name was changed to Home Life Financial Assurance Corporation. On August 1, 1994, the corporation transferred its corporate domicile from the State of Florida to the State of Ohio.

These Articles of Incorporation and Redomestication supersede the existing Articles of Incorporation of Home Life Financial Assurance Corporation.

ARTICLE A

NAME OF THE CORPORATION

The name of the corporation is

ANTHEM HEALTH & LIFE INSURANCE COMPANY

ARTICLE B

PRINCIPAL OFFICE

The address of the Corporation's principal office in the State of Indiana is 120 Monument Circle, Indianapolis, Indiana 46204. The name of its registered agent at such address is Sandra Miller.

ARTICLE C

PURPOSES

The Corporation is organized under the Indiana Insurance Law, Chapter 162 of the Acts of 1935, as amended, and the purposes for which it is organized are:

Certification Number: 2010011365565

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/21/1996
Effective Date: 03/21/1996

To insure the lives of persons and to make every insurance appertaining thereto or connected therewith including insurance against permanent mental or physical disability resulting from accident or disease, or against accidental death combined with a policy for life insurance and to grant, purchase or dispose of annuities.

To insure against bodily injury or death by accident and against disablement resulting from sickness and every insurance appertaining thereto.

All to the extent permitted and authorized by the Department of Insurance.

ARTICLE D

TERM OF EXISTENCE

The term for which the Corporation shall continue is perpetual.

ARTICLE E

SHARES

The total number of shares which the Corporation has authority to issue is 2,000,000 shares of Common Stock (the "Common Shares") with a par value of $2.00 each.

ARTICLE F

PAID-IN CAPITAL

The amount of paid-in capital is Two Million, Five Hundred Twenty Thousand Dollars ($2,520,000).

ARTICLE G

PLAN OF BUSINESS

The business of the Corporation shall be conducted on the legal reserve stock plan.

ARTICLE H

DATA RESPECTING OFFICERS AND DIRECTORS

The names and addresses of the persons elected to serve as Officers and Directors at the time of this reinstatement and until the next Annual Meeting of the Shareholder, or until their

Certification Number: 2010011365565

successors are elected and qualify, are:

Dwane R. Houser 9842 Forestglen Drive Cincinnati, Ohio 45242	Stefen F. Brueckner 4745 Burley Hills Drive Cincinnati, Ohio 45243	William F. Milnes, Jr. 331 Sunny Acres Cincinnati, Ohio 45255
Robert C. Heird 113 Lakeview Court Loveland, Ohio 45140	James A. White 11 Ashland Court Skillman, N.J. 08558	Wayne R. Hanus 54 Green Meadow Middletown, NJ 07748
Jeremiah J. Hanrahan 161 Monroe Avenue Belle Mead, NJ 08502		

ARTICLE I

PROVISIONS FOR REGULATION OF BUSINESS AND CONDUCT OF AFFAIRS OF CORPORATION

Section I.1. The Corporation shall have the right to engage in all lines of activity allied with or incidental to the purposes for which it is formed, not forbidden by the laws of the State of Indiana, and shall have the capacity to act, the authority and all of the general rights, privileges and powers referred to in Section 80 of Chapter 162 of the Acts of 1935, as amended.

Section I.2. The number of Directors of the Corporation shall not be less than five (5) nor more than twenty-one (21), the exact number of Directors to be determined, from time to time, in such manner as the By-Laws may prescribe.

ARTICLE J

MANNER OF ADOPTION AND VOTE

Section J.1. Action by Directors On February 1, 1996, a resolution was adopted by the Board of Directors of the Corporation proposing to the Shareholder of the Corporation entitled to vote in respect of the Amendment that the provisions and terms of its Articles of Incorporation be amended so as to read as set forth in these Articles of Incorporation and Redomestication and meeting of such Shareholder was called to be held February 1, 1996 to adopt or reject the Articles of Incorporation and Redomestication, unless the same was so approved by written consent.

Section J.2. Action by Shareholder At a duly-called meeting held February 1, 1996 the holder of one million two hundred sixty thousand shares of the Corporation, being all of the shares of the Corporation entitled to vote in respect of the Amendment, adopted the Amendment.

Section J.3. Compliance with Legal Requirements The manner of the adoption of the Amendment, and the vote by which it was adopted, constitute full legal compliance with the

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/21/1996
Effective Date: 03/21/1996

provisions of the Indiana Insurance Law, the Articles of Incorporation and the By-Laws of the Corporation.

ARTICLE K

Meetings of stockholders may be held within or without the State of Indiana, as the by-laws may provide. The books of the Corporation may be kept outside the state of Indiana at such place or places as may be designated from time to time by the Board of Directors or in the by-laws of the Corporation.

ARTICLE L

The Corporation reserves the right to amend, alter, change or repeal any provision contained in these Articles of Incorporation in the manner now or hereinafter prescribed herein and by the laws of the State of Indiana, and all rights conferred upon stockholders herein are granted subject to this reservation.

James A. White

Jeremiah J. Hanrahan

Wayne R. Hanus

Subscribed and sworn to before me this 19th day of January, 1996.

KIM R. NOVAK
Notary Public of New Jersey
My Commission Expires May 17, 2000
Lic. 2177955

Notary Public

(soibylaw)klm

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/21/1996
Effective Date: 03/21/1996

STATE OF INDIANA

OFFICE OF THE ATTORNEY GENERAL

INDIANA GOVERNMENT CENTER SOUTH, FIFTH FLOOR
402 WEST WASHINGTON STREET • INDIANAPOLIS, IN 46204-2770

PAMELA CARTER
ATTORNEY GENERAL

TELEPHONE (317) 232-6201

March 21, 1996

CERTIFICATION

I have examined the Articles of Incorporation and Redomestication of Anthem Health and Life Insurance Company and I certify that they conform to the provisions of the Indiana Insurance Law and are not inconsistent with the State and Federal Constitutions.

Respectfully submitted,

PAMELA CARTER
Attorney General of Indiana
Atty No. 0004242-49

Gordon E. White, Jr.
Deputy Attorney General
Atty No. 0001041-49

84019

Certification Number: 2010011365565

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/10/1999
Effective Date: 03/10/1999

1996031230

CERTIFICATE - CHANGE IN PRINCIPAL OFFICE

To: Indiana Department of Insurance
311 W. Washington Street, Suite 300
Indianapolis, IN 46204

To: Indiana Secretary of State
201 State House
Indianapolis, IN 46204

This will certify that, pursuant to authorization by the Board of Directors, the Principal Office of Anthem Health & Life Insurance Company has changed to 10401 North Meridian Street, Suite 350, Indianapolis, Indiana 46290.

G.R. Derback, Vice President and Treasurer

R.G. Schultz, Assistant Secretary

STATE OF Colorado)
) ss.
COUNTY OF Arapahoe)

On this 1st day of March, 1999, the undersigned personally appeared before me, known to me to be the persons whose names are subscribed above as Glen R. Derback and Richard G. Schultz, and acknowledged that they have executed the same, and that the foregoing statements are true and correct.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal.

Notary Public

My Commission Expires: April 9, 2000

VALERIE A. ADAIR NOTARY PUBLIC STATE OF COLORADO

Certification Number: 2010011365565

19960312 30

NOTICE OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT ALL CORPORATIONS

State Form 26276 (R / 1-88)

Provided by: EVAN BAYH

Indiana Secretary of State
Room 155, State House
Indianapolis, IN 46204
(317) 232-6576

Indiana Code 23-1-24-2 (for profit corporations)
Indiana Code 23-7-1 1-53 (non-profit corporations)
NO FILING FEE

President original and 2 copies

Name of Corporation	Date of Incorporation
Anthem Health Life Insurance Company	March 21, 1996

Current Registered Office Address	ZIP Code
120 Monument Circle, Indianapolis, IN	46204

New Registered Office Address
One North Capitol Avenue, Indianapolis, Indiana 46204

Current Registered Agent *(Type or Print Name)*
Sandra Miller

New Registered Agent *(Type or Print Name)*
C T Corporation System

SUE ANNE GILROY
APR 13 1999
RECEIVED

STATEMENT BY REGISTERED AGENT OR CORPORATION

This statement is a representation that the new registered agent has consented to the appointment as registered agent, or statement attached signed by registered agent giving consent to act as the new registered agent.

After the change or changes are made, the street address of this corporation's registered agent and the address of its registered office will be identical.

The resident agent filing this statement of change of the registered agent's business street address has notified the represented corporation in writing of the change, and the notification was manually signed or signed in facsimile.

IN WITNESS WHEREOF, the undersigned being the Assistant Secretary of said corporation executes this notice and verifies, subject to penalties of perjury, that the statements contained herein are true, this 7 day of April, 19 99.

Signature	Printed Name
R. Schultz	Richard Schultz

(INDIANA - 847 - 3/3/88)

19960312 30

FILING #0004114403 PG 16 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02822
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

STATEMENT OF CONSENT TO ACT AS REGISTERED AGENT

C T Corporation System hereby accepts the appointment to serve as registered agent in Indiana for Anthem Health Life Insurance Company .
(Name of Corporation)

4-13, 1999

C T CORPORATION SYSTEM

By Marcia J. Sunahara

Marcia J. Sunahara, Asst. V.P.
(Print Name and Title)

(IND. - 855 - 6/21/88)

Certification Number: 2010011365565

APPROVED
AND
FILED
IND. SECRETARY OF STATE

APPROVED
DEPARTMENT OF INSURANCE
JUN 30 1999
STATE OF INDIANA
INSURANCE COMMISSIONER

RECEIVED
CORPORATIONS DIV.
99 JUL 19 PM 3:55
SUE ANNE GILROY

RECEIVED
JUL 02 1999
ATTORNEY
OF INDIANA

RESTATED ARTICLES OF INCORPORATION

OF

ALTA HEALTH & LIFE INSURANCE COMPANY

PREAMBLE

The Corporation was originally incorporated on May 2, 1963 under the laws of the State of Florida as Orange State Life Insurance Company. On June 15, 1982, the Corporation's name was changed to Home Life Financial Assurance Corporation. On August 1, 1994, the Corporation transferred its corporate domicile from the State of Florida to the State of Ohio. On March 21, 1996, the Corporation's name was changed to Anthem Health & Life Insurance Company and its corporate domicile was transferred from the State of Ohio to the State of Indiana.

These Restated Articles of Incorporation supersede the existing Articles of Incorporation and Redomestication of Anthem Health & Life Insurance Company.

ARTICLE A

NAME OF THE CORPORATION

The name of the Corporation is ALTA HEALTH & LIFE INSURANCE COMPANY.

ARTICLE B

PRINCIPAL OFFICE

The address of the Corporation's principal office in the State of Indiana is 10401 North Meridian Street, Suite 350, Indianapolis, Indiana 46290.

ARTICLE C

PURPOSES

The Corporation is organized under the Indiana Insurance Law, Chapter 162 of the Acts of 1935, as amended, and the purposes for which it is organized are:

> To insure the lives of persons and to make every insurance appertaining thereto or connected therewith including insurance against permanent mental or physical disability resulting from accident or disease, or against accidental death combined with a policy for life insurance and to grant, purchase or dispose of annuities.

To insure against bodily injury or death by accident and against disablement resulting from sickness and every insurance appertaining thereto.

All to the extent permitted and authorized by the Department of Insurance.

ARTICLE D

TERM OF EXISTENCE

The term for which the Corporation shall continue is perpetual.

ARTICLE E

SHARES

The total number of shares which the Corporation has authority to issue is 2,000,000 shares of common stock with a par value of $2.00 each, for total authorized capital of $4,000,000.

ARTICLE F

PAID-IN CAPITAL

The amount of paid-in capital is $2,520,000.

ARTICLE G

PLAN OF BUSINESS

The business of the Corporation shall be conducted on the legal reserve stock plan.

ARTICLE H

DIRECTORS AND OFFICERS

The following are the names and addresses of the directors of the Corporation who have been elected to serve until the next annual meeting of shareholders, or until their successors are elected and qualified:

Director's Name	Address
Mitchell T.G. Graye	8515 E. Orchard Road Englewood, Colorado 80111
William T. McCallum	8515 E. Orchard Road Englewood, Colorado 80111

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FILED 03/05/2010 12:30 PM PAGE 02825
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Director's Name	Address
Steve H. Miller	8505 E. Orchard Road Englewood, Colorado 80111
James D. Motz	8505 E. Orchard Road Englewood, Colorado 80111
Michael R. Quigley	10401 N. Meridian Street, Suite 350 Indianapolis, Indiana 46290
Martin Rosenbaum	8505 E. Orchard Road Englewood, Colorado 80111
James A. White	1 Centennial Avenue Piscataway, New Jersey 08854

The following are the names, positions and addresses of the principal officers of the Corporation who have been elected to serve until the next annual meeting of directors, or until their successors are elected and qualified:

Officer's Name	Position Held	Address
William T. McCallum	Chairman of the Board	8515 E. Orchard Road Englewood, Colorado 80111
James D. Motz	Vice Chairman and Chief Executive Officer	8505 E. Orchard Road Englewood, Colorado 80111
James A. White	President	1 Centennial Avenue Piscataway, New Jersey 08854
Mitchell T.G. Graye	Executive Vice President and Chief Financial Officer	8515 E. Orchard Road Englewood, Colorado 80111
John T. Hughes	Senior Vice President and Chief Investment Officer	8515 E. Orchard Road, Englewood, Colorado 80111
D.Craig Lennox	Senior Vice President, General Counsel and Secretary	8515 E. Orchard Road, Englewood, Colorado 80111
Glen R. Derback	Vice President and Treasurer	8515 E. Orchard Road, Englewood, Colorado 80111
James L. McCallen	Vice President and Actuary	8515 E. Orchard Road, Englewood, Colorado 80111

ARTICLE I

PROVISIONS FOR REGULATION OF BUSINESS AND CONDUCT OF AFFAIRS OF CORPORATION

Section I.1. The Corporation shall have the right to engage in all lines of activity allied with or incidental to the purposes for which it is formed, not forbidden by the laws of the State of Indiana, and shall have the capacity to act, the authority and all of the general rights, privileges and powers referred to in Section 80 of Chapter 162 of the Acts of 1935, as amended.

Section I.2. The number of Directors of the Corporation shall not be less than five nor more than twenty-one, the exact number of Directors to be determined, from time to time, in such manner as the By-Laws may prescribe.

ARTICLE J

MANNER OF ADOPTION AND VOTE

Section J.1. Action by Directors On June 15, 1999, a resolution was adopted by the Board of Directors of the Corporation proposing to the sole shareholder of the Corporation that the provisions and terms of its Articles of Incorporation and Redomestication be amended so as to read as set forth in these Restated Articles of Incorporation.

Section J.2. Action by Sole Shareholder On June 15, 1999, a resolution was adopted by the sole shareholder of the Corporation, adopting these Restated Articles of Incorporation.

Section J.3. Compliance with Legal Requirements The manner of the adoption of the Restated Articles of Incorporation, and the vote by which it was adopted, constitute full legal compliance with the provisions of the Indiana Insurance Law, the Articles of Incorporation and Redomestication and the By-Laws of the Corporation.

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FILED 03/05/2010 12:30 PM PAGE 02827
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

ARTICLE K

The Corporation reserves the right to amend, alter, change or repeal any provision contained in these Restated Articles of Incorporation in the manner now or hereinafter prescribed herein and by the laws of the State of Indiana, and all rights conferred upon stockholders herein are granted subject to this reservation.

J.D. Motz
Vice Chairman and
Chief Executive Officer

D.C. Lennox
Senior Vice President,
General Counsel and Secretary

Subscribed and sworn before me this 25th day of June, 1999.

Notary Public

My commission expires April 9, 2000.

STATE OF INDIANA

OFFICE OF THE ATTORNEY GENERAL

INDIANA GOVERNMENT CENTER SOUTH, FIFTH FLOOR
402 WEST WASHINGTON STREET • INDIANAPOLIS, IN 46204-2770

JEFFREY A. MODISETT
ATTORNEY GENERAL

TELEPHONE (317) 232-6201

19960831230

July 10, 1999

CERTIFICATION

I have examined the Restated Articles of Incorporation of Alta Health & Life Insurance Company which is changing its name from Anthem Health & Life Insurance Company, and I certify that they conform to the provisions of the Indiana Insurance Law and are not inconsistent with the State and Federal Constitutions.

Respectfully submitted,

JEFFREY A. MODISETT
Attorney General of Indiana
Atty No. 0014704-49

Gordon E. White, Jr.
Deputy Attorney General
Atty No. 0001041-49

15981

Certification Number: 2010011365565

19960312 30

Alta Health & Life Insurance Company
PO Box 2110
Denver, CO 80201 0759
800 521 5174
www.altaic.com

February 8, 2001

Sue Anne Gilroy
Indiana Secretary of State
P.O. Box 5501
Indianapolis, IN 46255

APPROVED
ACKNOWLEDGED
FILED
IND. SECRETARY OF STATE

RE: Alta Health & Life Insurance Company

Dear Mrs. Gilroy:

This letter is sent to inform you of a change in the presidency of Alta Health & Life Insurance Company. Effective January 1, 2001 James White retired from his position as President. J. D. Motz, the current Chairman and Chief Executive Officer was appointed to fill the presidency. His biographical affidavit is currently on file with your office because of his previous positions as Director and Officer of the corporation.

Also, please note that our corporate office has had a change in the city name, due to postal reorganization. The address is: 8505 East Orchard Road, Greenwood Village, CO 80111.

Thank you for adding this information to our business entity file.

Sincerely,

Connie Page

Connie Page
Legal Assistant

Indiana Secretary of State
Packet: 1996031230
Filing Date: 02/13/2001
Effective Date: 02/13/2001

1996031230

Alta Health & Life Insurance Company
PO Box 230
Denver, CO 80201-0230
800-521-5124
www.ahlic.com

February 8, 2001

Sue Anne Gilroy
Indiana Secretary of State
P.O. Box 5501
Indianapolis, IN 46255

APPROVED
AND
FILED
IND. SECRETARY OF STATE

RE: Alta Health & Life Insurance Company

Dear Mrs. Gilroy:

This letter is sent to inform you of a change in the presidency of Alta Health & Life Insurance Company. Effective January 1, 2001 James White retired from his position as President. J. D. Motz, the current Chairman and Chief Executive Officer was appointed to fill the presidency. His biographical affidavit is currently on file with your office because of his previous positions as Director and Officer of the corporation.

Also, please note that our corporate office has had a change in the city name, due to postal reorganization. The address is: 8505 East Orchard Road, Greenwood Village, CO 80111.

Thank you for adding this information to our business entity file.

Sincerely,

Connie Page

Connie Page
Legal Assistant

INDIANA SECRETARY OF STATE

SYSTEM GENERATED
ADMINISTRATIVE DISSOLUTION/REVOCATION

Pursuant to the provisions set forth in Indiana Code Title 23
the entity has been Administratively Dissolved or
the Certificate of Authority revoked.

A certified copy of this document authenticates the date of
the Administrative Dissolution/Revocation

Certification Number: 2010011365565

Indiana Secretary of State
Packet: 1996031230
Filing Date: 05/21/2002
Effective Date: 05/21/2002

State of Indiana
Office of the Secretary of State

CERTIFICATE OF REINSTATEMENT

of

ALTA HEALTH & LIFE INSURANCE COMPANY

I, SUE ANNE GILROY, Secretary of State of Indiana, hereby certify that Application of Reinstatement of the above For-Profit Domestic Corporation have been presented to me at my office, accompanied by the fees prescribed by law and that the documentation presented conforms to law as prescribed by the provisions of the Indiana Business Corporation Law.

NOW, THEREFORE, with this document I certify that said transaction will become effective Tuesday, May 21, 2002.

In Witness Whereof, I have caused to be affixed my signature and the seal of the State of Indiana, at the City of Indianapolis, May 21, 2002.

Sue Anne Gilroy

SUE ANNE GILROY,
SECRETARY OF STATE

1996031230 / 2002052459762

Certification Number: 2010011365565

Indiana Secretary of State
Packet: 1996031230
Filing Date: 05/21/2002
Effective Date: 05/21/2002

19960312 30

APPLICATION FOR REINSTATEMENT

State Form 4160 (R8 / 3-97) / 111
Approved by the State Board of Accounts 1995

SUE ANNE GILROY
SECRETARY OF STATE
CORPORATIONS DIVISION
302 W. Washington St., Rm. E018
Indianapolis, IN 46204
Telephone: (317) 232-6576

Indiana Code 23-1-46-3 *(for profit corporation)*
Indiana Code 23-17-23-3 *(not-for-profit corporation)*

Application must include:

1. **Certificate of Clearance** issued by the Indiana Department of Revenue
2. **Corporate Reports and Fees:** please call our information line to learn what reports are delinquent (317) 232-6576
   a. Up to and including 1995, Annual Reports filed every year.
      Annual Report fee $10.00
   b. Beginning with 1996, Biennial Reports filed every two years.
      Biennial Report fee $30.00
      Corporations incorporated in an even year, file every even year.
      Corporations incorporated in an odd year, file every odd year.
   c. Nonprofit corporations file Annual Reports every year.
      Nonprofit Corporate Report fee $10..00
3. **Restatement filing fee: $30.00**

APPROVED
INDIANA DEPARTMENT OF REVENUE

THIS APPLICATION CANNOT BE ACCEPTED WITHOUT A NOTICE OF CLEARANCE FOR REINSTATEMENT FROM THE INDIANA DEPARTMENT OF REVENUE.

SECTION I - CORPORATE INFORMATION

Name of corporation	Date of incorporation *(mo., day, yr.)*
Alta Health & Life Insurance Company	5/2/1963

Effective date of administrative dissolution
2/8/2002

SECTION II - AFFIDAVIT OF CORPORATE OFFICER OF DIRECTOR

The undersigned, being at least one of the principal officers or a director of the above-named corporation deposes and says:

A. that the grounds for dissolution did not exist or have been eliminated, and;

B. that the Corporation's name satisfies the requirements of Indiana Code 23-1-23-1, or Indiana Code 23-17-5-1.

IN WITNESS WHEREOF, the undersigned being the Assistant Secretary (Title) of said corporation executes this application and verifies, subject to penalties of perjury, that the statements contrained herein are true, this 1st day of May, ~~19~~ 2002.

Signature	Printed name
R. Schultz	Richard G. Schultz, Assistant Secretary

Certification Number: 20100113655 65

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FILED 03/05/2010 12:30 PM PAGE 02834
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Indiana Secretary of State
Packet: 1996031230
Filing Date: 05/21/2002
Effective Date: 05/21/2002

RECEIVED
APR 2 6 2002
LAW DEPT

Indiana Department of Revenue

CERTIFICATE OF CLEARANCE FOR REINSTATEMENT

AD-190 (Rev. 1/01)
SF#

Name of Corporation

Alta Health & Life Insurance Company
8515 East Orchard Road
Greenwood Village, CO 80111

Federal ID#
591031071
TID #
0102240450
Date Issued (Valid for 60 days)
04/12/2002

TO: Sue Anne Gilroy
Secretary of State
Corporations Division

The corporation named above has filed with the Department of State Revenue an affidavit, Form AD-19, disclosing that the corporation is applying for a Certificate of Reinstatement from the Secretary of State, and requesting a Certificate of Clearance from this Department stating all taxes and fees owed by the corporation have been paid.

An examination of the corporation's existing accounts for listed taxes and fees required to be administered or collected by the Department has determined that all taxes, fees, interest, and penalties due have been paid or satisfied. Execution of this document does not preclude the Department from future examination and adjustment of the corporation's Indiana tax accounts for any period.

This Certificate of Clearance shall be null and void sixty (60) days after its date of issue.

Kenneth L. Miller, Commissioner
Indiana Department of Revenue

Diane Freeman, Administrator
Compliance Division

BY:

Instructions to the corporation:

This notice is the signed original. You are to include this certification along with the other documents constituting your **Application for Reinstatement** (SF#4160). Do Not Mail this certificate separately to the Secretary of State unless you are so directed.

NOTICE OF CHANGE OF PRINCIPAL OFFICE ADDRESS

State Form 50656 (R/1-03)

TODD ROKITA
SECRETARY OF STATE
CORPORATIONS DIVISION
302 W. Washington St., Rm. E018
Indianapolis, IN 46204
Telephone: (317) 232-6576

INSTRUCTIONS: *Use 8 1/2" x 11" white paper for attachments.*
Present original and one copy to address in upper right corner of this form.
Please TYPE or PRINT.
Please visit our office on the web at www.sos.in.gov

Indiana Code 23-1-1-1 et seq.

NO FILING FEE

Name of corporation or other entity	Date of incorporation / organization / registration
Alta Health & Life Insurance Co.	3/21/1996
Current principal office address (number and street, city, state, ZIP code)	
8515 E. Orchard Road, Greenwood Village, CO 80111	
New principal office address (number and street, city, state, ZIP code)	
11595 N. Meridian Street, Suite 600, Carmel, IN 46032	

IN WITNESS WHEREOF, the undersigned executes this notice and verifies, subject to the penalties of perjury, that the statements contained herein are true, this 19th day of May, 20 09.

Signature	Title
Jennifer Grant	Assistant Secretary

Indiana Secretary of State
Packet: 1996031230
Filing Date: 05/22/2009
Effective Date: 05/22/2009

APPROVED AND FILED
IND. SECRETARY OF STATE

COPY

Certification Number: 2010011365565

CIGNA CORPORATION
1601 Chestnut Street
Philadelphia, PA 19192

March 5, 2010

FILING #0004114403 PG 30 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02836
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Connecticut Secretary of State
30 Trinity Street
Hartford, CT 06106

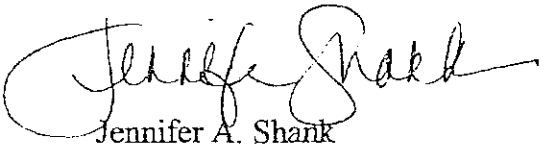
Re: CIGNA Health and Life Insurance Company

Dear Sir/Madam:

I currently have the above-referenced name reserved for use in Connecticut. I hereby transfer the reservation to CT Corporation System.

Thank you for your assistance.

Very truly yours,



Jennifer A. Shank

CIGNA DENTAL HEALTH OF CALIFORNIA, INC.

COMPLETE CHARTER:

- Articles of Incorporation of CIGNA Dental Health of California, Inc. filed on October 22, 1985

State of California

OFFICE OF THE SECRETARY OF STATE

I, *MARCH FONG EU*, Secretary of State of the State of California, hereby certify:

That the annexed transcript has been compared with the record on file in this office, of which it purports to be a copy, and that same is full, true and correct.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this

OCT 23 1985

March Fong Eu

Secretary of State

1354969

ENDORSED
FILED
In the office of the Secretary of State
of the State of California

OCT 2 2 1985

MARCH FONG EU, Secretary of State
Sharon K. Hawkins
Deputy

ARTICLES OF INCORPORATION

OF

CIGNA DENTAL HEALTH

OF CALIFORNIA, INC.

(A California Corporation)

I

The name of this corporation is CIGNA DENTAL HEALTH OF CALIFORNIA, INC.

II

The purpose of this corporation is to engage in any lawful act or activity for which a corporation may be organized under the General Corporation Law of California other than the banking business, the trust company business or the practices of a profession permitted to be incorporated by the California Corporations Code.

III

The name and address in this state of the corporation's initial agent for service of process are:

CT CORPORATION SYSTEM

IV

This corporation is authorized to issue one class of shares which shall be designated as "common" shares. The total number of such shares which this corporation is authorized to issue is ten thousand (10,000).

DATED: October 18, 1985

ALFRED M. CLARK III, Incorporator

I, the undersigned, declare that I am the person who executed the above Articles of Incorporation, and such instrument is my act and deed.

DATED: October 18, 1985

ALFRED M. CLARK III

(Department of Corporations Use Only)
Fee Paid $_____
Receipt No. _____

Department of Corporations File No., if any
_____
(Insert File Number(s) of Previous Filings Before the Department, if any)

FEE: $25.00 $35.00 $50.00 $150.00 $300.00
(Circle the appropriate amount of fee.
See Corp. Code Section 25608(c))

COMMISSIONER OF CORPORATIONS
STATE OF CALIFORNIA

NOTICE OF TRANSACTION PURSUANT TO CORPORATIONS CODE SECTION 25102(f)

A. Check one: Transaction under (X) Section 25102(f) ( ) Rule 260.103.

1. Name of Issuer: CIGNA DENTAL HEALTH OF CALIFORNIA, INC.
2. Address of Issuer: 1525 N.W. 167 Street, Miami, Florida 33169
Street City State ZIP
Mailing Address: P.O. Box 4650, Miami, Florida 33269-1650
Street City State ZIP
3. Area Code and Telephone Number: (305) 621-1100
4. Issuer's state (or other jurisdiction) of incorporation or organization: California
5. Title of class or classes of securities sold in transaction: Common Stock
6. The value of the securities sold or proposed to be sold in the transaction, determined in accordance with Corp. Code Sec. 25608(g) in connection with the fee required upon filing this notice, is (fee based on amount shown in line (iii) under "Total Offering"):

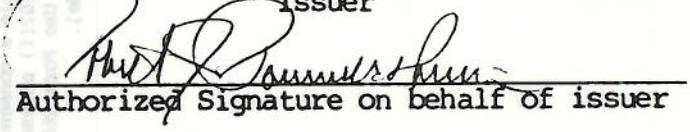
	California	Total Offering
(a) (i) in money	$ Ø	$ 1,000
(ii) in consideration other than money	$ Ø	$ Ø
(iii) total of (i) and (ii)	$ Ø	$ 1,000

(b) ( ) Change in rights, preferences, privileges or restrictions of or on outstanding securities. ($25.00 fee.) (See Rule 260.103.)

7. Type of filing under Securities Act of 1933, if applicable: None

8. Date of Notice: November 7, 1985

CIGNA DENTAL HEALTH OF CALIFORNIA, INC.
Issuer



Authorized Signature on behalf of issuer

ROBERT J. POMMERSHEIM
Print name and title of signatory

( ) Check if issuer already has a consent to service of process on file with the Commissioner.

Name, Address and Phone number of contact person:
David A. Ebershoff, Esq., Hill, Farrer & Burrill, 445 South Figueroa Street, 34th Floor, Los Angeles, California 90071, (213) 620-0460

Instruction: Each issuer (other than a California corporation) filing a notice under Section 25102(f) must file a consent to service of process (Form 260.165), unless it already has a consent to service on file with the Commissioner.

260.102.14(c) (10/84)

STATE OF COLORADO

DEPARTMENT OF STATE

CERTIFICATE

I, **NATALIE MEYER**, *Secretary of State of the State of Colorado hereby certify that*

According to the records of this office

CIGNA DENTAL HEALTH OF COLORADO, INC.
(COLORADO CORPORATION)

has complied with the applicable provisions of the laws of the State of Colorado and on this date is in good standing and authorized and competent to transact business or to conduct its affairs within this state.

Date of Inc.
3-19-86

DATED: APR 1 1986

Natalie Meyer
SECRETARY OF STATE

6324
DATE INC 3-19-86

CIGNA DENTAL HEALTH OF COLORADO, INC. BY

ARTICLES OF INCORPORATION

The undersigned natural person, being 18 or more years of age, hereby establishes a corporation pursuant to the statutes of Colorado and adopts the following Articles of Incorporation:

FIRST: The name of the Corporation is CIGNA Dental Health of Colorado, Inc.

SECOND: The Corporation shall have perpetual existence.

THIRD: (a) Purposes. The purposes for which the Corporation is organized are as follows: to transact all lawful business for which corporations may be incorporated pursuant to the Colorado Corporation Code, and specifically to establish and operate a prepaid dental care plan organization pursuant to Article 16.5 of Title 10 of the Colorado Revised Statutes.

(b) Powers. In furtherance of its lawful purposes the Corporation shall have and may exercise all of the rights, powers and privileges now or hereafter exercisable by corporations organized under the laws of Colorado. In addition, it may do everything necessary, suitable, convenient or proper for the accomplishment of any of its corporate purposes.

FOURTH: The aggregate number of shares which the Corporation shall have authority to issue is 10,000 shares of Common with a par value of $.01 per share.

FIFTH: The shareholders of the Corporation shall not have cumulative voting rights in the election of directors.

SIXTH: The shareholders of the Corporation shall not have any preemptive rights.

SEVENTH: The Board of Directors may from time to time distribute to the shareholders in partial liquidation, out of stated capital or capital surplus of the Corporation, a portion of its assets, in cash or property, subject to the limitations contained in the statutes of Colorado.

EIGHTH: The following provisions are inserted for the regulation of the internal affairs of the Corporation, and they are in furtherance of and not in limitation or exclusion of the powers conferred by law:

(a) Negation of equitable interests in shares or rights. Except as otherwise provided in the By-Laws and resolved by the Board of Directors, the Corporation shall be entitled to treat the registered holder of any shares of the Corporation as the owner thereof for all purposes, including all rights deriving from such shares, and shall not be bound to recognize any equitable or other claim to, or interest in, such shares or rights deriving from such shares, on the part of any other person, including but without limiting the generality hereof, a purchaser, assignee or transferee of such shares or of rights deriving from such shares, unless and until such purchaser, assignee, transferee or other person becomes the registered holder of such shares, whether or not the Corporation shall have either actual or constructive notice of the interest of such purchaser, assignee, transferee or other person; and no

such purchaser, assignee, transferee or other person shall be entitled to receive notice of the meetings of the shareholders, to vote at such meetings, to examine a list of the shareholders, to be paid dividends or other sums payable to shareholders, or to own, enjoy and exercise any other property or rights deriving from such shares against the Corporation, until such purchaser, assignee, transferee or other person has become the registered holder of such shares.

(b) Restrictions on transfer of stock. The Corporation is granted the right to impose such restrictions on the transfer of the shares as a majority of the Board of Directors deems necessary, advisable or proper.

NINTH: The address of the initial registered office of the Corporation is 1700 Broadway, Suite 1211, Denver, Colorado 80290. The name of its initial registered agent at such address is C. T. Corporation Company.

TENTH: Three directors shall constitute the initial Board of Directors, their names and addresses being as follows:

NAME	ADDRESS
Lawrence Brody, D.D.S.	1525 N.W. 167 Street, Suite 250 Miami, Florida 33169
Martin Samuels, C.P.A.	1525 N.W. 167 Street, Suite 250 Miami, Florida 33169
Robert J. Pommersheim	1525 N.W. 167 Street, Suite 250 Miami, Florida 33169

ELEVENTH: The name and address of the incorporator is:

NAME	ADDRESS
Susan L. Jones, Esq.	1675 Broadway, Suite 2600 Denver, CO 80202

TWELFTH: Pursuant to Section 7-4-118(2), C.R.S. 1973, any and every action requiring the vote or concurrence of holders of two-thirds of the outstanding shares entitled to vote thereon, or of any class or series, may be taken by the vote or concurrence of a majority of such shares or class or series thereof.

DATED: November 19, 1985.

Susan L. Jones

VERIFICATION

STATE OF COLORADO)
) ss.
COUNTY OF DENVER)

I, Irene K. Baker a Notary Public, hereby certify that on the 19th day of Novmeber, 1985, personally appeared before me, Susan L. Jones, who, being by me first duly sworn, declared that she is the person who signed the foregoing document as incorporator and that the statements therein contained are true.

WITNESS my hand and official seal.

Irene K. Baker
Notary Public

Address: 1675 Broadway, Suite 2600
Denver, CO 80202

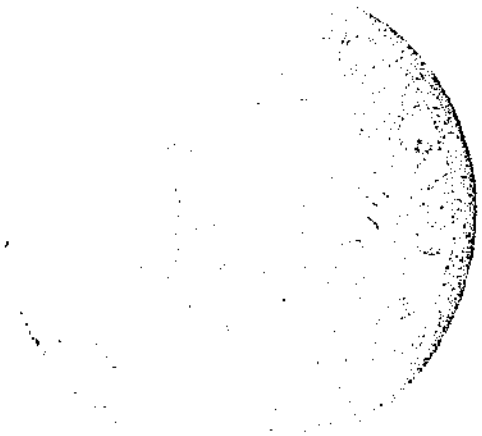
My Commission Expires: 7/2/89

[SEAL]

Date of Incorporation
varified with
Sec of State of CO
as 3/19/86

~~Nov 19, 1986~~

~~Date 4/23/87~~



DEPARTMENT OF STATE

3/19/86

Secretary of State

G14316

FILED

DEC 22 10 59 AM '82

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

ARTICLES OF INCORPORATION

OF

PREFERRED HEALTH CARE, INC.

ARTICLE I.

CORPORATE NAME

The name of this Corporation shall be:

PREFERRED HEALTH CARE, INC.

ARTICLE II.

NATURE OF CORPORATE BUSINESS

The Corporation may engage in any activity or business permitted under the laws of the United States and under the laws of the State of Florida.

ARTICLE III.

CAPITAL STOCK

The amount of capital stock authorized shall be Three Million (3,000,000) shares with a par value of one cent ($.01) per share, of which one million (1,000,000) shares shall be Preferred Stock and two million (2,000,000) shares shall be Common Stock.

The Board of Directors is authorized to issue all or part of the authorized shares of Preferred Stock as a class or in series as set forth by resolution. The relative rights and preferences, with regard to dividend rates, redemption rights, conversion privileges, if any; voting power, if any, and other privileges and limitations of each series relative to each other series of Preferred Stock and to the Common Stock of the corporation, if the Preferred Stock is issued in series or relative to the Common Stock alone, if the Preferred Stock is issued as a class, shall be fixed by resolution of the Board of Directors. The Board of Directors shall file a statement with the Department of State as provided by Section 607.047 of the Florida Statutes or any successor provision of law.

Whenever used herein or in any other corporate document, the term "Preferred Stock" shall mean and include Preferred Stock issued as a class without series, or one or more series thereof or both unless the context shall otherwise require.

ARTICLE IV.

INITIAL REGISTERED AGENT AND INITIAL REGISTERED OFFICE

The Corporation's initial Registered Agent and Registered Office in the State of Florida shall be:

S.S.R.S.& H. REGISTERED AGENT CORPORATION
c/o Sparber, Shevin, Rosen, Shapo & Heilbronner, P.A.
30th Floor, AmeriFirst Building
One Southeast Third Avenue
Miami, Florida 33131

ARTICLE V.

BOARD OF DIRECTORS

The number of Directors may be altered from time to time by By-Laws adopted by the Stockholders. However, the Corporation shall have no less than one (1) Director at any time.

ARTICLE VI.

INITIAL DIRECTOR

The name and post office address of the first Director of the Corporation is:

Name	Address
MARTIN SAMUELS	540 N.W. 165 Street Road Suite 201-204 Miami, Florida 33169

The first Director shall hold office until the first annual meeting of the Stockholders of the Corporation.

ARTICLE VII.

INCORPORATOR

The name and post office address of the Incorporator executing these Articles of Incorporation is as follows:

Incorporator	Address
S.S.R.S.& H. Registered Agent Corporation	c/o Sparber, Shevin, Rosen, Shapo & Heilbronner, P.A. 30th Floor, AmeriFirst Building One Southeast Third Avenue Miami, Florida 33131

THE UNDERSIGNED Incorporator, for the purpose of forming a Corporation to do business within the State of Florida, does make and file these Articles of Incorporation, hereby declaring and certifying that the facts stated are true.

S.S.R.S.& H. REGISTERED AGENT CORPORATION

By _____ (SEAL)

STATE OF FLORIDA)
COUNTY OF DADE) SS.:

BE IT REMEMBERED that on this day before me, a Notary Public duly authorized in the State and County named above to take acknowledgments, personally appeared _____, to me known to be an authorized signatory of the person described as the Incorporator in the foregoing Articles of Incorporation, and he acknowledged before me that he executed said Articles of Incorporation.

WITNESS my hand and official seal at Miami, said County and State, this 17 day of December, 1985.

_____
NOTARY PUBLIC

Notary Public, State of Florida
My Commission Expires Sept. 21, 1986

The undersigned hereby accepts the foregoing designation as initial Registered Agent and agrees to comply with the provisions of law applicable to said designation.

S.S.R.S.& H. REGISTERED AGENT CORPORATION

By _____
Registered Agent

STATEMENT OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT, OR BOTH

To the Secretary of State of the State of Florida.

Pursuant to the provisions of Sections 607.034 and 607.037, Florida Statutes, the undersigned corporation, organized under the laws of the State of Florida, submits the following statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida.

FIRST: The name of the corporation is PREFERRED HEALTH CARE, INC.

SECOND: The address of its present registered office is 1 Southeast Third Ave. 30th Floor, Amerifirst Building, Miami, Florida 33131

THIRD: The address to which its registered office is to be changed is c/o C T Corporation System, 8751 West Broward Blvd., Plantation, Florida 33324

FOURTH: The name of its present registered agent is S.R.S. & H. Registered Agent Corporation

FIFTH: The name of its successor registered agent is C T CORPORATION SYSTEM

FILED
SECRETARY OF STATE
TALLAHASSEE, FLORIDA
FEB 27 10 47 AM '86

SIXTH The address of its registered office and the address of the business office of its registered agent, as changed, will be identical.

SEVENTH: Such change was authorized by resolution duly adopted by its board of directors.

Dated January 22, 1986, 1986.

Preferred Health Care, Inc.
(exact corporate name)

SIGNATURE By: Martin Jannes
(President or Vice-President)

DATE January 30, 1986

C T CORPORATION SYSTEM
SIGNATURE By: Diane L Cleaver
(Registered Agent) Specialist

DATE 2-10-86

FILING FEE: $3.00

(FLA. - 350 - 7/29/82)

FILED
APR 23 2 51 PM '86
TALLAHASSEE, FLORIDA

ARTICLES OF AMENDMENT

OF

PREFERRED HEALTH CARE, INC.

Pursuant to section 607.181 of the General Corporation Act of Florida, the undersigned corporation adopts these Articles of Amendment.

FIRST: The name of the corporation is PREFERRED HEALTH CARE, INC.

SECOND: The Articles of Incorporation of this corporation is amended by changing the article number "I" so that, as amended, said article shall read as follows: I. The name of the corporation is CIGNA DENTAL HEALTH, INC.

THIRD: The amendment to the Articles of Incorporation was adopted by the shareholders of the corporation on the 1st day of April , 1986 .

Signed this 9th day of April , 1986.

PREFERRED HEALTH CARE, INC.

By _____
President,

By _____
Secretary,

STATE OF FLORIDA

COUNTY OF DADE

The foregoing instrument was adopted before me this 9thday of April , 1986, by Laurence Brody, President of PREFERRED HEALTH CARE, INC. on behalfof the corporation.

My commission expires _____

Doris Fenech
Notary Public

(SEAL)

NOTARY PUBLIC STATE OF FLORIDA
MY COMMISSION EXP. SEP 29,1989
BONDED THRU GENERAL INS. UND.

ARTICLES OF MERGER

OF

CIGNA Dental Administrators, Inc.
(a Florida corporation)

and

CIGNA Dental Data Systems, Inc.
(a Florida corporation)

and

CIGNA Dental Management Systems, Inc.
(a Florida corporation)

INTO

CIGNA Dental Health, Inc.
(a Florida corporation)

Pursuant to Section 607.1104 of the Florida Business Corporation Act, the undersigned corporations adopt the following Articles of Merger:

FIRST: The plan of merger is attached hereto as Exhibit A and is hereby incorporated by this reference.

SECOND: The effective date of the merger is January 1, 1994.

THIRD: Shareholder approval was not required.

FOURTH: The plan of merger was adopted by the board of directors of CIGNA Dental Health, Inc. on December 10, 1993.

Signed this 20th day of December, 1993.

CIGNA Dental Health, Inc.

By: _____
Zayra F. Calderon
President

ATTEST: _____
Pamela S. Williams
Assistant Secretary

CIGNA Dental Administrators, Inc.

By: _____
Zayra F. Calderon
President

ATTEST: _____
Pamela S. Williams
Assistant Secretary

CIGNA Dental Data Systems, Inc.

By: _____
Zayra F. Calderon
President

ATTEST: _____
Pamela S. Williams
Assistant Secretary

CIGNA Dental Management Systems, Inc.

By: _____
Zayra F. Calderon
President

ATTEST: _____
Pamela S. Williams
Assistant Secretary

Exhibit A

AGREEMENT AND PLAN OF MERGER

of

CIGNA Dental Administrators, Inc.
and
CIGNA Dental Data Systems, Inc.
and
CIGNA Dental Management Systems, Inc.

into

CIGNA Dental Health, Inc.

Agreement and Plan of Merger dated as of the 10th day of December, 1993 between CIGNA Dental Health, Inc., a Florida corporation (sometimes hereinafter referred to as the "Surviving Corporation"), CIGNA Dental Administrators, Inc., a Florida corporation, CIGNA Dental Data Systems, Inc., a Florida corporation, and CIGNA Dental Management Systems, Inc., a Florida corporation (such latter three corporations sometimes hereinafter collectively referred to as the "Merged Corporations"):

WITNESSETH THAT:

WHEREAS, CIGNA Dental Health, Inc., CIGNA Dental Administrators, Inc., CIGNA Dental Data Systems, Inc., and CIGNA Dental Management Systems, Inc. deem it advisable to merge into a single corporation; and

WHEREAS, said CIGNA Dental Health, Inc. had its original Articles of Incorporation filed in the office of the Secretary of State of Florida on December 22, 1982, and has an authorized capital stock consisting of 1,000,000 preferred shares of the par value of $.01 per share, and 2,000,000 shares of common stock of the par value of $.01 per share, of which 987,500 shares of common stock are now issued and outstanding and are owned by Connecticut General Corporation, a Connecticut corporation, and no shares of preferred stock are now issued and outstanding; and

WHEREAS, said CIGNA Dental Administrators, Inc. had its original Articles of Incorporation filed in the office of the Secretary of State of Florida on August 28, 1987, and has an authorized capital stock consisting of 1,000 shares of common no par value stock, of which 1,000 shares of such common stock are now issued and outstanding and are owned by CIGNA Dental Health, Inc.; and

WHEREAS, said CIGNA Dental Data Systems, Inc. had its original Articles of Incorporation filed in the office of the Secretary of State of Florida on June 15, 1984, and has an authorized capital stock consisting of 1,000 shares of common stock of the par value of $1.00 per share, of which 500 shares of such common stock are

now issued and outstanding and are owned by CIGNA Dental Health, Inc.; and

WHEREAS, said CIGNA Dental Management Systems, Inc. had its original Articles of Incorporation filed in the office of the Secretary of State of Florida on May 15, 1974, and has an authorized capital stock consisting of 200,000 shares of preferred stock of the par value of $.001 per share and 1,000,000 shares common stock of the par value of $.001 per share, of which 847,500 shares of common stock are now issued and outstanding and are owned by CIGNA Dental Health, Inc., and no shares of preferred stock are now issued and outstanding; and

WHEREAS, each of said CIGNA Dental Health, Inc., CIGNA Dental Administrators, Inc., CIGNA Dental Data Systems, Inc. and CIGNA Dental Management Systems, Inc. has the power and authority under the laws of the State of Florida to merge into a single corporation; and

WHEREAS, the Board of Directors of CIGNA Dental Health, Inc. in accord with the laws of the State of Florida, the Articles of Incorporation, as amended, and the Bylaws, as amended, of said corporation, the Board of Directors of CIGNA Dental Administrators, Inc. in accord with the laws of the State of Florida, the Articles of Incorporation, as amended, and the Bylaws of said corporation, the Board of Directors of CIGNA Dental Data Systems, Inc. in accord with the laws of the State of Florida, the Articles of Incorporation, as amended, and the Bylaws, as amended, of said corporation and the Board of Directors of CIGNA Dental Management Systems, Inc. in accord with the laws of the State of Florida, the Articles of Incorporation, as amended, and the Bylaws, as amended, of said corporation, each have duly authorized the execution and delivery of this Agreement and Plan of Merger (sometimes hereafter referred to as this "Plan") by the President and attested by the Assistant Secretary of each corporation, for the purpose of merging said four corporations into a single corporation which shall be CIGNA Dental Health, Inc., a corporation of the State of Florida;

NOW THEREFORE, the parties to this Plan, in consideration of the mutual covenants, agreements and provisions hereinafter contained, do hereby prescribe the terms and conditions of said merger and mode of carrying the same into effect as follows:

FIRST: CIGNA Dental Administrators, Inc, CIGNA Dental Data Systems, Inc. and CIGNA Dental Management Systems, Inc. shall be merged with and into CIGNA Dental Health, Inc., which shall be the corporation surviving the merger and shall continue as a Florida domestic business corporation.

SECOND: The Articles of Incorporation of CIGNA Dental Health, Inc., as amended, in effect on the effective date of the merger provided for in this Plan shall continue in full force and effect as the Articles of Incorporation of the Surviving Corporation.

THIRD: The Bylaws of CIGNA Dental Health, Inc., as amended to date and in effect on the effective date of the merger provided for in this Plan shall continue unchanged as the Bylaws of the Surviving Corporation until the same shall thereafter be altered, amended or repealed in accordance with law or the Articles of Incorporation or Bylaws of the Surviving Corporation.

FOURTH: The manner of converting the outstanding shares of the capital stock shall be as follows:

(a) The outstanding 987,500 shares of common stock of CIGNA Dental Health, Inc. shall continue to be outstanding, and from and after the effective date of this merger, said shares shall be all of the issued and outstanding shares of the corporation surviving the merger.

(b) The 1,000 shares of common stock of CIGNA Dental Administrators, Inc. which shall be outstanding on the effective date of this merger, and all rights in respect thereof, shall forthwith all be cancelled.

(c) The 500 shares of common stock of CIGNA Dental Data Systems, Inc. which shall be outstanding on the effective date of this merger, and all rights in respect thereof, shall forthwith all be cancelled.

(d) The 847,500 shares of common stock of CIGNA Dental Management Systems, Inc. which shall be outstanding on the effective date of this merger, and all rights in respect thereof, shall forthwith all be cancelled.

(e) After the effective date of this merger, the holders of the outstanding certificates representing shares of common stock of CIGNA Dental Administrators, Inc., CIGNA Dental Data Systems, Inc. and CIGNA Dental Management Systems, Inc. shall surrender the same to the Surviving Corporation and said certificates shall be cancelled. Until so surrendered, the outstanding shares of the stock of each of the Merged Corporations to be cancelled, as provided herein, may be treated by the Surviving Corporation for all corporate purposes as though said cancellation had taken place.

FIFTH: Shareholders of each subsidiary who, except for the applicability of Section 607.1104 of the Florida Business Corporation Act (the "Act"), would be entitled to vote and who dissent from the merger pursuant to Section 607.1320 of the Act, may be entitled, if they comply with the provisions of the Act regarding the rights of dissenting shareholders, to be paid the fair value of their shares.

SIXTH: Other terms and conditions of the merger are as follows:

(a) The name of the Surviving Corporation shall be CIGNA Dental Health, Inc.

(b) The registered office of the Surviving Corporation is and shall be c/o C T Corporation System, 8751 West Broward Boulevard, Plantation, Florida 33324.

(c) The Directors and officers of the Surviving Corporation shall continue in office until the next annual meetings of the stockholders and of the Board of Directors, respectively, or until their successors shall have been elected and qualified.

(d) The effective date of this Plan and of the merger to be effected pursuant to the provisions hereof shall be January 1, 1994.

(e) At the effective date of this Plan (as defined in Section (d) hereof) the separate existence of each of the Merged Corporations shall cease and all the property, rights, privileges, franchises, patents, trademarks, licenses, registrations and other assets of every right and kind belonging to the Merged Corporations, by virtue of the merger and without any further act or deed, shall be deemed to be vested in CIGNA Dental Health, Inc. as the corporation surviving the merger and it shall thenceforth be responsible for all liabilities and obligations of CIGNA Dental Administrators, Inc., CIGNA Dental Data Systems, Inc. and CIGNA Dental Management Systems, Inc.

(f) The Merged Corporations hereby agree from time to time, as and when requested by the Surviving Corporation or by its successors or assigns, to execute and deliver or cause to be executed and delivered all such deeds and instruments and to take or cause to be taken such further or other action as the Surviving Corporation may deem necessary or desirable in order to vest in and confirm to the Surviving Corporation title to and possession of any property of the Merged Corporations acquired or to be acquired by reason of or as a result of the merger herein provided for and otherwise to carry out the intent and purposes hereof, and the proper officers and the Directors of the Merged Corporations and the proper officers and the Directors of the Surviving Corporation are fully authorized, in the name of the Merged Corporations or otherwise, to take any and all such action.

(g) The Surviving Corporation is and shall continue to be a corporation organized under the laws of the State of Florida and shall continue to be controlled by the laws of the State of Florida.

SEVENTH: This Plan may be abandoned by any party to this Plan at any time prior to filing the Articles of Merger with the Florida Department of State.

IN WITNESS WHEREOF, the parties to this Agreement and Plan of Merger have caused these presents to be executed by the President and attested by the Assistant Secretary of each party hereto as the respective act, deed and agreement of each of the corporations, as of the 10th day of December, 1993.

CIGNA Dental Health, Inc.

By: _____
Zayra F. Calderon
President

ATTEST: _____
Pamela S. Williams
Assistant Secretary

CIGNA Dental Administrators, Inc.

By: _____
Zayra F. Calderon
President

ATTEST: _____
Pamela S. Williams
Assistant Secretary

CIGNA Dental Data Systems, Inc.

By: _____
Zayra F. Calderon
President

ATTEST: _____
Pamela S. Williams
Assistant Secretary

CIGNA Dental Management Systems, Inc.

By: _____
Zayra F. Calderon
President

ATTEST: _____
Pamela S. Williams
Assistant Secretary

CERTIFICATE OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT, OR BOTH

(FOR USE BY DOMESTIC AND FOREIGN, PROFIT AND NON-PROFIT CORPORATIONS)

CORPORATION NAME CIGNA DENTAL HEALTH OF NEW JERSEY, INC.

STATE OF ORIGINAL INCORPORATION New Jersey

IMPORTANT—INCLUDE INFORMATION ON BOTH THE PRIOR AND NEW AGENT

PRIOR AGENT NAME: Timothy J. Hinlicky, Esq.	NEW AGENT NAME: THE CORPORATION TRUST COMPANY
PRIOR AGENT STREET ADDRESS: 3 Greentree Center, Ste. 401 Route 73 & Greentree Road	NEW AGENT STREET ADDRESS: 28 WEST STATE STREET
CITY: Marlton STATE: NJ ZIP: 08053	CITY: TRENTON STATE: N.J. ZIP: 08608

The corporation states that the address of its new registered office and the address of its new registered agent are identical. Further, the changes designated on this form were authorized by resolution duly adopted by its board of directors or members.

By Gail M. Garcia (Signature of Officer) Title Vice President/Secretary (Print or Type)

Date May 19, 1988

NOTE—This form must be executed by the chairman of the board, or the president, or vice president of the corporation.

FEES: Change of Agent Name—$10.00
Change of Agent Address—$10.00
Change of Both—$10.00

MAIL TO: Secretary of State
Change of Agent Unit
State House, CN 300
Trenton, NJ 08625

MAKE CHECKS PAYABLE TO THE SECRETARY OF STATE (NO CASH PLEASE).

IMPORTANT NOTICE

The failure of the corporation to notify the Secretary of State of a change in the registered agent or registered office will result in a penalty of $200.00 and the entering of a docketed judgment against the corporation in the Superior Court of New Jersey.

(N. J. - 2001 - 8/20/84)

C-104G

FOR OFFICIAL USE ONLY

FILED

MAY 31 1988

JANE BURGIO
Secretary of State

Rev. 10/1/83

FILED

SEP 3 1985

JANE BURGIO
Secretary of State

607283
NCP

CERTIFICATE OF AMENDMENT TO THE CERTIFICATE OF INCORPORATION OF

DHI, Inc.
(For Use by Domestic Corporations Only)

To: The Secretary of State
State of New Jersey

Pursuant to the provisions of Section 14A:9-2(4) or 14A:9-4(3), Corporations, General, of the New Jersey Statutes, the undersigned corporation executes the following Certificate of Amendment to its Certificate of Incorporation:

1. The name of the corporation is DHI, Inc.

2. The following amendment to the Certificate of Incorporation was approved by the directors and thereafter duly adopted by the sole holder of the corporation on the 15th day of August, 1985:

Resolved, that Article 1 of the Certificate of Incorporation be amended to read as follows:

The name of the corporation is CIGNA Dental Health of New Jersey, Inc.

3. The number of shares entitled to vote upon the amendment was 10,000.

If the shares of any class or series are entitled to vote thereon as a class, set forth below the designation and number of shares entitled to vote thereon of each such class or series. (Omit if not applicable.)

(Use the following paragraph if amendment adopted by shareholders at a meeting)

4. The number of shares voting for and against such amendment is as follows: (If the shares of any class or series are entitled to vote as a class, set forth the number of shares of each such class and series voting for and against the amendment, respectively.)

Number of Shares Voting For Amendment	Number of Shares Voting Against Amendment

(Use the following paragraph if the amendment was adopted by the written consents of the shareholders without a meeting, in the manner authorized by N.J.S. Sec. 14A:5-6)

4. That in lieu of a meeting and vote of the shareholders and in accordance with the provisions of Section 14A:5-6, the amendment was adopted by the shareholders without a meeting pursuant to the written consents of the shareholders and the number of shares represented by such consents is 10,000 shares. (If any class or series are entitled to vote as a class, set forth the number of shares of any class or series entitled to vote as a class and indicate that the amendment was also approved by the written consent of that class of shareholders and the number of shares of said class or series represented by the consents.)

(N.J. - 2003 - 5/1/74) -1-

0100200276

0226 0468

(If the amendment is accompanied by a reduction of stated capital, the following clause may be inserted in the Certificate of Amendment, in lieu of filing a Certificate of Reduction under Section 14A:7-19, Corporations, General, of the New Jersey Statutes. Omit this clause if not applicable.)

5. The stated capital of the corporation is reduced in the following amount: _____. The manner in which the reduction is effected is as follows:

N/A

The amount of stated capital of the corporation after giving effect to the reduction is $_____. (Must be set forth in dollars.)

6. If the amendment provides for an exchange, reclassification or cancellation of issued shares, set forth a statement of the manner in which the same shall be affected. (Omit if not applicable.)

N/A

(Use the following only if an effective date, not later than 30 days subsequent to the date of filing is desired.)

7. The effective date of this Amendment to the Certificate of Incorporation shall be immediately.

Dated this 15th day of August, 1985.

DHI, Inc.
(Corporate Name)

By Martin Samuels
(Signature)

Martin Samuels, Executive Vice President
(Type or Print Name and Title)

(*May be executed by the chairman of the board, or the president, or a vice-president of the corporation.)

359—N J CERTIFICATE OF INCORPORATION
One or more Incorporators

ADGRV T

FILED

JUL 18 1983

JANE BURGIO
Secretary of State

Certificate of Incorporation of

DHI Inc.

This is to certify that, *there is hereby organized a corporation under and by virtue of N.J.S. 14A:1-1 et seq., the "New Jersey Business Corporation Act."*

14A:2-7 (1) (a) *1. The name of the corporation is* DHI Inc.

14A:2-7 (1) (g) *2. The address (and zip code) of this corporation's initial registered office is*
115 High Street, Mount Holly, New Jersey 08060

and the name of this corporation's initial registered agent at such address is
Timothy J. Hinlicky, Esquire

14A:2-7 (1) (b) *3. The purposes for which this corporation is organized are:*

To engage in any activity within the purposes for which corporations may be organized under the "New Jersey Business Corporation Act." N.J.S. 14A:1-1 et seq.

14A 2-7 (1) (b) 5. *The first Board of Directors of this corporation shall consist of* 3 *Director(s) and the name and address of each person who is to serve as such Director is:*

Name	*Address*	*Zip Code*
Laurence B. Brody, D.D.S.	17301 NW.27th Avenue Miami, FL	33055
P.C. Damico, D.D.S.	55 N. & Laurel St. Hazelton, PA	18201
Donald F. Hockman, D.D.S.	308 W. Johnson Hwy. Norristown, PA	19401

14A 2-7 (1) (c) 6. *The name and address of each incorporator is:*

Name	*Address*	*Zip Code*
Timothy J. Hinlicky, Esquire Parker, McCay and Criscuolo	115 High Street Mt. Holly, NJ	08060

In Witness Whereof, *each individual incorporator, each being over the age of eighteen years, has signed this Certificate; or if the incorporator be a corporation, has caused this Certificate to be signed by its authorized officers, this* 18th *day of* July *19* 83.

Timothy J. Hinlicky, Esq. .....

.....

.....

14A:2-7 (1) (c) 4. *The aggregate number of shares which the corporation shall have authority to issue is*

Ten Thousand, common stock.

I, The Secretary of State of the State Of New Jersey, DO HEREBY CERTIFY that the foregoing is A true copy of CERTIFICATE OF Incorporation and the endorsements thereon, as the same is taken from and compared with the original filed in my office on the 18 day of July ,A.D. 1983 and now remaining on file and of record therein.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my Official Seal at Trenton, this 18 day of July 1983 , A.D.

SECRETARY OF STATE

Jane Burgio

Certificate of Incorporation of

DHI Inc.

FORWARDED FOR RECORDING AND FILING

BY: (INCLUDE ADDRESS AND ZIP CODE)

Timothy J. Hinlicky, Esquire
Parker, McCay and Criscuolo
115 High Street
Mount Holly, New Jersey 08060

Department of State

The State of Ohio

Sherrod Brown
Secretary of State

656812

Certificate

It is hereby certified that the Secretary of State of Ohio has custody of the Records of Incorporation and Miscellaneous Filings; that said records show the filing and recording of: ARF

of:

CIGNA DENTAL HEALTH OF OHIO, INC.

United States of America
State of Ohio
Office of the Secretary of State

Recorded on Roll F672 at Frame 1824 of the Records of Incorporation and Miscellaneous Filings.

Witness my hand and the seal of the Secretary of State, at the City of Columbus, Ohio, this 17TH **day of** JUNE, **A.D. 19**85.

Sherrod Brown

Sherrod Brown
Secretary of State

FOSTER-1821

APPROVED
BY KHF
DATE 6-17-85
AMOUNT 100 00

ARTICLES OF INCORPORATION

OF

CIGNA DENTAL HEALTH OF OHIO, INC.

The undersigned, desiring to form a corporation for profit under Chapter 1701 of the Ohio Revised Code, does hereby certify:

1. The name of the corporation is CIGNA Dental Health of Ohio, Inc.

2. The place in Ohio where the principal office of the corporation is to be located is the city of Columbus, County of Franklin. The address of its statutory agent in the State of Ohio is 813 Carew Tower, in the City of Cincinnati, County of Hamilton. The name of its registered agent at such address is CT Corporation System.

3. The nature of the business or purposes to be conducted or promoted is:

To engage in any lawful act or activity for which corporations may be formed under Sections 1701.01 to 1701.98, inclusive, of the Ohio Revised Code.

4. The total number of shares of common stock which the corporation shall have authority to issue is One Thousand (1,000) and the par value of each of such shares is One Dollar ($1.00) amounting in the aggregate to One Thousand Dollars ($1,000).

5. The name and mailing address of the incorporator is as follows: Charles S. DeRousie, 52 East Gay Street, P. O. Box 1008, Columbus, Ohio 43216-1008.

061485

6. The corporation is to have perpetual existence.

7. In furtherance and not in limitation of the powers conferred by statute, the board of directors is expressly authorized:

To make, alter or repeal by-laws for their own government not inconsistent with the articles or the regulations.

8. Elections of directors need not be by written ballot unless the regulations of the corporation shall so provide.

9. Meetings of stockholders may be held within or without the State of Ohio, as the regulations may provide. The books of the corporation may be kept (subject to any provision contained in the statutes) outside the State of Ohio at such place or places as may be designated from time to time by the board of directors or in the regulations of the corporation.

10. The corporation reserves the right to amend, alter, change or repeal any provision contained in these articles of incorporation, in the manner now or hereafter prescribed by statute, and all rights conferred upon stockholders herein are granted subject to this reservation.

The undersigned, being the incorporator hereinbefore named, for the purpose of forming a corporation pursuant to the General Corporation Law of the State of Ohio, does make this certificate, hereby declaring and certiftying that this is his act and deed and the facts herein stated are true, and accordingly has hereunto set his hand this 14th day of June, 1985.

Charles S. DeRousie

Charles S. DeRousie, Incorporator

P0672-1820

ORIGINAL APPOINTMENT OF AGENT

The undersigned, being the sole incorporator of CIGNA Dental Health of Ohio, Inc., hereby appoints CT Corporation System, a corporation which is authorized by its articles to act as such agent, and which has a business address in the State of Ohio, upon which any process, notice, or demand required or permitted by statute to be served upon the corporation may be served. The complete address of CT Corporation System is:

CT Corporation System
813 Carew Tower
Hamilton County
Cincinnati, Ohio 45202

Charles S. DeRousie, Incorporator

Columbus, Ohio
June 14, 1985

061485

783818

FILED
In the Office of the
Secretary of State of Texas

JUL 13 1990

Corporations Section

To the Secretary of State
of the State of Texas:

C T Corporation System, as the registered agent for the domestic and foreign corporations named on the attached list submits the following statement for the purpose of changing the registered office for such corporations, in the State of Texas:

1. The name of the corporation is See attached list

2. The post office address of its present registered office is c/o C T CORPORATION SYSTEM, 1601 ELM STREET, DALLAS, TEXAS 75201

3. The post office address to which its registered office is to be changed is c/o C T CORPORATION SYSTEM, 350 N. ST. PAUL STREET, DALLAS, TEXAS 75201

4. The name of its present registered agent is C T CORPORATION SYSTEM

5. The name of its successor registered agent is C T CORPORATION SYSTEM

6. The post office address of its registered office and the post office address of the business office of its registered agent, as changed, will be identical.

7. Notice of this change of address has been given in writing to each corporation named on the attached list 10 days prior to the date of filing of this certificate.

Dated July 2, 1990.

C T CORPORATION SYSTEM

By [signature]

Its Vice President

ASSUMED NAME CERTIFICATE

FILED
In the Office of the
Secretary of State of Texas
NOV 19 1998
Corporations Section

1. The name of the corporation, limited liability company, limited partnership, or registered limited liability partnership as stated in its articles of incorporation, articles of organization, certificate of limited partnership, application or comparable document is CIGNA Dental Health of Texas, Inc.

2. The assumed name under which the business or professional service is or is to be conducted or rendered is CIGNA Dental

3. The state, country, or other jurisdiction under the laws of which it was incorporated, organized or associated is Texas, and the address of its registered or similar office in that jurisdiction is 350 N. St. Paul Street, Dallas, Tx 75201

4. The period, not to exceed 10 years, during which the assumed name will be used is 10 years

5. The entity is a (circle one): (business corporation,) non-profit corporation, professional corporation, professional association, limited liability company, limited partnership, registered limited liability partnership or some other type of incorporated business, professional or other association (specify)

6. If the entity is required to maintain a registered office in Texas, the address of the registered office is C T Corporation System and the name of its registered agent at such address is 350 N. St. Paul Street, Dallas, TX 75201. The address of the principal office (if not the same as the registered office) is 600 East Las Colinas Blvd., Suite 1000 Irving, TX 75039

7. If the entity is not required to or does not maintain a registered office in Texas, the office address in Texas is N/A and if the entity is not incorporated, organized or associated under the laws of Texas, the address of its place of business in Texas is N/A and the office address elsewhere is N/A

8. The county or counties where business or professional services are being or are to be conducted or rendered under such assumed name are (if applicable, use the designation "ALL" or "ALL EXCEPT"):

All

(Certificate must be executed and acknowledged by the owner of the name.)

Pamela S. Williams

Signature of officer, ~~general partner, manager, representative or attorney-in-fact of the entity~~

Pamela S. Williams Assistant Secretary

Before me on this 13th day of November, 19 98, personally appeared Pamela S. Williams and acknowledged to me that she executed the foregoing certificate for the purposes therein expressed.

(Notary Seal)

Johanna B. Snyder

Notary Public, State of ~~Texas~~ CT

Johanna B. Snyder

My Commission expires July 31, 2001

INSTRUCTIONS FOR FILING ASSUMED NAME CERTIFICATE

1. A corporation, limited liability company, limited partnership or registered limited liability partnership, which regularly conducts business or renders a professional service in this state under a name other than the name contained in its articles of incorporation, articles of organization, certificate of limited partnership or application, must file an assumed name certificate with the secretary of state and with the appropriate county clerk in accordance with section 36.11 of the Texas Business and Commerce Code.

2. The information provided in paragraph 6 as regards the registered agent and registered office address in Texas must match the information on file in this office. To verify the information on file with this office, you may contact our corporate information unit at (512) 463-5555. Forms to change the registered agent/office are available from this office should you require to update this information.

3. A certificate executed and acknowledged by an attorney-in-fact shall include a statement that the attorney-in-fact has been duly authorized in writing by his principal to execute and acknowledge the same.

4. For purposes of filing with the secretary of state, the assumed name registrant should submit an originally executed assumed name certificate accompanied by the filing fee of $25 to the **Secretary of State, Statutory Filings Division, Corporations Section, P.O. Box 13697, Austin, Texas 78711-3697. The phone number is (512) 463-5582, TDD: (800) 735-2989, FAX: (512) 463-5709.**

5. All assumed name certificates to be filed with the county clerk must be forwarded directly to the appropriate county clerk by the assumed name registrant.

6. Whenever an event occurs that causes the information in the assumed name certificate to become materially misleading (e.g. change of registered agent/office or a change of name), a new certificate must be filed within 60 days after the occurrence of the events which necessitate the filing.

7. A registrant that ceases to transact business or render professional services under an assumed name for which a certificate has been filed may file an abandonment of use pursuant to the Texas Business and Commerce Code, §36.14. Forms for this purpose are available from this office.

ARTICLES OF CORRECTION

OF

CIGNA DENTAL HEALTH OF TEXAS, INC.

These Articles are adopted to correct a document which is an inaccurate record of corporate action, contains an inaccurate or erroneous statement or was defectively or erroneously executed, sealed, acknowledged or verified.

I.

The name of the corporation is CIGNA Dental Health of Texas, Inc.

II.

The document to be corrected is the Articles of Incorporation filed in the office of the Secretary of State on January 31, 1986.

III.

The error to be corrected is the spelling of the name of one of the directors constituting the initial Board of Directors. The correct spelling of the name of such director is as follows: Robert J. Pommersheim.

IV.

Article VI of the Articles of Incorporation, as corrected, shall read as follows:

"The number of directors constituting the initial Board of Directors is three (3), and the names and addresses of the persons who are to serve as directors until the first annual meeting of shareholders, or until their successors are elected and qualified, are as follows:

Laurence Brody	1525 N. W. 167 Street Suite 250 Miami, Florida 33169
Martin Samuels	1525 N. W. 167 Street Suite 250 Miami, Florida 33169
Robert J. Pommersheim	1525 N. W. 167 Street Suite 250 Miami, Florida 33169"

President

Secretary

STATE OF FLORIDA)
)
COUNTY OF DADE)

I, the undersigned, a Notary Public in and for FLORIDA, _____, do hereby certify that on the 19 day of JUNE, 1987, personally appeared Laurence B. Brody, Gail M. Garcia of CIGNA Dental Health of Texas, Inc. who, being by me duly sworn, declared that he is the person who signed the foregoing instrument on behalf of said corporation, in the capacity therein stated and that the statements therein contained are true.

Dorsi Fenech
Notary Public

My Commission Expires:

[illegible]

6283A

ASSUMED NAME CERTIFICATE
FOR AN INCORPORATED BUSINESS OR PROFESSION

FILED
In the Office of the
Secretary of State of Texas
JAN 26 1987
Clerk III-L
Corporations Section

1. The assumed name under which the business or professional service is or is to be conducted or rendered is CIGNA Dental Health

2. The name of the incorporated business or profession as stated in its Articles of Incorporation or comparable document is CIGNA Dental Health of Texas, Inc.

3. The state, country, or other jurisdiction under the laws of which it was incorporated is Texas and the address of its registered or similar office in that jurisdiction is 1601 Elm Street, Dallas, Texas 75201

4. The period, not to exceed ten years, during which the assumed name will be used is Ten years

5. The corporation is a (circle one):

business corporation, nonprofit corporation, professional corporation, professional association or other type of corporation (specify) _____

or other type of

incorporated business, professional or other association or

legal entity (specify) _____

6. If the corporation is required to maintain a registered office in Texas, the address of the registered office is 1601 Elm Street, Dallas, TX 75201

and the name of its registered agent at such address is C T Corporation System

The address of the principal office (if not the same as the registered office) is Eight Greenway Plaza, Suite 626, Houston, TX 77046

7. If the corporation is not required to or does not maintain a registered office in Texas, the office address in Texas is N/A

and if the corporation is not incorporated, organized, or associated under the laws of Texas, the address of its place of business in Texas is N/A

and the office address elsewhere is N/A

8. The county or counties where business or professional services are being or are to be conducted or rendered under such assumed name are (if applicable, use the designation "ALL" or "ALL EXCEPT _____"): ALL

Gail M Garcia

Signature of officer, representative, or attorney-in-fact of the corporation

Before me on this 21 day of January, 19 87, personally appeared Gail Garcia and acknowledged to me that she executed the foregoing certificate for the purposes therein expressed.

NOTARY PUBLIC STATE OF FLORIDA
MY COMMISSION EXP JUNE 20,1989
BONDED THRU GENERAL INS. UND

Doris Fenech

(Notarial Seal) Notary Public Dade County

NOTE: A certificate executed and acknowledged by an attorney-in-fact shall include a statement that the attorney-in-fact has been duly authorized in writing by his principal to execute and acknowledge the same.

ARTICLES OF CORRECTION

OF

CIGNA DENTAL HEALTH OF TEXAS, INC.

These Articles are adopted to correct a document which is an inaccurate record of corporate action, contains an inaccurate or erroneous statement or was defectively or erroneously executed, sealed, acknowledged or verified.

I.

The name of the corporation is CIGNA Dental Health of Texas, Inc.

II.

The document to be corrected is the Articles of Incorporation filed in the office of the Secretary of State on January 28, 1986.

III.

The error to be corrected is the spelling of the name of one of the directors constituting the initial Board of Directors. The correct spelling of the name of such director is as follows: Robert J. Pommersheim.

IV.

Article VI of the Articles of Incorporation, as corrected, shall read as follows:

"The number of directors constituting the initial Board of Directors is three (3), and the names and addresses of the persons who are to serve as directors until the first annual meeting of shareholders, or until their successors are elected and qualified, are as follows:

Laurence Brody	1525 N.W. 167 Street Suite 250 Miami, Florida 33169
Martin Samuels	1525 N.W. 167 Street Suite 250 Miami, Florida 33169
Robert J. Pommersheim	1525 N.W. 167 Street Suite 250 Miami, Florida 33169"

_____, President ~~or Vice President~~

_____, Secretary ~~or Assistant Secretary~~

STATE OF FLORIDA §
§
COUNTY OF DADE §

I, the undersigned, a Notary Public in and for Dade County, Florida, do hereby certify that on the 18th day of March, 1986, personally appeared Laurence B. Brody, Gail M. Garcia of CIGNA Dental Health of Texas, Inc., who, being by me duly sworn, declared that he is the person who signed the foregoing instrument on behalf of said corporation, in the capacity therein stated and that the statements therein contained are true.

Doris Fleneck
Notary Public

My Commission Expires:

NOTARY PUBLIC STATE OF FLORIDA
MY COMMISSION EXP JUNE 20,1989
BONDED THRU GENERAL INS. AND.

ARTICLES OF INCORPORATION

OF

CIGNA DENTAL HEALTH OF TEXAS, INC.

I.

The name of the corporation is CIGNA Dental Health of Texas, Inc.

II.

The period of its duration is perpetual.

III.

The purpose for which the corporation is organized is to engage in the transaction of any or all lawful business for which a corporation may be incorporated under the Texas Business Corporation Act.

IV.

The aggregate number of shares which the corporation shall have authority to issue is 10,000 shares of the Common Stock of the par value of $0.01 each.

V.

The street address of the initial registered office of the corporation is 1601 Elm Street, Dallas, Texas 75201, and the name of its initial registered agent at such address is CT Corporation System.

VI.

The number of directors constituting the initial Board of Directors is three (3), and the names and addresses of the persons who are to serve as directors until the first annual meeting of shareholders, or until their successors are elected and qualified, are as follows:

Laurence Brody	1525 N.W. 167 Street Suite 250 Miami, Florida 33169
Martin Samuels	1525 N.W. 167 Street Suite 250 Miami, Florida 33169
Robert J. Pommerscheim	1525 N.W. 167 Street Suite 250 Miami, Florida 33169

VII.

The preemptive right of any shareholder of the corporation to acquire additional, unissued or treasury shares of the corporation, or securities of the corporation convertible into or carrying a right to subscribe to or acquire shares of the corporation, is hereby denied.

VIII.

Cumulative voting by the shareholders of the corporation at any election for directors of the corporation is hereby prohibited. Every shareholder entitled to vote at each such election shall have the right to vote, in person or by proxy, the number of shares owned by him for as many persons as there

are directors to be elected and for whose election he has a right to vote.

IX.

The corporation shall indemnify any and all persons who may serve or who may have served at any time as directors or officers of the corporation or who, at the request of the Board of Directors of the corporation, may serve or at any time have served as directors and officers of another corporation in which the corporation at such time owned or may own shares of stock or of which it was or may be a creditor, and their respective heirs, administrators, successors and assigns, against any and all expenses, including amounts paid upon judgments, counsel fees and amounts paid in settlement (before or after suit is commenced), actually and necessarily incurred by such persons in connection with the defense or settlement of any claim, action, suit or proceeding, in which they, or any of them, are made parties, or a party, or which may be asserted against them or any of them, by reason of being or having been directors or officers or a director or officer of the corporation, or of such other corporation, except in relation to matters as to which any such director or officer or former director or officer or person shall be adjudged in any action, suit or proceeding to be guilty of negligence or misconduct in the performance of duty. Such indemnification

shall be in addition to any other rights to which those indemnified may be entitled under any law, By-Law, agreement, vote of shareholders or otherwise.

X.

Except to the extent such power may be modified or divested by action of shareholders representing a majority of the issued and outstanding shares of the capital stock of the corporation, the power to alter, amend or repeal the By-Laws of the corporation shall be vested in the Board of Directors.

XI.

The corporation shall not commence business until it has received for the issuance of its shares consideration of the value of at least one thousand dollars ($1,000.00), consisting of money, labor done or property actually received.

XII.

The name and address of the Incorporator is as follows:

J. Kenneth Menges, Jr.
4100 First City Center
1700 Pacific Avenue
Dallas, Texas 75201

IN WITNESS WHEREOF, the incorporator has executed these Articles of Incorporation, this 27th day of JANUARY, 1986.

J. Kenneth Menges, Jr.

STATE OF TEXAS §
§
COUNTY OF DALLAS §

I, the undersigned, a Notary Public in and for Dallas County, Texas, do hereby certify that on the 27th day of January, 1986, personally appeared before me J. Kenneth Menges, Jr., who, being by me duly sworn, declared that he is the person who signed the foregoing instrument as incorporator and that the statements therein contained are true.

Notary Public in and for
the State of Texas

My Commission Expires:
July 31, 1988

SECTION IV – SUBMITTAL REQUIREMENTS
4.2.14 Authorization to Provide Services

Proposers should provide certification from the appropriate State offices that your company is authorized to provide the services contained within your proposal.

We have provided proof of authorization directly following this document.

Florida Office of Insurance Regulation

CIGNA HEALTH AND LIFE INSURANCE COMPANY

Is hereby authorized to transact insurance in the State of Florida.

This certificate signifies that the company has satisfied all requirements of Florida Insurance Code for the issuance of a Life And Health Insurer Certificate Of Authority and remains subject to the laws of Florida.

Date of Issuance: February 17, 1964

No. 10 - 591031071

Kevin M. McCarty
Commissioner
Office of Insurance Regulation

Certificate of Authority

AL00455

STATE OF FLORIDA

OFFICE OF

INSURANCE COMMISSIONER AND TREASURER

THIS IS TO CERTIFY THAT:

CIGNA DENTAL HEALTH OF FLORIDA INC
1525 NW 167 ST/SALES ADMIN/4TH FLOOR
MIAMI, FLORIDA 33169

HAS DULY QUALIFIED PURSUANT TO CHAPTER 636, FLORIDA STATUTES FOR A PREPAID LIMITED HEALTH SERVICE ORGANIZATION CERTIFICATE OF AUTHORITY AND IS HEREBY AUTHORIZED TO WRITE THE FOLLOWING LINE(S) OF BUSINESS.

0451 DENTAL PLANS

ISSUE DATE	TYPE	CLASS	APPLICATION	TAXES & FEES	COMPANY CODE	EXPIRATION DATE
06 01 94	10	36	45091501	500.00	66007	

TREASURER
INSURANCE COMMISSIONER
FIRE MARSHAL

DOI AL FORM 1

SECTION VIII – REFERENCES

Provide references for four (4) current clients. We would prefer that these be Florida public sector employers with more than 500 subscribers.

1. **Name of Organization** City of Miami
   Total Number of Full-Time Employees 3,309 eligible employees
   Name & Title of Contact Ann-Mrie Sharpe, ARM-P, Director
   Telephone Number 305.416.1381
   Fax Number 305.416.1710
   E-mail Address asharpe@miamigov.com
   Type of Benefits Provided Dental, Medical, Pharmacy, Stoploss
   Number of Employees Covered 2,722 employees enrolled
   Plan Inception Date 10/1/1994

2. **Name of Organization** Clerk & Comptroller Palm Beach County
   Total Number of Full-Time Employees 650 eligible employees
   Name & Title of Contact Jennifer Chripczuk, Benefits Manager
   Telephone Number 561.355.4988
   Fax Number 561.656.7392
   E-mail Address jchripczuk@mypalmbeachclerk.com
   Type of Benefits Provided Dental, Medical, Pharmacy, FSA, Vision, Stop Loss
   Number of Employees Covered 672 enrolled employees
   Plan Inception Date 1/1/2010

3. **Name of Organization** The City of West Palm Beach
   Total Number of Full-Time Employees 1,589 eligible employees
   Name & Title of Contact Patricia Brosamer, HRIS and Benefits Manager
   Telephone Number 561.494.1013
   Fax Number 561.686.6970
   E-mail Address pbrosamer@wpb.org
   Type of Benefits Provided Dental, Medical, Pharmacy, Onsite, Stop Loss
   Number of Employees Covered 1,589 employees enrolled
   Plan Inception Date 1/1/2004

Reference Form, continued

4. **Name of Organization** Town of Jupiter
   Total Number of Full-Time Employees 831 eligible employees
   Name & Title of Contact Dawn Loren, Human Resources Director
   Telephone Number 561.741.2335
   Fax Number 561.745.1530
   E-mail Address dawnl@jupiter.fl.us
   Type of Benefits Provided Dental, Medical, Vision, Pharmacy, EAP, Stop Loss,
   Number of Employees Covered 831 enrolled employees
   Plan Inception Date 1/1/2015

The above four references are from <u>current clients</u> with whom your firm has contracts. Please provide two (2) references from <u>former clients</u> with whom your company may no longer have the contract or contract expired within the past 12 months. We would prefer that these be Florida public sector employers with more than 500 subscribers.

5. **Name of Organization** City of Coral Springs
   Total Number of Full-Time Employees 842 employees eligible
   Name & Title of Contact Dale Pazdra, Director of Human Resources
   Telephone Number 954.344.1152
   Fax Number N/A
   E-mail Address hrdrp@coralsprings.org
   Type of Benefits Provided Dental (termed)
   Number of Employees Covered 824 employees enrolled
   Plan Inception Date 1/1/1995

6. **Name of Organization** Opis Management Resources, LLC
   Total Number of Full-Time Employees 1,552 employees eligible
   Name & Title of Contact Jenifer Price, HR Generalist
   Telephone Number 813.558.6535
   Fax Number N/A
   E-mail Address jennifer.price@opismr.com
   Type of Benefits Provided Dental (termed)
   Number of Employees Covered 921 employees enrolled
   Plan Inception Date 4/1/2009

SECTION IV – SUBMITTAL REQUIREMENTS

4.2.16 Proposing Company History

Proposers should indicate number of years the company has offered group dental plans.

DHMO

We have specialized in a dental management program since 1974 when Florida granted Dental Health, Inc. a Certificate of Authority to provide managed dental care. In 1984, Dental Health, Inc. became a subsidiary of Cigna Corporation, marking the first entry of a major national insurance organization into the managed dental care field.

DPPO

The DPPO plan was introduced in July 1996, and licensed at varying times in states throughout the U.S.

Cigna has no exceptions to the RFP provisions. We have provided clarifying responses to certain RFP provisions below.

General Terms and Conditions

Part III Bidding And Award Procedures:

3.12 QUALIFICATIONS/INSPECTION: Bids will only be considered from firms normally engaged in providing the types of commodities/services specified herein. The City reserves the right to inspect the Bidder's facilities, equipment, personnel, and organization at any time, or to take any other action necessary to determine Bidder's ability to perform. The Procurement Director reserves the right to reject bids where evidence or evaluation is determined to indicate inability to perform.

Cigna is happy to arrange an onsite visit for the City at one of our facilities; dates and other factors need to be agreed upon by both parties. Cigna will select the person within our company to conduct the onsite visit. In addition, certain information may be considered restricted and cannot be shared externally. In those situations, we will work with other ways of getting the information you need without divulging restricted information. Under a fully insured arrangement, Cigna is fully responsible for claims administration and carries all risk associated with such processes; therefore, external audits are not permitted. Cigna does have an internal claim quality assurance program to monitor internal performance standards to ensure the accuracy of claim payments.

Part V Purchase Order And Contract Terms:

5.12 RECORDS/AUDIT: The Contractor shall maintain during the term of the contract all books of account, reports and records in accordance with generally accepted accounting practices and standards for records directly related to this contract. The Contractor agrees to make available to the City Auditor or designee, during normal business hours and in Broward, Miami-Dade or Palm Beach Counties, all books of account, reports and records relating to this contract should be retained for the duration of the contract and for three years after the final payment under this Agreement, or until all pending audits, investigations or litigation matters relating to the contract are closed, whichever is later.

Cigna maintains its records in accordance with legal, regulatory, and business requirements, as well as our own record retention policy. Cigna has record retention/destruction policies in place that address every type of record, including paper and electronic.

When required by applicable state or federal law and in keeping with the standards of the industry and Cigna's standard audit and review procedures, Cigna shall cooperate with a required audit or review of applicable documents conducted by a duly authorized representative. Cigna is fully responsible for claims administration and carries all risk associated with such processes therefore, external audits are not permitted. Cigna has an internal claim quality assurance program to monitor internal performance standards to ensure the accuracy of claims payment.

5.18 PATENTS AND ROYALTIES: The Contractor, without exception, shall indemnify and save harmless the City and its employees from liability of any nature and kind, including cost and expenses for or on account of any copyrighted, patented or un-patented invention, process, or article manufactured or used in the performance of the contract, including its use by the City. If the Contractor uses any design, device, or materials covered by letters, patent or copyright, it is mutually agreed and understood without exception that the bid prices shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

Since the beginning of the statement highlighted in gray is written rather broadly, we should provide a response to clarify that we indemnifying for intellectual property. Cigna shall indemnify and save harmless the City against any claim arising from the actual infringement of any third-party intellectual property right by any copyrighted, patented or un-patented invention, process, or article provided by Cigna to the City in the course of performance of the contract.

5.22 Public Records

4. Upon completion of the Contract, transfer, at no cost, to the City all public records in possession of the Contractor or keep and maintain public records required by the City to perform the service. If the Contractor transfers all public records to the City upon completion of this Contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of this Contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the City, upon request from the City's custodian of public records, in a format that is compatible with the information technology systems of the City.

Cigna will give the City reasonable access to claim records and data, subject to Cigna's standard confidentiality procedures and agrees to transfer claim data to a successor administrator to the extent administratively feasible and at a mutually agreeable fee. At the termination of an agreement, Cigna is willing to discuss with the City whether, if feasible, to destroy or return all protected health information (PHI) created or received throughout the term of the agreement. If such return or destruction is not feasible, the protections of the agreement can be extended to the information and further uses and disclosures can be limited to those purposes that make the return or destruction of the information infeasible. Some records must be maintained to satisfy state and federal requirements and may be needed to support the administration of run-out claim activity, if applicable**.**

Detail by Entity Name

Foreign Profit Corporation

CIGNA HEALTH AND LIFE INSURANCE COMPANY

Filing Information

Document Number	F96000002814
FEI/EIN Number	59-1031071
Date Filed	06/04/1996
State	CT
Status	ACTIVE
Last Event	AMENDMENT AND NAME CHANGE
Event Date Filed	03/24/2010
Event Effective Date	NONE

Principal Address

900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Changed: 04/23/2013

Mailing Address

900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Changed: 04/23/2013

Registered Agent Name & Address

CHIEF FINANCIAL OFFICER
200 E. GAINES ST
TALLAHASSEE, FL 32399-0000

Name Changed: 03/17/2003

Address Changed: 04/07/2014

Officer/Director Detail

Name & Address

Title President and Director

MANDERS, MATTHEW
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Treasurer, VP

LAMBERT, SCOTT
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

BARRETT, ELLEN
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

GORMAN, STEPHANIE
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

HOUGH, CAROL
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

MC GINLEY-GRAZIOSI, SHEILA
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

MCGOLDRICK, FRANCIS
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

OVERBYE, KATHERINE
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

SMITH, VICTORIA
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

BUCKLEY, TIMOTHY
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

PALMER, ERIC
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

POTANKA, EDWARD
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

RUSSELL, DAVID
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

RUSSELL, DAVID
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

SATALINE, FRANK , JR.
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Director

SNOW, CHRISTOPHER
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Title Secretary

KRISHTUL, ANNA
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06002

Annual Reports

Report Year	Filed Date

2014	04/07/2014
2015	04/15/2015
2016	04/23/2016

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03/27/2002 -- ANNUAL REPORT	View image in PDF format
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06/07/2000 -- ANNUAL REPORT	View image in PDF format
11/23/1999 -- Name Change	View image in PDF format
05/04/1999 -- ANNUAL REPORT	View image in PDF format
02/19/1998 -- ANNUAL REPORT	View image in PDF format
09/17/1997 -- ANNUAL REPORT	View image in PDF format
06/04/1996 -- DOCUMENTS PRIOR TO 1997	View image in PDF format
06/04/1996 -- Foreign Qualification	View image in PDF format

Florida Department of State, Division of Corporations

Florida Department of State

- Division of Corporations

Sunbiz.org DIVISION of CORPORATIONS an official State of Florida website

Detail by Entity Name

Florida Profit Corporation
CIGNA DENTAL HEALTH OF FLORIDA, INC.

Filing Information

Document Number	G29835
FEI/EIN Number	59-1611217
Date Filed	03/11/1983
State	FL
Status	ACTIVE
Last Event	AMENDMENT
Event Date Filed	08/14/1998
Event Effective Date	NONE

Principal Address

1571 SAWGRASS CORPORATE PARKWAY
SUITE 140
SUNRISE, FL 33323

Changed: 04/22/2016

Mailing Address

1571 SAWGRASS CORPORATE PARKWAY
SUITE 140
SUNRISE, FL 33323

Changed: 04/22/2016

Registered Agent Name & Address

CT CORPORATION SYSTEM

1200 SOUTH PINE ISLAND ROAD
PLANTATION, FL 33324

Name Changed: 04/27/1992

Address Changed: 04/27/1992

Officer/Director Detail

Name & Address

Title President, Director

MANDERS, MATTHEW
1571 SAWGRASS CORPORATE PARKWAY
SUITE 140
SUNRISE, FL 33323

Title Secretary

KRISHTUL, ANNA
1571 SAWGRASS CORPORATE PARKWAY
SUITE 140
SUNRISE, FL 33323

Title Treasurer and VP

LAMBERT, SCOTT
1571 SAWGRASS CORPORATE PARKWAY
SUNRISE, FL 33323

Title Director

VAYER, JULIE
1571 SAWGRASS CORPORATE PARKWAY
SUITE 140
SUNRISE, FL 33323

Title VP and Director

GANESAN, DINESH
1571 SAWGRASS CORPORATE PARKWAY
SUITE 140
SUNRISE, FL 33323

Annual Reports

Report Year	Filed Date
2014	04/07/2014
2015	04/16/2015

2016	04/22/2016

Document Images

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2.14 Minimum Qualifications

In order to be considered, a Proposer must, as of the proposal return date specified in this RFP and throughout the duration of its program, meet the following applicable minimum qualifications. Proposer must provide documentation of existing qualifications in the proposal.

Dental Maintenance Organization

- **Authorized by the Florida Department of Financial Services to provide the goods and services requested in the RFP.**

  Confirmed. We have provided proof of authorization directly following this document.

- **Comply with any requirements imposed upon the Proposer by the Florida Department of Insurance with respect to quality assurance.**

  Confirmed.

Insurance Company and PPO Dental Plan

- **Licensed by the State of Florida Department of Insurance to provide the goods and services requested in the RFP; and**

  Confirmed. We have provided copies of our license in the Authorization to Provide Services section of this proposal.

- **Hold an A.M. Best rating of "A" or better and a financial size category of IV or higher or hold an A.M. Best financial performance rating of "6" or better for those insurers with a letter rating of NA-2 or NA-3 and a financial size category of IV or higher.**

  Confirmed. On June 24, 2015, A.M. Best placed the financial strength rating of "A" under review with negative implications.(1) A.M. Best has rated CHLIC a financial size "XV."

  (1) In July 2015, following the announcement of a proposed merger between Anthem and Cigna, Cigna's credit rating outlooks were modified to reflect the increased debt levels of the new combined company.

Proposers shall satisfy each of the following requirements cited below. Failure to do so may result in the proposal being deemed non-responsive.

2.14.2 Before awarding a contract, the City reserves the right to require that a Proposer submit such evidence of qualifications as the City may deem necessary. Further, the City may consider any evidence of the financial, technical, and other qualifications and abilities of a firm or principals, including previous experiences of same with the City and performance evaluation for services, in making the award in the best interest of the City.

Confirmed.

2.14.3 Firm or principals shall have no record of judgments, pending lawsuits against the City or criminal activities involving moral turpitude and not have any conflicts of interest that have not been waived by the City Commission.

- **2.14.4Neither firm nor any principal, officer, or stockholder shall be in arrears or in default of any debt or contract involving the City, (as a party to a contract, or otherwise); nor have failed to perform faithfully on any previous contract with the City.**

  Confirmed.

2.15 Lobbying Activities

Any contractor submitting a response to this solicitation must comply, if applicable, with City of Fort Lauderdale Ordinance No. C-00-27 & Resolution No. 07-101, Lobbying Activities. Copies of Ordinance No. C-00-27 and Resolution No. 07-101 may be obtained from the City Clerk's Office on the 7th Floor of City Hall, 100 N. Andrews Avenue, Fort Lauderdale, Florida. The ordinance may also be viewed on the City's website at: http://www.fortlauderdale.gov/clerk/LobbyistDocs/lobbyist_ordinance.pdf.

Noted.

2.16 Protest Procedure

2.16.1 Any Proposer or Bidder who is not recommended for award of a contract and who alleges a failure by the city to follow the city's procurement ordinance or any applicable law may protest to the director of procurement services division (director), by delivering a letter of protest to the director within five (5) days after a notice of intent to award is posted on the city's web site at the following link: http://www.fortlauderdale.gov/departments/finance/procurement-services/notices-of-intent-to-award.

2.16.2 The complete protest ordinance may be found on the city's web site at the following link: http://www.fortlauderdale.gov/purchasing/protestordinance.pdf

Noted.

2.17 Public Entity Crimes

Contractor, by submitting a proposal attests she/he/it has not been placed on the convicted vendor list. A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a proposal on a contract to provide any goods or services to a public entity, may not submit a proposal on a contract with a public entity for the construction or repair of a public building or public work, may not submit proposals on leases of real property to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public

entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, Florida Statutes, for Category Two for a period of 36 months from the date of being placed on the convicted vendor list.

Confirmed.

2.18 Insurance Requirements

2.18.1 The Contractor shall furnish proof of insurance requirements as indicated below. The coverage is to remain in force at all times during the contract period. The following minimum insurance coverage is required. The City is to be added as an "additional insured" with relation to General Liability Insurance. This MUST be written in the description section of the insurance certificate, even if you have a check-off box on your insurance certificate. Any costs for adding the City as "additional insured" will be at the contractor's expense.

Confirmed. We have provided our certificate of insurance in the Required Forms section of this proposal.

2.18.2 The City of Fort Lauderdale shall be given notice 10 days prior to cancellation or modification of any stipulated insurance. The insurance provided shall be endorsed or amended to comply with this notice requirement. In the event that the insurer is unable to accommodate, it shall be the responsibility of the Contractor to provide the proper notice. Such notification will be in writing by registered mail, return receipt requested and addressed to the Procurement Services Division.

Cigna will endeavor to notify the City 10 days prior to cancellation or modification of policies. Cigna and its subsidiaries and affiliates engage in numerous contractual relations with varying contractual requirements. Our insurers are unable to unilaterally administer the 30-day notice of cancellation requirement on a blanket basis.

Cigna's insurance premiums, on every insurance program, are paid in full at policy inception, thereby eliminating any chance of policy cancellation because of nonpayment of premiums. Cigna is a Fortune 125 organization and maintains reasonable and customary insurance coverage to comply with various statutory requirements. Over the course of 20 consecutive years, no insurance policies have been cancelled because of nonpayment of insurance premiums.

2.18.3 The Contractor's insurance must be provided by an A.M. Best's "A-" rated or better insurance company authorized to issue insurance policies in the State of Florida, subject to approval by the City's Risk Manager. Any exclusions or provisions in the insurance maintained by the contractor that precludes coverage for work contemplated in this RFP shall be deemed unacceptable, and shall be considered breach of contract.

Noted.

Workers' Compensation and Employers' Liability Insurance

Limits: Workers' Compensation – Per Florida Statute 440
Employers' Liability - $500,000

Any firm performing work on behalf of the City of Fort Lauderdale must provide Workers' Compensation insurance. Exceptions and exemptions will be allowed by the City's Risk Manager, if they are in accordance with Florida Statute. For additional information contact the Department of Financial Services, Workers' Compensation Division at (850) 413-1601 or on the web at www.fldfs.com.

Noted.

Commercial General Liability Insurance

Covering premises-operations, products-completed operations, independent contractors and contractual liability.

Limits: Combined single limit bodily injury/property damage $1,000,000. This coverage must include, but not limited to:

a. **Coverage for the liability assumed by the contractor under the indemnity provision of the contract.**
b. **Coverage for Premises/Operations**
c. **Products/Completed Operations**
d. **Broad Form Contractual Liability**
e. **Independent Contractors**

Noted.

Automobile Liability Insurance

Covering all owned, hired and non-owned automobile equipment.

Limits: Bodily injury $250,000 each person, $500,000 each occurrence
Property damage $100,000 each occurrence

Noted.

Professional Liability (Errors & Omissions)

Consultants
Limits: $2,000,000 per occurrence

2.18.4 A copy of ANY current Certificate of Insurance should be included with your proposal.

2.18.5 In the event that you are the successful Proposer, you will be required to provide a certificate naming the City as an "additional insured" for General Liability. Certificate holder should be addressed as follows:

City of Fort Lauderdale
Procurement Services Division
100 N. Andrews Avenue, Room 619
Fort Lauderdale, FL 33301

Noted.

2.19 Award of Contract

A Contract (the "Agreement") may be awarded by the City Commission. The City reserves the right to execute or not execute, as applicable, a contract with the Proposer(s) that is determined to be in the City's best interests. The City reserves the right to award a contract to more than one Proposer, at the sole and absolute discretion of the in the City.

Noted.

2.20 Uncontrollable Circumstances ("Force Majeure")

The City and Contractor will be excused from the performance of their respective obligations under this agreement when and to the extent that their performance is delayed or prevented by any circumstances beyond their control including, fire, flood, explosion, strikes or other labor disputes, act of God or public emergency, war, riot, civil commotion, malicious damage, act or omission of any governmental authority, delay or failure or shortage of any type of transportation, equipment, or service from a public utility needed for their performance, provided that:

2.20.1 The non performing party gives the other party prompt written notice describing the particulars of the Force Majeure including, but not limited to, the nature of the occurrence and its expected duration, and continues to furnish timely reports with respect thereto during the period of the Force Majeure;

2.20.2 The excuse of performance is of no greater scope and of no longer duration than is required by the Force Majeure;

2.20.3 No obligations of either party that arose before the Force Majeure causing the excuse of performance are excused as a result of the Force Majeure; and

2.20.4 The non performing party uses its best efforts to remedy its inability to perform. Notwithstanding the above, performance shall not be excused under this Section for a period in excess of two (2) months, provided that in extenuating circumstances, the City may excuse performance for a longer term. Economic hardship of the Contractor will not constitute Force

Majeure. The term of the agreement shall be extended by a period equal to that during which either party's performance is suspended under this Section.

Agreed; however, nothing herein relieves City of Fort Lauderdale's obligation to pay premiums beyond the grace period.

2.21 Canadian Companies

The City may enforce in the United States of America or in Canada or in both countries a judgment entered against the Contractor. The Contractor waives any and all defenses to the City's enforcement in Canada, of a judgment entered by a court in the United States of America. All monetary amounts set forth in this Contract are in United States dollars.

Confirmed.

2.22 News Releases/Publicity

News releases, publicity releases, or advertisements relating to this contract or the tasks or projects associated with the project shall not be made without prior City approval.

Agreed; however, Cigna respectfully requests that this provision be reciprocal.

2.23 Contract Period

The initial contract term shall commence upon date of award by the City or January 1, 2018 whichever is later, and shall expire three years from that date. The City reserves the right to extend the contract for two, additional one year term, providing all terms conditions and specifications remain the same, both parties agree to the extension, and such extension is approved by the City.

In the event services are scheduled to end because of the expiration of this contract, the Contractor shall continue the service upon the request of the City as authorized by the awarding authority. The extension period shall not extend for more than 120 days beyond the expiration date of the existing contract. The Contractor shall be compensated for the service at the rate in effect when this extension clause is invoked by the City.

Noted.

2.24 Substitution of Personnel

It is the intention of the City that the Contractor's personnel proposed for the contract will be available for the contract term. In the event the Contractor wishes to substitute personnel, he shall propose personnel of equal or higher qualifications and all replacement personnel are subject to City approval. In the event substitute personnel are not satisfactory to the City and the matter cannot be resolved to the satisfaction of the City, the City reserves the right to cancel the Contract for cause. See Section 5.09 General Conditions.

Noted.

2.25 Service Organization Controls

The Contactor shall provide a current SSAE 16, SOC 2, Type I report with their proposal. Awarded Contractor will be required to provide an SSAE 16, SOC 2, Type II report annually during the term of this contract. If the Contractor cannot provide the SSAE 16, SOC 2, Type I report at time of proposal submittal, a current SOC 3 report will be accepted.

CIGNA Corporation is a public company registered with the Securities Exchange Commission (SEC) which requires annual financial statement audits and quarterly financial reviews be performed by an independent auditor. Additionally, CIGNA Corporation is required to comply with the Sarbanes-Oxley Act of 2002, which requires management and the independent auditor to test and report annually on the operating effectiveness of our internal controls over financial reporting. As a result of these existing reporting requirements, which are filed with the SEC and accessible to customers through the SEC's web site (www.SEC.gov<http://www.sec.gov/>), we believe the financial and internal control information currently available to existing and potential customers provides an assessment of our overall financial stability.
In addition, our insurance companies are regulated by state insurance departments and undergo periodic examination by insurance regulatory authorities.
For customers required to comply with the internal controls over financial reporting requirements of the Sarbanes-Oxley Act of 2002, we do not believe the scope of your assessment over internal controls extends to fully insured products as these customers are only liable for the agreed upon premium rates and would not be financially impacted by our internal controls.

Confirmed. We have included the SSAE 16 Healthcare Bridge Letter in the Exhibits section of this proposal.

2.26 Business Associate Agreement

The City shall require recommended awarded Proposer, and possibly any sub-contractor to execute a Business Associate Agreement. A Sample Business Associate Agreement is attached as Exhibit A. The sample document does not need to be executed and provided with your RFP, but will need to be executed upon award of contract.

Since this is a fully-insured offering, Cigna is not the Business Associate of the City as defined under HIPAA. Rather, Cigna is the Covered Entity and a business associate agreement is not needed. Cigna is willing to put language into the City's agreement which states that Cigna is governed by HIPAA as a Covered Entity and that Cigna will comply with the HIPAA Privacy and Security Rules as amended by HITECH.

END OF SECTION

Group Contract

and
Cigna Dental Health

Member Services 1.800. Cigna24
(Reaches all Regional locations)

Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Delaware, Inc.
Cigna Dental Health of Florida, Inc. (**a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)**
Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska)
Cigna Dental Health of Kentucky, Inc. (Kentucky and Illinois)
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of North Carolina, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Pennsylvania, Inc.
Cigna Dental Health of Virginia, Inc.
Regional Offices
P.O. Box 453099
Sunrise, Florida 33345-3099

THIS IS A LEGAL CONTRACT BETWEEN THE ABOVE MENTIONED GROUP AND THE CIGNA DENTAL COMPANIES LISTED ABOVE. IT IS ISSUED IN CONSIDERATION OF THE PRE-CONTRACT APPLICATION AND PAYMENT OF THE PREMIUMS/PREPAYMENT FEES AS THEY ARE DUE. READ YOUR GROUP CONTRACT CAREFULLY.

85600 08.11.05

TABLE OF CONTENTS

A. DEFINITIONS

Capitalized terms in this contract (the "Contract"), unless otherwise defined, shall have the meanings set forth below.

Cigna Dental: The Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this Contract.

Covered Persons: Subscribers and their Dependents who are enrolled in the Dental Plan.

Dental Plan: Managed dental care plan to be provided pursuant to this Contract.

Dependent: Those Covered Persons which are named as Dependents of a Subscriber, as further defined in the applicable Plan Booklet, Evidence of Coverage and/or Certificate of Coverage.

Evidence of Coverage: Subscriber's dental plan booklet or certificate of coverage which summarizes the dental plan and covered benefits. The Evidence of Coverage is attached hereto and made a part of this Contract as if fully set forth herein.

Group: Employer, labor union, association, or other organization named on the title page of this Contract.

Patient Charge Schedule: List of covered services and associated patient charges, which is attached hereto and incorporated herein by reference, and as it may be revised during the term of this Contract.

Pre-Contract: The Cigna Dental Pre-Contract Application which designates certain terms and conditions of coverage and which is attached hereto and made a part hereof by reference.

Premiums/Prepayment Fees: The fees/premiums stated in the Pre-Contract which the Group must remit to Cigna Dental for Covered Persons each calendar month during the term of this Contract.

Subscriber: Employee or member of the Group who is enrolled in the Dental Plan.

B. THE DENTAL PLAN

1. Cigna Dental shall provide dental benefits to Subscribers and Dependents in accordance with the terms of this Contract and as set out in the attached Pre-Contract, Evidence of Coverage, applicable State Riders, and Patient Charge Schedule.

2. The terms and conditions of the Evidence of Coverage including State Riders, applicable Patient Charge Schedule, and any amendments or revisions thereto, are incorporated into this Contract by reference and made a part hereof as if fully set forth herein. Each Subscriber shall receive an Evidence of Coverage outlining the terms, exclusions and limitations of the coverage provided hereunder. Any conflicts between the Group Contract and

Evidence of Coverage shall be resolved according to the terms most favorable to the Subscriber.

3. The relationship between Cigna Dental Health and a Network Dentist is an independent contractor relationship. All contracts between Cigna Dental Health and Network Dentists state that under no circumstances shall any Covered Person be liable to any Network Dentist for any sums owed to the Network Dentist by Cigna Dental Health, notwithstanding any delay by Cigna Dental Health in paying the Network Dentist any such sums. Cigna Dental Health shall provide reasonable notice to the Group of any termination, breach of contract, or inability to perform of any Network Dentist if Cigna Dental Health determines that Covered Persons may be materially and adversely affected thereby.

C. PREMIUMS/PREPAYMENT FEES

In consideration of the services to be rendered and made available by Cigna Dental pursuant to this Contract, the Group shall remit to Cigna Dental the Premium/Prepayment Fee for the initial month of coverage on or before the first day of said month accompanied by a list of persons to be covered under the Dental Plan. On or before the twelfth (12th) day of each month during the term of this Contract, Cigna Dental will send the Group an alphabetized list of Subscribers and a statement of Premiums/Prepayment Fees due for that month of coverage. On or before the twenty-fifth (25th) day of each month during the term of this Contract, the Group shall remit the Premium/Prepayment Fee to Cigna Dental with an updated list indicating Covered Persons to be added to or deleted from the Dental Plan and any changes in type of coverage. Alternative payment mechanisms developed for the Group by Cigna Dental shall supersede the terms of this Paragraph.

Premiums/Prepayment Fees are guaranteed for an initial period of twelve (12) months (unless otherwise extended in the Pre-Contract). However, Premiums/Prepayment Fees may be adjusted by Cigna Dental upon 30 days' notice to the Group if, in Cigna Dental's sole opinion, its liability is altered by any state or federal law.

D. GRACE PERIOD/REINSTATEMENT

1. Cigna Dental shall provide written notice of non-receipt of payment on or before the twelfth (12th) day of the month following the month for which Premiums/Prepayment Fees remain due and owing. Group shall have an additional thirty-one (31) days for the payment of any Premium/Prepayment Fee except the first. The Contract shall remain in full force and effect during this Grace Period. If the Premium/Prepayment Fees are not remitted by the end of the Grace Period, the Contract will terminate on the last day of the Grace Period. The Group will remain liable to Cigna Dental for any Premium/Prepayment Fees accrued during the Grace Period.

2. If proper payment is received by Cigna Dental on or before the expiration of the Grace Period, the Contract shall remain in full force and effect. If the Contract terminates due to non-payment of the required Premiums/Prepayment Fees, the Group may request that Cigna Dental reinstate the Contract. The Group must make this request and pay all past due and current Premiums/Prepayment Fees to Cigna Dental within fifteen (15) days after the expiration of the applicable Grace Period.

3. If Cigna Dental elects to reinstate this Contract, the coverage provided herein will resume as of the date of termination with no gap in coverage. If Cigna Dental elects not to reinstate the Contract, it will notify the Group of such decision in writing. In such event, any unearned Premium/Prepayment Fees submitted with the request for reinstatement will be returned to the Group.

4. Cigna Dental's reinstatement of the Contract or waiver of the right to terminate this Contract pursuant to this Section shall not constitute a waiver of any future right to terminate for nonpayment of Premium/Prepayment Fees.

E. EFFECTIVE DATE/TERM & RENEWAL

The Group's effective date of coverage under the Dental Plan (the "Effective Date") shall be the date listed on the Pre-Contract, for and in consideration of Cigna Dental's receipt of the Premium/Prepayment Fees.

The original term of this Contract shall extend from the Effective Date until the expiration of the initial Premium/Prepayment Fee Guarantee as set forth in the Pre-Contract (the "Expiration Date"). This Contract shall be automatically renewed on an annual basis effective the day following the Expiration Date (the "Renewal Date") unless otherwise terminated as provided herein. The Patient Charge Schedule shall be in effect for a minimum of one year.

The Premium/Prepayment Fee and Patient Charge Schedule shall be reviewed and may be adjusted on an annual basis at the anniversary of the Renewal Date upon sixty (60) days' notice from Cigna Dental.

F. ELIGIBILITY

1. The Group shall determine which of its employees, associates or members are eligible to enroll in the Dental Plan. The Group shall be responsible for providing eligibility information to Cigna Dental on a timely basis as provided in Section C hereinabove. Where the Group provides eligibility information of any kind, including but not limited to electronic data, tapes or software, the data must be accurate and accessible.

2. The Group will have at least one open enrollment period every eighteen (18) months. Such open enrollment periods are required for as long as the Contract exists unless Cigna Dental and the Group mutually agree to a shorter period of time. Subscribers and Dependents may be disenrolled only during the Group's open enrollment periods unless there has been a life status change such as divorce or termination.

3. In the event a Covered Person is eligible for benefits pursuant to the requirements of the Family and Medical Leave Act of 1993 or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Group shall be responsible for collecting the Subscriber's portion of the Premium/Prepayment Fees, if any, for which the Subscriber would have been responsible if Subscriber had not taken the leave or become qualified for COBRA coverage.

G. COMPLIANCE WITH THE FEDERAL OMNIBUS BUDGET RECONCILIATION ACT OF 1993

The parties agree, as follows, to perform the terms of this Contract in accordance with the requirements of the Federal Omnibus Budget Reconciliation Act of 1993:

1. Cigna Dental shall not take into account that a Covered Person is eligible for or is provided medical assistance under 12 U.S.C. §1396a (section 1902 of the Social Security Act) in covering or providing benefits to or on behalf of said Covered Person under the Dental Plan.

2. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administrative order to provide dental coverage for his or her child:

(a) Cigna Dental Health and the Group:

(i) Shall not deny enrollment of the child in the Dental Plan on any of the following grounds:

a) The child was born out of wedlock,

b) The child is not claimed as a dependent on the Subscriber's federal income tax return, or

c) The child does not reside with the Subscriber or in the Dental Plan's service area.

(ii) Shall allow the Subscriber to enroll the child in the Dental Plan under family coverage, without regard to any enrollment season restrictions, provided that the child is otherwise eligible for Dental Plan coverage.

(iii) Shall enroll the child in the Dental Plan under the family coverage upon application of the child's other parent or the Department of Human Resources in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the Subscriber fails to enroll the child.

(iv) Except as otherwise provided herein, shall not terminate the child's Dental Plan coverage unless Cigna Dental and the Group are provided satisfactory written evidence that:

a) The court or administrative order is no longer in effect, or

b) The child is or will be enrolled in comparable dental coverage through another dental plan, which coverage will take effect no later than the effective date of termination.

(b) The Group shall withhold from Subscriber's compensation the Subscriber's share, if any, of Premiums for Dental Plan

coverage and shall pay the appropriate Premiums to Cigna Dental pursuant to the terms of this Contract.

(c) If the Subscriber is not the child's custodial parent, Cigna Dental and the Group shall:

(i) Provide such information to the custodial parent as may be necessary for the child to obtain benefits under the Dental Plan.
(ii) Permit the custodial parent or dentist (with custodial parent's approval) to submit claims for Covered Services without the approval of the non-custodial parent.
(iii) Make payments, pursuant to this Contract, on the claims submitted under clause (b) of this paragraph directly to the custodial parent, the dentist, or the Department of Human Resources.

(d) Cigna Dental shall not impose on any State agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered under the Dental Plan requirements that are different from requirement applicable to an agent or assignee of any other individual covered under the Dental Plan.

3. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administration order to provide dental coverage for his or her child who does not reside in the Dental Plan's service area, the following alternatives for coverage are available:

(a) If the Group offers its employees a choice between the Dental Plan or indemnity dental coverage, the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's service area, except as provided herein for emergencies and specialty referrals; or the family shall be covered under the indemnity dental coverage.

(b) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental has a network of dentists in the service area within which the child resides, the child shall be covered under a contract between the Group and the affiliate of Cigna Dental and the Subscriber shall be covered under a contract between the Group and Cigna Dental.

(c) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental does not have a network in the service area within which the child resides, the family shall be covered by an indemnity dental policy which the Group shall obtain or the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's service area, except as provided herein for emergencies and specialty referrals.

(d) Except as otherwise restricted by federal law, the Subscriber shall be permitted to change his or her dental coverage election (between the Dental Plan and indemnity dental coverage) without regard to any enrollment reason restrictions.

4. A child who is less than 18 years of age and is placed for adoption with a Subscriber shall be entitled to benefits under the same terms and conditions that apply to the Subscriber's natural, Dependent children, irrespective of whether the adoption has become final. Cigna Dental shall not restrict Dental Plan coverage of any dependent child adopted by or placed for adoption with a Subscriber solely on the basis of any pre-existing condition of the child at the time that the child would otherwise become eligible for coverage under the Dental Plan if the adoption or placement for adoption occurs while the Subscriber is eligible for coverage under the Dental Plan. As used in this paragraph, "placement for adoption" means the assumption and retention by a Subscriber of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with Subscriber terminates upon the termination of such legal obligations.

5. A subscriber's foster child shall be treated the same as a newborn child and shall be eligible for coverage on the same basis, under the terms of this Contract, upon placement in Subscriber's home. As used in this paragraph, "Foster child" means a minor over whom a Subscriber has been appointed (1) guardian by a court of competent jurisdiction in the state or (2) the primary or sole custodian by order of a court of competent jurisdiction. As used in this paragraph, "placement in the Subscriber's home" means physically residing with a Subscriber who has been appointed guardian or custodian as long as that Subscriber has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the Subscriber on a more than temporary or short-term basis.

H. ADMINISTRATION AND RECORDS

1. The Group shall cooperate with Cigna Dental with respect to soliciting and enrolling persons eligible to enroll in the Dental Plan and in obtaining authorized payroll withholding from Subscribers to the extent that the applicable Premium/Prepayment Fees exceed the Group's contribution, if any, on Subscriber's behalf.

2. The Group shall provide to Cigna Dental enrollment information, including copies of all signed enrollment and change forms. Cigna Dental shall be permitted to inspect the Group's records which have a bearing on coverage of Covered Persons hereunder, including but not limited to records pertaining to eligibility, enrollment, payment of Premiums/Prepayment Fees and administration of benefits hereunder, and shall be permitted to make copies thereof at any reasonable time upon reasonable prior notice to the Group.

3. Cigna Dental shall keep administrative records of all Covered Persons, but shall not be liable for any obligation dependent upon information from the Group prior to the receipt of such information in a form satisfactory to Cigna Dental. Incorrect information furnished by the Group may be corrected if Cigna Dental shall not have acted in reliance upon such information to its prejudice.

4. Cigna Dental is entitled to receive from each dentist who renders service to a Covered Person hereunder all information reasonably necessary to fulfill the terms of this Contract. Covered Persons, by their enrollment in the Dental Plan, authorize each dentist who renders service to the Covered Person to disclose to Cigna Dental all facts pertaining to such service and to render to Cigna Dental reports and/or copies of records pertaining to such service for Cigna Dental administrative or quality management purposes.

I. TERMINATION OF CONTRACT

In addition to termination for nonpayment of Premium/Prepayment Fees as set out in Section D hereinabove, either the Group or Cigna Dental may terminate this Contract for any reason, including low participation, effective as of any Renewal Date by providing a minimum of sixty (60) days' prior written notice to the other party.

In the event of termination of this Contract by either Cigna Dental or the Group, the Group shall provide a notice of termination to each Covered Person. Upon the request of Cigna Dental, Group agrees to provide Cigna Dental proof of such notice and the date of such notice.

In the event of termination of this Contract, Cigna Dental shall within thirty (30) days return to the Group the pro rata portion of Premium/Prepayment Fees, if any, which correspond to any unexpired period for which payment has been received, if any, less amounts due to Cigna Dental. Cigna Dental will pay covered claims incurred by Covered Persons prior to termination. This subsection shall not apply to termination by Cigna Dental made as a result of fraud or deception in the use of services or facilities, or knowingly permitting such fraud or deception by another.

J. NOTICE

Any notice required by this Contract shall be in writing and mailed with postage fully prepaid and addressed to the Group at the address listed on the Pre-Contract and to Cigna Dental at:

P.O. Box 453099
Sunrise, Florida 33345-3099
Attn: Contracts Administration

The Group shall disseminate to Covered Persons any notice from Cigna Dental of material matters no later than thirty (30) days after receipt thereof.

K. ASSIGNMENT

Group shall not assign this Contract or its rights hereunder nor delegate its duties hereunder without the prior written consent of Cigna Dental.

L. AMENDMENTS TO CONTRACT

Except as otherwise provided herein, Cigna Dental may amend this Contract by giving the Group sixty (60) days' prior written notice of the proposed amendment. Failure of the Group to object in writing to any such proposed amendment within such notice period shall constitute the Group's acceptance of the amendment as of its effective date. Except as otherwise provided herein, changes in the Premium/Prepayment Fees or Patient Charge Schedule shall be effective as of the Renewal Date following proper notice.

In the event that federal, state, or municipal laws or regulations should change, alter or modify the present services, levels of premiums to Cigna Dental, standards of eligibility of Covered Persons, or any operations of Cigna Dental such that the terms, benefits and conditions of this Contract must be modified accordingly, Cigna Dental shall have the right to amend this Contract upon 30 days' written notice to the Group.

Except as otherwise provided herein, this Contract may be amended only in writing as approved by both the Group and Cigna Dental. Only a duly authorized officer of Cigna Dental has the authority to amend this Contract.

M. ENTIRE CONTRACT

This Contract, including the attached Plan Booklet/Evidence of Coverage/Certificate of Coverage, State Riders, Patient Charge Schedule, Pre-Contract Application, and any amendments thereto, represents the entire agreement between the parties with respect to the subject matter. Having executed the Pre-Contract, the Group shall be deemed to have accepted the terms of this Contract unless written notice is given to Cigna Dental within twenty (20) days of receipt hereof. The invalidity or unenforceability of any Section or sub-Section of this Contract shall not affect the validity or enforceability of the remaining Sections or sub-Sections hereof.

N. GOVERNING LAW

This Contract shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with laws of the state in which the Subscriber receives services under the Dental Plan and with pertinent federal laws and regulations. Any provision required to be in the Contract by relevant state statute or regulation shall bind Cigna Dental whether or not contained herein. In the event this Contract contains any provisions not in conformity with relevant and applicable state or federal laws, the Contract shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable law.

O. INCONTESTABILITY

In the absence of fraud, all statements contained in a written application made by a Subscriber are considered representations and not

warranties. Coverage can be voided: (a) during the first two years for material misrepresentations contained in a written enrollment form; and, (b) after the first two years, for fraudulent misstatement contained in a written enrollment form.

CIGNA DENTAL HEALTH PLAN OF ARIZONA, INC.

BY: _____

TITLE:_____

DATE:_____

CIGNA DENTAL HEALTH OF COLORADO, INC.

BY: _____

TITLE:_____

DATE: _____

CIGNA DENTAL HEALTH OF DELAWARE, INC.

BY: _____

TITLE:_____

DATE: _____

CIGNA DENTAL HEALTH OF FLORIDA, INC.

BY: _____

TITLE:_____

DATE: _____

CIGNA DENTAL HEALTH OF KANSAS, INC. (Kansas and Nebraska)

BY: _____

TITLE:_____

DATE: _____

CIGNA DENTAL HEALTH OF KENTUCKY, INC. (Kentucky and Illinois)

BY: _____

TITLE: _____

DATE: _____

CIGNA DENTAL HEALTH OF MARYLAND, INC.

BY: _____

TITLE: _____

DATE: _____

CIGNA DENTAL HEALTH OF NORTH CAROLINA, INC.

BY: _____

TITLE: _____

DATE: _____

CIGNA DENTAL HEALTH OF NEW JERSEY, INC.

BY: _____

TITLE: _____

DATE: _____

CIGNA DENTAL HEALTH OF OHIO, INC.

BY: _____

TITLE: _____

DATE: _____

CIGNA DENTAL HEALTH OF PENNSYLVANIA, INC.

BY: _____

TITLE: _____

DATE: _____

CIGNA DENTAL HEALTH OF VIRGINIA, INC.

BY: _____

TITLE: _____

DATE: _____

08/11/05

Group Contract

and
Cigna Dental Health of California, Inc.

Member Services 1.800.Cigna24

Cigna Dental Health of California, Inc.
400 North Brand Boulevard, Suite 400
Glendale, California 91203

THIS IS A LEGAL CONTRACT BETWEEN THE ABOVE MENTIONED GROUP AND CIGNA DENTAL HEALTH OF CALIFORNIA, INC. IT IS ISSUED IN CONSIDERATION OF THE PRE-CONTRACT APPLICATION AND PAYMENT OF THE PREPAYMENT FEES AS THEY ARE DUE. READ YOUR GROUP CONTRACT CAREFULLY.

TABLE OF CONTENTS

A. DEFINITIONS

Capitalized terms in this contract (the "Contract"), unless otherwise defined, shall have the meanings set forth below.

Cigna Dental: Cigna Dental Health of California, Inc.

Combined Evidence of Coverage and Disclosure Form: Subscriber's dental plan booklet which summarizes the Dental Plan and Covered Services.

Covered Persons: Subscribers and their Dependents who are enrolled in the Dental Plan.

Covered Services: The dental procedures listed on the applicable Patient Charge Schedule to be provided by Cigna Dental in consideration for the payment of the Prepayment Fees.

Dental Plan: The plan of managed dental care benefits to be provided pursuant to this Contract.

Dependent: Those Covered Persons which are named as Dependents of a Subscriber, as further defined in the Combined Evidence of Coverage and Disclosure Form.

Group: Employer, labor union, association, or other organization named on the title page of this Contract.

Patient Charge Schedule: List of Covered Services and associated copayments, which is attached to the Combined Evidence of Coverage and Disclosure Form.

Pre-Contract: The Cigna Dental Pre-Contract Application which designates certain Group-specific terms and conditions of coverage.

Prepayment Fees: The premium or fees stated in the Pre-Contract which the Group must pay to Cigna Dental for Covered Persons each calendar month during the term of this Contract.

Subscriber: Employee or member of the Group who is enrolled in the Dental Plan.

B. THE DENTAL PLAN

1. Cigna Dental shall provide Covered Services to Subscribers and Dependents in accordance with the terms of this Contract and as set out in the attached Pre-Contract, Combined Evidence of Coverage and Disclosure Form, and Patient Charge Schedule.

2. The terms and conditions of the Pre-Contract, Combined Evidence of Coverage and Disclosure Form including the applicable Patient Charge Schedule, and any amendments or revisions thereto, are incorporated into this Contract by reference and made a part hereof as if fully set forth herein. Each Subscriber shall receive a Combined Evidence of Coverage and Disclosure Form outlining the terms and conditions, exclusions and limitations of the coverage provided hereunder. Any conflicts between the Group Contract and Combined Evidence of Coverage and Disclosure Form shall be resolved according to the terms most favorable to the Subscriber.

3. The relationship between Cigna Dental and its Network Dentists is an independent contractor relationship. All contracts between Cigna Dental and Network Dentists state that under no circumstances shall any Covered Person be liable to any Network Dentist for any sums owed to the Network Dentist by Cigna Dental, notwithstanding any delay by Cigna Dental in paying the Network Dentist any such sums. Cigna Dental shall provide reasonable notice to the Group of any termination, breach of contract, or inability to perform of any Network Dentist if Cigna Dental determines that Covered Persons may be materially and adversely affected thereby.

C. PREPAYMENT FEES

In consideration of the services to be rendered and made available by Cigna Dental pursuant to this Contract, the Group shall remit to Cigna Dental the Prepayment Fee for the initial month of coverage on or before the first day of said month accompanied by a list of persons to be covered under the Dental Plan. On or before the twelfth (12th) day of each month during the term of this Contract, Cigna Dental will send the Group an alphabetized list of Subscribers and a statement of Prepayment Fees due for that month of coverage. On or before the twenty-fifth (25th) day of each month during the term of this Contract, the Group shall remit the Prepayment Fee to Cigna Dental with an updated list indicating Covered Persons to be added to or deleted from the Dental Plan and any changes in type of coverage. Alternative payment mechanisms developed for the Group by Cigna Dental shall supersede the terms of this Paragraph.

Prepayment Fees are guaranteed for an initial period of twelve (12) months (unless otherwise extended in the Pre-Contract). However, Prepayment Fees may be adjusted by Cigna Dental upon 30 days' notice to the Group if, in Cigna Dental's sole opinion, its liability is altered by any state or federal law. Additionally, Cigna Dental reserves any and all rights to change the Prepayment Fees or applicable Copayments during the term of the Group Contract if Cigna Dental determines Group’s information relied upon by Cigna Dental in setting the Prepayment Fees materially changes or is determined by Cigna Dental to be inaccurate.

D. GRACE PERIOD/REINSTATEMENT

1. Cigna Dental shall provide written notice of non-receipt of payment and intent to terminate the Contract on or before the twelfth (12th) day of the month following the month for which Prepayment Fees remain due and owing. Group shall have an additional thirty-one (31) days for the payment of any Prepayment Fee except the initial Prepayment Fee. The Contract shall remain in full force and effect during this Grace Period. If the Prepayment Fees are not remitted by the end of the Grace Period, the Contract will terminate on the last day of the Grace Period. The Group will remain liable to Cigna Dental for any Prepayment Fees accrued during the Grace Period.

2. If proper payment is received by Cigna Dental on or before the expiration of the Grace Period, the Contract shall remain in full force and effect. If the Contract terminates due to non-payment of the required Prepayment Fees, the Group may request that Cigna Dental reinstate the Contract. The Group must make this request and pay all past due and current Prepayment Fees to Cigna Dental within fifteen (15) days after the expiration of the applicable Grace Period.

3. If Cigna Dental elects to reinstate this Contract, the coverage provided herein will resume as of the date of termination with no gap in coverage. If Cigna Dental elects not to reinstate the Contract, it will notify the Group of such decision in writing. In such event, any unearned Prepayment Fees submitted with the request for reinstatement will be returned to the Group.

4. Cigna Dental's reinstatement of the Contract or waiver of the right to terminate this Contract pursuant to this Section shall not constitute a waiver of any future right to terminate for nonpayment of Prepayment Fees.

E. EFFECTIVE DATE/TERM & RENEWAL

The Group's effective date of coverage under the Dental Plan (the "Effective Date") shall be the date listed on the Pre-Contract, for and in consideration of Cigna Dental's receipt of the Prepayment Fees.

The original term of this Contract shall extend from the Effective Date until the expiration of the initial Prepayment Fee Guarantee as set forth in the Pre-Contract (the "Expiration Date"). This Contract shall be automatically renewed on an annual basis effective the day following the Expiration Date (the "Renewal Date") unless otherwise terminated as provided herein. The Patient Charge Schedule shall be in effect for a minimum of one year, except as otherwise provided in Section C.

The Prepayment Fee and Patient Charge Schedule shall be reviewed and may be adjusted on an annual basis at the anniversary of the Renewal Date upon sixty (60) days' notice from Cigna Dental.

F. ELIGIBILITY

1. The Group shall determine which of its employees, associates or members are eligible to enroll in the Dental Plan. The Group shall be responsible for providing eligibility information to Cigna Dental on a timely basis as provided in Section C hereinabove. Where the Group provides eligibility information of any kind, including but not limited to electronic data, tapes or software, the data must be accurate and accessible.

2. The Group will have at least one open enrollment period every eighteen (18) months. Such open enrollment periods are required for as long as the Contract exists unless Cigna Dental and the Group mutually agree to a shorter period of time. Subscribers and Dependents may be disenrolled only during the Group's open enrollment periods unless there has been a life status change such as divorce or termination.

3. In the event a Covered Person is eligible for benefits pursuant to the requirements of the Family and Medical Leave Act of 1993 or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Group shall be responsible for collecting the Subscriber's portion of the Prepayment Fees, if any, for which the Subscriber would have been responsible if Subscriber had not taken the leave or become qualified for COBRA coverage.

G. COMPLIANCE WITH THE FEDERAL OMNIBUS BUDGET RECONCILIATION ACT OF 1993

The parties agree, as follows, to perform the terms of this Contract in accordance with the requirements of the Federal Omnibus Budget Reconciliation Act of 1993:

1. Cigna Dental shall not take into account that a Covered Person is eligible for or is provided medical assistance under 12 U.S.C. §1396a (section 1902 of the Social Security Act) in covering or providing benefits to or on behalf of said Covered Person under the Dental Plan.

2. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administrative order to provide dental coverage for his or her child:

(a) Cigna Dental and the Group:

(i) Shall not deny enrollment of the child in the Dental Plan on any of the following grounds:

a) The child was born out of wedlock,

b) The child is not claimed as a dependent on the Subscriber's federal income tax return, or

c) The child does not reside with the Subscriber or in the Dental Plan's service area.

(ii) Shall allow the Subscriber to enroll the child in the Dental Plan under family coverage, without regard to any enrollment season restrictions, provided that the child is otherwise eligible for Dental Plan coverage.

(iii) Shall enroll the child in the Dental Plan under the family coverage upon application of the child's other parent or the Department of Human Resources in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the Subscriber fails to enroll the child.

(iv) Except as otherwise provided herein, shall not terminate the child's Dental Plan coverage unless Cigna Dental and the Group are provided satisfactory written evidence that:

a) The court or administrative order is no longer in effect, or

b) The child is or will be enrolled in comparable dental coverage through another dental plan, which coverage will take effect no later than the effective date of termination.

(b) The Group shall withhold from Subscriber's compensation the Subscriber's share, if any, of Premiums for Dental Plan coverage and shall pay the appropriate Prepayment Fees to Cigna Dental pursuant to the terms of this Contract.

(c) If the Subscriber is not the child's custodial parent, Cigna Dental and the Group shall:

(i) Provide such information to the custodial parent as may be necessary for the child to obtain benefits under the Dental Plan.

(ii) Permit the custodial parent or dentist (with custodial parent's approval) to submit claims for Covered Services without the approval of the non-custodial parent.

(iii) Make payments, pursuant to this Contract, on the claims submitted under clause (b) of this paragraph directly to the custodial parent, the dentist, or the Department of Human Resources.

(d) Cigna Dental shall not impose on any State agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered under the Dental Plan requirements that are different from requirement applicable to an agent or assignee of any other individual covered under the Dental Plan.

3. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administration order to provide dental coverage for his or her child who does not reside in the Dental Plan's service area, the following alternatives for coverage are available:

(a) If the Group offers its employees a choice between the Dental Plan or indemnity dental coverage, the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's service area, except as provided herein for emergencies and specialty referrals; or the family shall be covered under the indemnity dental coverage.

(b) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental has a network of dentists in the service area within which the child resides, the child shall be covered under a contract between the Group and the affiliate of Cigna Dental and the Subscriber shall be covered under a contract between the Group and Cigna Dental.

(c) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental does not have a network in the service area within which the child resides, the family shall be covered by an indemnity dental policy which the Group shall obtain or the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's

service area, except as provided herein for emergencies and specialty referrals.

(d) Except as otherwise restricted by federal law, the Subscriber shall be permitted to change his or her dental coverage election (between the Dental Plan and indemnity dental coverage) without regard to any enrollment reason restrictions.

4. A child who is less than 18 years of age and is placed for adoption with a Subscriber shall be entitled to benefits under the same terms and conditions that apply to the Subscriber's natural, Dependent children, irrespective of whether the adoption has become final. Cigna Dental shall not restrict Dental Plan coverage of any dependent child adopted by or placed for adoption with a Subscriber solely on the basis of any pre-existing condition of the child at the time that the child would otherwise become eligible for coverage under the Dental Plan if the adoption or placement for adoption occurs while the Subscriber is eligible for coverage under the Dental Plan. As used in this paragraph, "placement for adoption" means the assumption and retention by a Subscriber of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with Subscriber terminates upon the termination of such legal obligations.

5. A subscriber's foster child shall be treated the same as a newborn child and shall be eligible for coverage on the same basis, under the terms of this Contract, upon placement in Subscriber's home. As used in this paragraph, "Foster child" means a minor over whom a Subscriber has been appointed (1) guardian by a court of competent jurisdiction in the state or (2) the primary or sole custodian by order of a court of competent jurisdiction. As used in this paragraph, "placement in the Subscriber's home" means physically residing with a Subscriber who has been appointed guardian or custodian as long as that Subscriber has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the Subscriber on a more than temporary or short-term basis.

H. ADMINISTRATION AND RECORDS

1. The Group shall cooperate with Cigna Dental with respect to soliciting and enrolling persons eligible to enroll in the Dental Plan and in obtaining authorized payroll withholding from Subscribers to the extent that the applicable Prepayment Fees exceed the Group's contribution, if any, on Subscriber's behalf.

2. The Group shall provide to Cigna Dental enrollment information, including copies of all signed enrollment and change forms. Cigna Dental shall be permitted to inspect the Group's records which have a bearing on coverage of Covered Persons hereunder, including but not limited to records pertaining to eligibility, enrollment, payment of Prepayment Fees and

administration of benefits hereunder, and shall be permitted to make copies thereof at any reasonable time upon reasonable prior notice to the Group.

3. Cigna Dental shall keep administrative records of all Covered Persons, but shall not be liable for any obligation dependent upon information from the Group prior to the receipt of such information in a form satisfactory to Cigna Dental. Incorrect information furnished by the Group may be corrected if Cigna Dental shall not have acted in reliance upon such information to its prejudice.

4. Cigna Dental is entitled to receive from each dentist who renders service to a Covered Person hereunder all information reasonably necessary to fulfill the terms of this Contract. Covered Persons, by their enrollment in the Dental Plan, authorize each dentist who renders service to the Covered Person to disclose to Cigna Dental all facts pertaining to such service and to render to Cigna Dental reports and/or copies of records pertaining to such service for Cigna Dental administrative or quality management purposes.

I. TERMINATION OF CONTRACT

The Group may terminate this Contract for any reason, effective as of any Renewal Date by providing a minimum of sixty (60) days' prior written notice to the other party. In addition to termination for nonpayment of Premium/Prepayment Fees as set out in Section D hereinabove, Cigna Dental may terminate this Contract for the following reasons:

1. For fraud or other intentional misrepresentation of material fact by the Group;
2. Low participation (i.e. less than ten enrollees);
3. If Cigna Dental ceases to provide or arrange for the provision of dental services for new dental plans in the state; provided, however, that notice of the decision to cease new or existing dental plans shall be provided as required by law at least 180 days prior to discontinuation of coverage; or
4. If Cigna Dental withdraws a group dental plan from the market; provided, however, that notice of withdrawal shall be provided as required by law at least 90 days prior to the discontinuation and that any other dental plan offered is made available to the Group.

In the event of termination of this Contract by either Cigna Dental or the Group, the Group shall provide a notice of termination to each Covered Person at least fifteen (15) days in advance of the effective date of termination. Upon the request of Cigna Dental, Group agrees to provide Cigna Dental proof of such notice and the date of such notice.

In the event of termination of this Contract, Cigna Dental shall within thirty (30) days return to the Group the pro rata portion of Premium/Prepayment Fees, if any, which correspond to any unexpired period for which payment has been received, if any, less amounts due to Cigna Dental. Cigna Dental will pay covered claims incurred by Covered Persons prior to termination. This subsection shall not apply to termination by Cigna Dental made as a result of fraud or deception in the use of services or facilities, or knowingly permitting such fraud or deception by another.

The Group, a Subscriber or a Dependent may request the Director of the California Department of Managed Health Care to review the termination of an enrollment under this Contract in accordance with California Health and Safety Code Section 1365(b).

J. NOTICE

Any notice required by this Contract shall be in writing and mailed with postage fully prepaid and addressed to the Group at the address listed on the Pre-Contract and to Cigna Dental at:

P.O. Box 453099
Sunrise, Florida 33345-3099
Attn: Contracts Administration

The Group shall disseminate to Covered Persons any notice from Cigna Dental of material matters no later than thirty (30) days after receipt thereof.

K. ASSIGNMENT

Group shall not assign this Contract or its rights hereunder nor delegate its duties hereunder without the prior written consent of Cigna Dental.

L. AMENDMENTS TO CONTRACT

Except as otherwise provided herein, Cigna Dental may amend this Contract by giving the Group sixty (60) days' prior written notice of the proposed amendment. Failure of the Group to object in writing to any such proposed amendment within such notice period shall constitute the Group's acceptance of the amendment as of its effective date. Except as otherwise provided herein, changes in the Prepayment Fees or Patient Charge Schedule shall be effective as of the Renewal Date following proper notice.

In the event that federal, state, or municipal laws or regulations should change, alter or modify the present services, levels of premiums to Cigna Dental, standards of eligibility of Covered Persons, or any operations of Cigna Dental such that the terms, benefits and conditions of this Contract must be modified accordingly, Cigna Dental shall have the right to amend this Contract upon 30 days' written notice to the Group.

Except as otherwise provided herein, this Contract may be amended only in writing as approved by both the Group and Cigna Dental. Only a duly authorized officer of Cigna Dental has the authority to amend this Contract.

M. ENTIRE CONTRACT

This Contract, including the Combined Evidence of Coverage and Disclosure Form, Patient Charge Schedule, Pre-Contract Application, and any amendments thereto, represents the entire agreement between the parties with

respect to the subject matter. Having executed the Pre-Contract, the Group shall be deemed to have accepted the terms of this Contract unless written notice is given to Cigna Dental within twenty (20) days of receipt hereof. The invalidity or unenforceability of any Section or sub-Section of this Contract shall not affect the validity or enforceability of the remaining Sections or sub-Sections hereof.

N. GOVERNING LAW

This Contract shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with laws of the state in which the Subscriber receives services under the Dental Plan and with pertinent federal laws and regulations. Any provision required to be in the Contract by relevant state statute or regulation shall bind Cigna Dental whether or not contained herein. In the event this Contract contains any provisions not in conformity with relevant and applicable state or federal laws, the Contract shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable law.

O. INCONTESTABILITY

In the absence of fraud, all statements contained in a written application made by a Subscriber are considered representations and not warranties. Coverage can be voided: (a) during the first two years for material misrepresentations contained in a written enrollment form; and, (b) after the first two years, for fraudulent misstatement contained in a written enrollment form.

CIGNA DENTAL HEALTH OF CALIFORNIA, INC.

BY: _____

TITLE: _____

DATE: _____

2/20/04

Group Contract

and
Cigna Dental Health

Member Services 1.800.Cigna24

Cigna Dental Health of Texas, Inc.
1640 Dallas Parkway
Plano, Texas 75093

THIS IS A LEGAL CONTRACT BETWEEN THE ABOVE MENTIONED GROUP AND THE CIGNA DENTAL COMPANIES LISTED ABOVE. IT IS ISSUED IN CONSIDERATION OF THE PRE-CONTRACT APPLICATION AND PAYMENT OF THE PREMIUMS AS THEY ARE DUE. READ YOUR GROUP CONTRACT CAREFULLY.

85600.TX 12.22.05

TABLE OF CONTENTS

A. DEFINITIONS

Capitalized terms in this contract (the "Contract"), unless otherwise defined, shall have the meanings set forth below.

Cigna Dental: The Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this Contract.

Covered Persons: Subscribers and their Dependents who are enrolled in the Dental Plan.

Dental Plan: Managed dental care plan to be provided pursuant to this Contract.

Dependent: Those Covered Persons which are named as Dependents of a Subscriber, as further defined in the applicable Plan Booklet, Evidence of Coverage and/or Certificate of Coverage.

Evidence of Coverage: Subscriber's dental plan booklet or certificate of coverage which summarizes the dental plan and covered benefits. The Evidence of Coverage is attached hereto and made a part of this Contract as if fully set forth herein.

Group: Employer, labor union, association, or other organization named on the title page of this Contract.

Patient Charge Schedule: List of covered services and associated patient charges, which is attached hereto and incorporated herein by reference, and as it may be revised during the term of this Contract.

Pre-Contract: The Cigna Dental Pre-Contract Application which designates certain terms and conditions of coverage and which is attached hereto and made a part hereof by reference.

Premiums: The premiums stated in the Pre-Contract which the Group must remit to Cigna Dental for Covered Persons each calendar month during the term of this Contract.

Subscriber: Employee or member of the Group who is enrolled in the Dental Plan.

B. THE DENTAL PLAN

1. Cigna Dental shall provide dental benefits to Subscribers and Dependents in accordance with the terms of this Contract and as set out in the attached Pre-Contract, Evidence of Coverage, applicable State Riders, and Patient Charge Schedule.

2. The terms and conditions of the Evidence of Coverage including State Riders, applicable Patient Charge Schedule, and any amendments or revisions thereto, are incorporated into this Contract by reference and made a part hereof as if fully set forth herein. Each Subscriber shall receive an Evidence of Coverage outlining the terms, exclusions and limitations of the coverage provided hereunder. Any conflicts between the Group Contract and Evidence of Coverage shall be resolved according to the terms most favorable to the Subscriber.

3. The relationship between Cigna Dental Health and a Network Dentist is an independent contractor relationship. All contracts between Cigna Dental Health and Network Dentists state that under no circumstances shall any Covered Person be liable to any Network Dentist for any sums owed to the Network Dentist by Cigna Dental Health, notwithstanding any delay by Cigna Dental Health in paying the Network Dentist any such sums. Cigna Dental Health shall provide reasonable notice to the Group of any termination, breach of contract, or inability to perform of any Network Dentist if Cigna Dental Health determines that Covered Persons may be materially and adversely affected thereby.

C. PREMIUMS

In consideration of the services to be rendered and made available by Cigna Dental pursuant to this Contract, the Group shall remit to Cigna Dental the Premium/Prepayment Fee for the initial month of coverage on or before the first day of said month accompanied by a list of persons to be covered under the Dental Plan. On or before the twelfth (12th) day of each month during the term of this Contract, Cigna Dental will send the Group an alphabetized list of Subscribers and a statement of Premiums due for that month of coverage. On or before the twenty-fifth (25th) day of each month during the term of this Contract, the Group shall remit the Premium/Prepayment Fee to Cigna Dental with an updated list indicating Covered Persons to be added to or deleted from the Dental Plan and any changes in type of coverage. The Group shall be responsible for payment of Premiums for Covered Persons through the last day of the month in which the Group notifies Cigna Dental that Covered Persons deleted from the Dental Plan. Alternative payment mechanisms developed for the Group by Cigna Dental shall supersede the terms of this Paragraph.

Premiums are guaranteed for an initial period of twelve (12) months (unless otherwise extended in the Pre-Contract). However, Premiums may be adjusted by Cigna Dental upon 30 days' notice to the Group if, in Cigna Dental's sole opinion, its liability is altered by any state or federal law.

D. GRACE PERIOD/REINSTATEMENT

1. Cigna Dental shall provide written notice of non-receipt of payment on or before the twelfth (12th) day of the month following the month for which Premiums remain due and owing. Group shall have an additional thirty-one (31) days for the payment of any Premium/Prepayment Fee except the first. The Contract shall remain in full force and effect during this Grace Period. If the Premiums are not remitted by the end of the Grace Period, the Contract will terminate on the last day of the Grace Period. The Group will remain liable to Cigna Dental for any Premium accrued during the Grace Period.

2. If proper payment is received by Cigna Dental on or before the expiration of the Grace Period, the Contract shall remain in full force and effect. If the Contract terminates due to non-payment of the required Premiums, the Group may request that Cigna Dental reinstate the Contract. The Group must make this request and pay all past due and current Premiums to Cigna Dental within fifteen (15) days after the expiration of the applicable Grace Period.

3. If Cigna Dental elects to reinstate this Contract, the coverage provided herein will resume as of the date of termination with no gap in coverage. If Cigna Dental elects not to reinstate the Contract, it will

notify the Group of such decision in writing. In such event, any unearned Premium submitted with the request for reinstatement will be returned to the Group.

4. Cigna Dental's reinstatement of the Contract or waiver of the right to terminate this Contract pursuant to this Section shall not constitute a waiver of any future right to terminate for nonpayment of Premium.

E. EFFECTIVE DATE/TERM & RENEWAL

The Group's effective date of coverage under the Dental Plan (the "Effective Date") shall be the date listed on the Pre-Contract, for and in consideration of Cigna Dental's receipt of the Premium.

The original term of this Contract shall extend from the Effective Date until the expiration of the initial Premium/Prepayment Fee Guarantee as set forth in the Pre-Contract (the "Expiration Date"). This Contract shall be automatically renewed on an annual basis effective the day following the Expiration Date (the "Renewal Date") unless otherwise terminated as provided herein. The Patient Charge Schedule shall be in effect for a minimum of one year.

The Premium/Prepayment Fee and Patient Charge Schedule shall be reviewed and may be adjusted on an annual basis at the anniversary of the Renewal Date upon sixty (60) days' notice from Cigna Dental.

F. ELIGIBILITY

1. The Group shall determine which of its employees, associates or members are eligible to enroll in the Dental Plan. The Group shall be responsible for providing eligibility information to Cigna Dental on a timely basis as provided in Section C hereinabove. Where the Group provides eligibility information of any kind, including but not limited to electronic data, tapes or software, the data must be accurate and accessible.

2. The Group will have at least one open enrollment period every eighteen (18) months. Such open enrollment periods are required for as long as the Contract exists unless Cigna Dental and the Group mutually agree to a shorter period of time. Subscribers and Dependents may be disenrolled only during the Group's open enrollment periods unless there has been a life status change such as divorce or termination.

3. In the event a Covered Person is eligible for benefits pursuant to the requirements of the Family and Medical Leave Act of 1993 or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Group shall be responsible for collecting the Subscriber's portion of the Premium, if any, for which the Subscriber would have been responsible if Subscriber had not taken the leave or become qualified for COBRA coverage.

G. COMPLIANCE WITH THE FEDERAL OMNIBUS BUDGET RECONCILIATION ACT OF 1993

The parties agree, as follows, to perform the terms of this Contract in accordance with the requirements of the Federal Omnibus Budget Reconciliation Act of 1993:

1. Cigna Dental shall not take into account that a Covered Person is eligible for or is provided medical assistance under 12 U.S.C. §1396a (section 1902 of the Social Security Act) in covering or providing benefits to or on behalf of said Covered Person under the Dental Plan.

2. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administrative order to provide dental coverage for his or her child:

(a) Cigna Dental Health and the Group:

(i) Shall not deny enrollment of the child in the Dental Plan on any of the following grounds:

a) The child was born out of wedlock,

b) The child is not claimed as a dependent on the Subscriber's federal income tax return, or

c) The child does not reside with the Subscriber or in the Dental Plan's service area.

(ii) Shall allow the Subscriber to enroll the child in the Dental Plan under family coverage, without regard to any enrollment season restrictions, provided that the child is otherwise eligible for Dental Plan coverage.

(iii) Shall enroll the child in the Dental Plan under the family coverage upon application of the child's other parent or the Department of Human Resources in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the Subscriber fails to enroll the child.

(iv) Except as otherwise provided herein, shall not terminate the child's Dental Plan coverage unless Cigna Dental and the Group are provided satisfactory written evidence that:

a) The court or administrative order is no longer in effect, or

b) The child is or will be enrolled in comparable dental coverage through another dental plan, which coverage will take effect no later than the effective date of termination.

(b) The Group shall withhold from Subscriber's compensation the Subscriber's share, if any, of Premiums for Dental Plan coverage and shall pay the appropriate Premiums to Cigna Dental pursuant to the terms of this Contract.

(c) If the Subscriber is not the child's custodial parent, Cigna Dental and the Group shall:

(i) Provide such information to the custodial parent as may be necessary for the child to obtain benefits under the Dental Plan.

(ii) Permit the custodial parent or dentist (with custodial parent's approval) to submit claims for Covered Services without the approval of the non-custodial parent.
(iii) Make payments, pursuant to this Contract, on the claims submitted under clause (b) of this paragraph directly to the custodial parent, the dentist, or the Department of Human Resources.

(d) Cigna Dental shall not impose on any State agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered under the Dental Plan requirements that are different from requirement applicable to an agent or assignee of any other individual covered under the Dental Plan.

3. If a Subscriber who is eligible for family coverage under the Dental Plan is required by a court or administration order to provide dental coverage for his or her child who does not reside in the Dental Plan's service area, the following alternatives for coverage are available:

(a) If the Group offers its employees a choice between the Dental Plan or indemnity dental coverage, the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's service area, except as provided herein for emergencies and specialty referrals; or the family shall be covered under the indemnity dental coverage.

(b) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental has a network of dentists in the service area within which the child resides, the child shall be covered under a contract between the Group and the affiliate of Cigna Dental and the Subscriber shall be covered under a contract between the Group and Cigna Dental.

(c) If the Group does not offer its employees any indemnity dental coverage and an affiliate of Cigna Dental does not have a network in the service area within which the child resides, the family shall be covered by an indemnity dental policy which the Group shall obtain or the family shall be covered under the Dental Plan and the child shall be treated at the Subscriber's Dental Office in the Dental Plan's service area, except as provided herein for emergencies and specialty referrals.

(d) Except as otherwise restricted by federal law, the Subscriber shall be permitted to change his or her dental coverage election (between the Dental Plan and indemnity dental coverage) without regard to any enrollment reason restrictions.

4. A child who is less than 18 years of age and is placed for adoption with a Subscriber shall be entitled to benefits under

the same terms and conditions that apply to the Subscriber's natural, Dependent children, irrespective of whether the adoption has become final. Cigna Dental shall not restrict Dental Plan coverage of any dependent child adopted by or placed for adoption with a Subscriber solely on the basis of any pre-existing condition of the child at the time that the child would otherwise become eligible for coverage under the Dental Plan if the adoption or placement for adoption occurs while the Subscriber is eligible for coverage under the Dental Plan. As used in this paragraph, "placement for adoption" means the assumption and retention by a Subscriber of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with Subscriber terminates upon the termination of such legal obligations.

5. A subscriber's foster child shall be treated the same as a newborn child and shall be eligible for coverage on the same basis, under the terms of this Contract, upon placement in Subscriber's home. As used in this paragraph, "Foster child" means a minor over whom a Subscriber has been appointed (1) guardian by a court of competent jurisdiction in the state or (2) the primary or sole custodian by order of a court of competent jurisdiction. As used in this paragraph, "placement in the Subscriber's home" means physically residing with a Subscriber who has been appointed guardian or custodian as long as that Subscriber has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the Subscriber on a more than temporary or short-term basis.

H. ADMINISTRATION AND RECORDS

1. The Group shall cooperate with Cigna Dental with respect to soliciting and enrolling persons eligible to enroll in the Dental Plan and in obtaining authorized payroll withholding from Subscribers to the extent that the applicable Premium exceed the Group's contribution, if any, on Subscriber's behalf.

2. The Group shall provide to Cigna Dental enrollment information, including copies of all signed enrollment and change forms. Cigna Dental shall be permitted to inspect the Group's records which have a bearing on coverage of Covered Persons hereunder, including but not limited to records pertaining to eligibility, enrollment, payment of Premiums and administration of benefits hereunder, and shall be permitted to make copies thereof at any reasonable time upon reasonable prior notice to the Group.

3. Cigna Dental shall keep administrative records of all Covered Persons, but shall not be liable for any obligation dependent upon information from the Group prior to the receipt of such information in a form satisfactory to Cigna Dental. Incorrect information furnished by the Group may be corrected if Cigna Dental shall not have acted in reliance upon such information to its prejudice.

4. Cigna Dental is entitled to receive from each dentist who renders service to a Covered Person hereunder all information reasonably necessary to fulfill the terms of this Contract. Covered Persons, by their enrollment in

the Dental Plan, authorize each dentist who renders service to the Covered Person to disclose to Cigna Dental all facts pertaining to such service and to render to Cigna Dental reports and/or copies of records pertaining to such service for Cigna Dental administrative or quality management purposes.

I. TERMINATION OF CONTRACT

In addition to termination for nonpayment of Premium as set out in Section D hereinabove, either the Group or Cigna Dental may terminate this Contract for any reason, including low participation, effective as of any Renewal Date by providing a minimum of sixty (60) days' prior written notice to the other party.

In the event of termination of this Contract by either Cigna Dental or the Group, the Group shall provide a notice of termination to each Covered Person. Upon the request of Cigna Dental, Group agrees to provide Cigna Dental proof of such notice and the date of such notice.

In the event of termination of this Contract, Cigna Dental shall within thirty (30) days return to the Group the pro rata portion of Premium, if any, which correspond to any unexpired period for which payment has been received, if any, less amounts due to Cigna Dental. Cigna Dental will pay covered claims incurred by Covered Persons prior to termination. This subsection shall not apply to termination by Cigna Dental made as a result of fraud or deception in the use of services or facilities, or knowingly permitting such fraud or deception by another.

J. NOTICE

Any notice required by this Contract shall be in writing and mailed with postage fully prepaid and addressed to the Group at the address listed on the Pre-Contract and to Cigna Dental at:

P.O. Box 453099
Sunrise, Florida 33345-3099
Attn: Contracts Administration

The Group shall disseminate to Covered Persons any notice from Cigna Dental of material matters no later than thirty (30) days after receipt thereof.

K. ASSIGNMENT

Group shall not assign this Contract or its rights hereunder nor delegate its duties hereunder without the prior written consent of Cigna Dental.

L. AMENDMENTS TO CONTRACT

Except as otherwise provided herein, Cigna Dental may amend this Contract by giving the Group sixty (60) days' prior written notice of the proposed amendment. Failure of the Group to object in writing to any such proposed amendment within such notice period shall constitute the Group's acceptance of the amendment as of its effective date. Except as otherwise provided

herein, changes in the Premium or Patient Charge Schedule shall be effective as of the Renewal Date following proper notice.

In the event that federal, state, or municipal laws or regulations should change, alter or modify the present services, levels of premiums to Cigna Dental, standards of eligibility of Covered Persons, or any operations of Cigna Dental such that the terms, benefits and conditions of this Contract must be modified accordingly, Cigna Dental shall have the right to amend this Contract upon 30 days' written notice to the Group.

Except as otherwise provided herein, this Contract may be amended only in writing as approved by both the Group and Cigna Dental. Only a duly authorized officer of Cigna Dental has the authority to amend this Contract.

M. ENTIRE CONTRACT

This Contract, including the attached Plan Booklet/Evidence of Coverage/Certificate of Coverage, State Riders, Patient Charge Schedule, Pre-Contract Application, and any amendments thereto, represents the entire agreement between the parties with respect to the subject matter. Having executed the Pre-Contract, the Group shall be deemed to have accepted the terms of this Contract unless written notice is given to Cigna Dental within twenty (20) days of receipt hereof. The invalidity or unenforceability of any Section or sub-Section of this Contract shall not affect the validity or enforceability of the remaining Sections or sub-Sections hereof.

N. GOVERNING LAW

This Contract shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with laws of the state in which the Subscriber receives services under the Dental Plan and with pertinent federal laws and regulations. Any provision required to be in the Contract by relevant state statute or regulation shall bind Cigna Dental whether or not contained herein. In the event this Contract contains any provisions not in conformity with relevant and applicable state or federal laws, the Contract shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable law.

O. INCONTESTABILITY

In the absence of fraud, all statements contained in a written application made by a Subscriber are considered representations and not warranties. Coverage can be voided: (a) during the first two years for material misrepresentations contained in a written enrollment form; and, (b) after the first two years, for fraudulent misstatement contained in a written enrollment form.

CIGNA DENTAL HEALTH OF TEXAS, INC.

BY: _____

TITLE: _____

DATE: _____

EXHIBITS

Cigna Dental Health of California, Inc.
400 North Brand Boulevard, Suite 400
Glendale, California 91203

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

This Combined Evidence of Coverage and Disclosure Form is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. A specimen copy of the Group Contract will be furnished upon request. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of dentists dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR DENTAL OFFICES, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION.

Important Cancellation Information – Please Read the Provision Entitled "Disenrollment from the Dental Plan–Termination of Benefits."

The Dental Plan is subject to the requirements of Chapter 2.2 of Division 2 of the Health and Safety Code and of Division 1 of Title 28 of the California Code of Regulations. Any provision required to be in the Group Contract by either of the above will bind the Dental Plan, whether or not provided in the Group Contract.

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at [1.800.Cigna24] if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

TABLE OF CONTENTS

I. DEFINITIONS

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of clinical necessity or appropriateness of care. Requests for payment authorizations that are declined by Cigna Dental based upon clinical necessity or appropriateness of care will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial. Adverse Determinations may be appealed as described in the Section entitled "What To Do If There Is A Problem."

Cigna Dental - Cigna Dental Health of California, Inc.

Clinical Necessity- to be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

A. be consistent with the symptoms, diagnosis or treatment of the condition present;
B. conform to professionally recognized standards of dental practice;
C. not be used primarily for the convenience of the customer or dentist of care; and
D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1986, as amended. The federal law that gives workers who lose their health benefits the right to choose, under certain circumstances, to continue group health benefits provided by the plan under certain circumstances.

Contract Fees - the fees contained in the Network Specialty Dentist agreement with Cigna Dental.

Copayment – the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Covered Services - the dental procedures listed on your Patient Charge Schedule.

Dental Office - your selected office of Network General Dentist(s).

Dental Plan – the plan of managed dental care benefits offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse; your [unmarried child] (including newborns, children of the non-custodial parent, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

A. less than [26] years old; or
B. less than [26] years old if he or she is both:
   1. a full-time student enrolled at an accredited educational institution, and

2. reliant upon you for maintenance and support; or

C. any age if he or she is both:

1. incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and

2 chiefly dependent upon you (the subscriber) for support and maintenance.

For a dependent child [26] years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category B above, you will need to furnish Cigna Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of [26] and once a year thereafter during his or her term of coverage.

For a child who falls into category C above, you will need to furnish Cigna Dental proof of the child's condition and his or her reliance upon you, within sixty (60) days from the date that you are notified by Cigna Dental to provide this information.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides; provided however, Cigna Dental will not deny enrollment to your dependent who resides outside the Cigna Dental service area if you are required to provide coverage for dental services to your dependent pursuant to a court order or administrative order.

This definition of "Dependent" applies unless modified by your Group Contract.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist – a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Pediatric Dentist- a licensed Network Specialty Dentist who has completed training in a specific program to provide dental health care for children.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to You.

Network General Dentist and Network Specialty Dentist include any dental clinic, organization of dentists, or other person or institution

licensed by the State of California to deliver or furnish dental care services that has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you.

Patient Charge Schedule - list of services covered under your Dental Plan and the associated Copayment.

Prepayment Fees – the premium or fees that your Group pays to Cigna Dental, on your behalf, during the term of your Group Contract. These fees may be paid all or in part by you.

Service Area - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

Subscriber/You - the enrolled employee or customer of the Group.

Usual Fee - the customary fee that an individual dentist most frequently charges for a given dental service.

II. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for dental plan operation purposes.

III. ELIGIBILITY/WHEN COVERAGE BEGINS

A. IN GENERAL

To enroll in the Dental Plan, you and your Dependents must live or work in the Service Area and be able to seek treatment for Covered Services within the Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health to be provided at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Prepayment Fees.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be

enrolled in the Dental Plan and you must begin paying Prepayment Fees, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Prepayment Fees, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

B. NEW ENROLLEE TRANSITION OF CARE

If you or your enrolled Dependents are new enrollees currently receiving services for any of the conditions described hereafter from a non-Network Dentist, you may request Cigna Dental to authorize completion of the services by the non-Network Dentist. Cigna Dental does not cover services provided by non-Network Dentists except for the conditions described hereafter that have been authorized by Cigna Dental prior to treatment. Rare instances where prolonged treatment by a non-Network Dentist might be indicated will be evaluated on a case-by-case basis by the Dental Director in accordance with professionally recognized standards of dental practice. Authorization to complete services started by a non-Network Dentist before you or your enrolled Dependents became eligible for Cigna Dental shall be considered only for the following conditions:

(1) an acute condition. An acute condition is a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of the covered services shall be provided for the duration of the acute condition.

(2)) newborn children between birth and age 36 months. Cigna Dental shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the effective date of coverage for a newly covered enrollee.

(3) performance of a surgery or other procedure that is authorized by Cigna Dental and has been recommended and documented by the non-Network Dentist to occur within 180 days of the effective date of your Cigna Dental coverage.

C. RENEWAL PROVISIONS

Your coverage under the Dental Plan will automatically be renewed, except as provided in the section entitled "Disenrollment From The Dental Plan – Termination of Benefits." All renewals will be in accordance with the terms and conditions of your Group Contract. Cigna Dental reserves any and all rights to change the Prepayment Fees or applicable Copayments during the term of the Group Contract if Cigna Dental determines Group’s information relied upon by Cigna Dental in setting the Prepayment Fees materially changes or is determined by Cigna Dental to be inaccurate.

IV. YOUR CIGNA DENTAL COVERAGE

Cigna Dental maintains its principal place of business at 400 North Brand Boulevard, Suite 400, Glendale, CA 91203, with a telephone number of 1.800.Cigna24.

This section provides information that will help you to better understand your Dental Plan. Included is information about how to access your dental benefits and your payment responsibilities.

A. CUSTOMER SERVICE

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at 1.800.Cigna24. If you have a question about your treatment plan, we can arrange a second opinion or consultation. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. PREPAYMENT FEES

Your Group sends a monthly Prepayment Fee (premium) to Cigna Dental for customers participating in the Dental Plan. The amount and term of this prepayment fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this Prepayment Fee to be withheld from your salary or to be paid by you to the Group.

C. OTHER CHARGES - COPAYMENTS

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. Network Specialty Dentists are compensated based on a contracted fee arrangement for services rendered. No bonuses or financial incentives are used as inducements to limit services. Network Dentists are also compensated by the Copayments that you pay, as set out in your Patient Charge Schedule. You may request general information about these matters from Customer Service or from your Network Dentist.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan, subject to plan exclusions and limitations. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the Copayments you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist is instructed to tell you about Copayments for Covered Services, the amount you must pay for optional or non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances. IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that

are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call customer services at 1-800-Cigna24 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Your Patient Charge Schedule is subject to change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Copayments at least 30 days prior to such change. You will be responsible for the Copayments listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. FACILITIES- CHOICE OF DENTIST

1. In General

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at 1.800.Cigna24 to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist’s office will have primary responsibility for your child’s care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist’s Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

2. Appointments

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

3. Office Transfers

If you decide to change Dental Offices, we encourage you to complete any dental procedure in progress first. To arrange a transfer, call Customer Service at 1.800.Cigna24. To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at 1.800.Cigna24.

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Copayments which you owe to your current Dental Office must be paid before the transfer can be processed. Copayments for procedures not completed at the time of transfer may be required to be prorated between your current Dental Office and the new Dental Office, but will not exceed the amount listed on your Patient Charge Schedule.

E. YOUR PAYMENT RESPONSIBILITY (General Care)

For Covered Services at your Dental Office, you will be charged the Copayments listed on your Patient Charge Schedule, subject to applicable exclusions and limitations. For services listed on your Patient Charge Schedule provided at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist available in the Service Area to treat you, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Copayment for Covered Services. Cigna Dental will pay the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. If you seek treatment for Covered Services from a non-Network Dentist without authorization from Cigna Dental, you will be responsible for paying the non-Network Dentist his or her Usual Fee.

See Section IV.G, Specialty Referrals, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. SPECIALTY CARE

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists – children's dentistry.
- Endodontists – root canal treatment.
- Periodontists – treatment of gums and bone.
- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist. Except for Pediatrics, Orthodontics and Endodontic services, payment authorization is required for coverage of services by a Network Specialty Dentist.

See Section IV.D, Facilities- Choice of Dentist, regarding treatment by a Pediatric Dentist.

G. SPECIALTY REFERRALS

1. IN GENERAL

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization prior to rendering the service. Prior authorization from Cigna Dental is not required for specialty referrals for Pediatrics, Orthodontics and Endodontic services. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

If your Patient Charge Schedule reflects coverage for Orthodontic services, a referral from a Network General Dentist is not required to receive care from a Network Orthodontist. However, your Network General Dentist may be helpful in assisting you to choose or locate a Network Orthodontist.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section V.A.7, Orthodontics.

Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental’s authorization. If you are unable to obtain treatment within the 90-day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

If Cigna Dental makes an Adverse Determination of the requested referral (i.e. Cigna Dental does not authorize

payment to the Network Specialty Dentist for Covered Services), or if the dental services sought are not Covered Services, you will be responsible to pay the Network Specialty Dentist's Usual Fee for the services rendered. If you have a question or concern regarding an authorization or a denial, contact Customer Service.

Specialty referrals will be authorized by Cigna Dental if the services sought are (i) Covered Services; (ii) rendered to an eligible customer; (iii) within the scope of the Specialty Dentists skills and expertise; and (iv) meet Clinical Necessity requirements. Cigna Dental may request medical information regarding your condition and the information surrounding the dentist's determination of the Clinical Necessity for the request. Cigna Dental shall respond in a timely fashion appropriate for the nature of your condition, not to exceed five business days from Cigna Dental's receipt of the information reasonably necessary and requested by Cigna Dental to make the determination. When you face imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal time frame for the decision making process would be detrimental to your life or health or could jeopardize your ability to regain maximum function, the decision to approve, modify, or deny requests shall be made in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request. Decisions to approve, modify, or deny requests for authorization prior to the provision of dental services shall be communicated to the requesting dentist within24 hours of the decision. Decisions resulting in denial, delay, or modification of all or part of the requested dental service shall be communicated to the Customer in writing within 2 business days of the decision. Adverse Determinations may be appealed as described in the Section entitled "What To Do If There Is A Problem/Grievances."
After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Copayment for Covered Services. Cigna Dental will reimburse the non-Network Dentist the difference between his or her Usual Fee and the applicable Copayment. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the

dentist's Usual Fee. Or, if you seek treatment for Covered Services from a non-Network Dentist without authorization from Cigna Dental, you will be responsible for paying the dentist's Usual Fee.

You may request from Customer Service a copy of the process that Cigna Dental uses to authorize, modify, or deny requests for specialty referrals and services.

2. SECOND OPINIONS

If you have questions or concerns about your treatment plan, second opinions are available to you upon request by calling Customer Service. Second opinions will generally be scheduled within 5 days. In the case of an imminent and serious health threat, as determined by Cigna Dental clinicians, second opinions will be rendered within 72 hours. Cigna Dental's policy statement on second opinions may be requested from Customer Service.

V. COVERED DENTAL SERVICES

A. CATEGORIES OF COVERED SERVICES

Dental procedures in the following categories of Covered Services are covered under your Dental Plan when listed on your Patient Charge Schedule and performed by your Network Dentist. Please refer to your Patient Charge Schedule for the procedures covered under each category and the associated Copayment.

1. DIAGNOSTIC/PREVENTIVE

Diagnostic treatment consists of the evaluation of a patient's dental needs based upon observation, examination, x-rays and other tests. Preventive dentistry involves the education and treatment devoted to and concerned with preventing the development of dental disease. Preventive Services includes dental cleanings, oral hygiene instructions to promote good home care and prevent dental disease, and fluoride application for children to strengthen teeth.

a. Limitation

The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency. If your Network Dentist certifies to Cigna Dental that, due to medical necessity you require certain Covered Services more frequently than the limitation allows, Cigna Dental will waive the limitation.

2. RESTORATIVE (Fillings)

Restorative dentistry involves materials or devices used to replace lost tooth structure or to replace a lost tooth or teeth.

3. CROWN AND BRIDGE

An artificial crown is a restoration covering or replacing the major part, or the whole of the clinical crown of a tooth. A

fixed bridge is a prosthetic replacement of one or more missing teeth cemented to the abutment teeth adjacent to the space. The artificial tooth used in a bridge to replace the missing tooth is called a pontic.

a. Complex Rehabilitation/Multiple Crown Units

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit copayment for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for complex rehabilitation for each unit beginning with the 6th unit when 6 or more units are prescribed in your Network General Dentist's treatment plan. The additional charge for complex rehabilitation will not be applied to the first 5 units of crown or bridge.

Note: Complex Rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

b. Limitations

(1) all charges for crown and bridge are per unit (each replacement or supporting tooth equals one unit).
(2) limit 1 every 5 years unless Cigna Dental determines that replacement is necessary because the existing crown or bridge is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes in tooth structure or supporting tissues since the placement of the crown or bridge.

c. Exclusion

(1) there is no coverage for crowns, bridges used solely for splinting. This exclusion will not apply if a crown or bridge is determined by Cigna Dental to be the treatment most consistent with professionally accepted standards of care.

(2) there is no coverage for implant supported prosthesis used solely for splinting unless specifically listed on your Patient Charge Schedule.
(3) there is no coverage for resin bonded retainers and associated pontics.
(4) there is no coverage for the recementation of any inlay, onlay, crown, post and core, fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
(5) the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.

4. ENDODONTICS

Endodontics is root canal treatment which may be required when the nerve of a tooth is damaged due to trauma, infection, or inflammation. Treatment consists of removing the damaged nerve from the root of the tooth and filling the root canal with a rubber-like material. Following endodontic treatment, a crown is usually needed to strengthen the weakened tooth.

Exclusions

1. Coverage is not provided for Endodontic treatment of teeth exhibiting a poor or hopeless periodontal prognosis.
2. Coverage is not provided for intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

5. PERIODONTICS

Periodontics is treatment of the gums and bone which support the teeth. Periodontal disease is chronic. It progresses gradually, sometimes without pain or other symptoms, destroying the support of the gums and bone. The disease is a combination of deterioration plus infection.

a. Preliminary Consultation
This consultation by your Network General Dentist is the first step in the care process. During the visit, you and your Network General Dentist will discuss the health of your gums and bone.

b. Evaluation, Diagnosis and Treatment Plan
If periodontal disease is found, your Network General Dentist or Network Specialty Dentist will develop a treatment plan. The treatment plan consists of mapping the extent of the disease around the teeth, charting the depth of tissue and bone damage and listing the procedures necessary to correct the disease.

Depending on the extent of your condition, your Network General Dentist or Network Specialty Dentist may recommend any of the following procedures:

(1) Non-surgical Program- this is a conservative approach to periodontal therapy. Use of this program depends upon how quickly you heal and how consistently you follow instructions for home care. This program may include:

- scaling and root planning
- oral hygiene instruction
- full mouth debridement

(2) Scaling and Root Planning- this periodontal therapy procedure combines scaling of the crown and root surface with root planning to smooth rough areas of the root. This procedure may be performed by the dental hygienist or your Network General Dentist.

(3) Osseous Surgery- bone (osseous) surgery is a procedure used in advanced cases of periodontal disease to restructure the supporting gums and bone. Without this surgery, tooth or bone loss may occur. Two checkups by the Periodontist are covered within the year after osseous surgery.

(4) Occlusal Adjustment- occlusal adjustment requires the study of the contours of the teeth, how they bite (occlude) and their position in the arch. It consists of a recontouring of biting surfaces so that direct biting forces are along the long axis of the tooth. If the biting forces are not properly distributed, the bone which supports the teeth may deteriorate.

(5) Bone Grafts and other regenerative procedures- this procedure involves placing a piece of tissue or synthetic material in contact with tissue to repair a defect or supplement a deficiency.

c. Limitations

1. Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

2. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

d. Exclusions

1. General anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, IV sedation is covered when medically necessary and provided in conjunction with Covered Services performed by a Periodontist. General anesthesia is not covered when provided by a Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

2. There is no coverage for Periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
3. There is no coverage for the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
4. There is no coverage for bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
5. There is no coverage for bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
6. There is no coverage for localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

6. ORAL SURGERY

Oral surgery involves the surgical removal of teeth or associated surgical procedures by your Network General Dentist or Network Specialty Dentist.

a. Limitation
The surgical removal of a wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Temporary pain from normal eruption is not considered disease. Your Patient Charge Schedule lists any limitations on oral surgery.

b. Exclusion
General anesthesia, sedation and nitrous oxide are not covered unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

7. ORTHODONTICS (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

a. Definitions - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
(1) Orthodontic Treatment Plan and Records - the preparation of orthodontic records and a treatment plan by the Orthodontist.
(2) Interceptive Orthodontic Treatment - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
(3) Comprehensive Orthodontic Treatment - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.

(4) Retention (Post Treatment Stabilization) - the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

b. Copayments

The Copayment for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Orthodontic Treatment Plan and Records. However, if (a) banding/appliance insertion does not occur within 90 days of such visit, (b) your treatment plan changes, or (c) there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Copayment for orthodontic treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Copayment will be reduced on a prorated basis.

c. Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

(1) incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
(2) orthognathic surgery and associated incremental costs;
(3) appliances to guide minor tooth movement;
(4) appliances to correct harmful habits; and
(5) services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

d. Orthodontics in Progress

If orthodontic treatment is in progress for you or your Dependent at the time you enroll, call Customer Service at [1.800.Cigna24] to find out the benefit to which you are entitled based upon your individual case and the remaining months of treatment.

e. Exclusion

Replacement of fixed and/or removable orthodontic appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

B. EMERGENCY DENTAL CARE - REIMBURSEMENT

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. Emergency dental care services may include examination, x-rays, sedative

fillings, dispensing of antibiotics or pain relief medication or other palliative services prescribed by the treating dentist. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. **Emergency Care Away From Home**
   If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Copayments listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference between the dentist's usual fee for emergency Covered Services and your Copayment, up to a total of $50 per incident. To receive reimbursement, send the dentist's itemized statement to Cigna Dental at the address listed for your state on the front of this booklet.

2. **Emergency Care After Hours**
   There is a Copayment listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Copayments.

VI. EXCLUSIONS

In addition to the exclusions listed in Section V, listed below are the services or expenses which are also NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section V.B.).
- services to the extent you, or your Dependent, are compensated for them under any group medical plan.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards..
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.

- prescription medications.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a

hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination. If special circumstances arise where a Network Dentist is not available, the Plan will make special arrangements for the provision of covered benefits as necessary for the dental health of the customer.)

- procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction and the primary purpose of the restoration is (a) to change the vertical dimension of occlusion; or (b) for cosmetic purposes.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- charges by dental offices for failing to cancel an appointment or canceling an appointment with less than 24 hours notice (i.e. a broken appointment). You will be responsible for paying any broken appointment fee unless your broken appointment was unavoidable due to emergency or exigent circumstances.
- consultations and/or evaluations associated with services that are not covered.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.

As noted in Section V, the following exclusions also apply:

- there is no coverage for crowns, bridges used solely for splinting. This exclusion will not apply if a crown or bridge is determined by Cigna Dental to be the treatment most consistent with professionally accepted standards of care.
- there is no coverage for implant supported prosthesis used solely for splinting unless specifically listed on your Patient Charge Schedule.
- there is no coverage for resin bonded retainers and associated pontics.
- general anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- replacement of fixed and/or removable orthodontic appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period., when this limitation is noted on the Patient Charge Schedule.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

Should any law require coverage for any particular service(s) noted above, the exclusion for that service(s) shall not apply.

VII. LIMITATIONS

In addition to the limitations listed in Section V, listed below are the services or expenses which have limited coverage under your Dental Plans. No payment will be made for expense incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated run by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made of the person had no insurance;
- due to injuries which are intentionally self-inflicted.

In addition to the above the following limitations will also apply.

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

Should any law require coverage for any particular service(s) noted above, the limitation for that service(s) shall not apply.

VIII. WHAT TO DO IF THERE IS A PROBLEM/GRIEVANCES

For the purposes of this section, any reference to "you" or "your" also refers to a representative or dentist designated by you to act on your behalf.

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request. No Plan employee shall retaliate or discriminate against a customer (including seeking disenrollment of the customer) solely on the basis that the customer filed a grievance. Instances of such retaliation or discrimination shall be grounds for disciplinary action, (including termination) against the employee.

A. YOUR RIGHTS TO FILE GRIEVANCES WITH CIGNA DENTAL

We want you to be completely satisfied with the care you receive. That is why we have established an internal grievance process for addressing your concerns and resolving your problems.

Grievances include both complaints and appeals. Complaints may include concerns about people, quality of service, quality of care, benefit interpretations or eligibility. Appeals are requests to reverse a prior denial or modified decision about your care. You may contact us by telephone or in writing with a grievance.

B. HOW TO FILE A GRIEVANCE

To contact us by phone, call us toll-free at 1.800.Cigna24 or the toll-free telephone number on your Cigna identification card. The hearing impaired may call the state TTY toll-free service listed in their local telephone directory.

Send written grievances to:

Cigna Dental Health of California, Inc.
P.O. Box 188047
Chattanooga, TN 37422-8047

We will provide you with a grievance form upon request, but you are not required to use the form in order to make a written grievance.

You may also submit a grievance online through the following Cigna website: http://my.cigna.com/health/consumer/medical/state/ca.html#dental.

If the Customer is a minor, is incompetent or unable to exercise rational judgment or give consent, the parent, guardian, conservator, relative, or other legal representative acting on behalf of the Customer, as appropriate, may submit a grievance to Cigna Dental or the California Department of Managed Health Care (DMHC or "Department"), as the agent of the Customer. Also, a participating dentist may join with or assist you or your agent in submitting a grievance to Cigna Dental or the DMHC.

1. Complaints

If you are concerned about the quality of service or care you have received, a benefit interpretation, or have an eligibility issue, you should contact us to file a verbal or written complaint. If you contact us by telephone to file a complaint, we will attempt to document and/or resolve your complaint over the telephone. If we receive your complaint in writing, we will send you a letter confirming that we received the complaint within 5 calendar days of receiving your notice. This notification will tell you whom to contact should you have questions or would like to submit additional information about your complaint. We will investigate your complaint and will notify you of the outcome within 30 calendar days.

2. Appeals

If your grievance does not involve a complaint about the quality of service or care, a benefit interpretation or an eligibility issue, but instead involves dissatisfaction with the outcome of a decision that was made about your care and you want to request Cigna Dental to reverse the previous decision, you should contact us within one year of receiving the denial notice to file a verbal or written appeal. Be sure to share any new information that may help justify a reversal of the original decision. Within 5 calendar days from when we receive your appeal, we will confirm with you, in writing, that we received it. We will tell you whom to contact at Cigna Dental should you have questions or would like to submit additional information about your appeal. We will make sure your appeal is handled by someone who has authority to take action and who was not involved in the original decision. We will investigate your appeal and notify you of our decision, within 30 calendar days. You may request that the appeal process be expedited, if there is an imminent and serious threat to your health, including severe pain, potential loss of life, limb or major bodily function. A Dental Director for Cigna Dental, in consultation with your treating dentist, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna Dental will respond orally and in writing with a decision within 72 hours.

C. YOU HAVE ADDITIONAL RIGHTS UNDER STATE LAW

Cigna Dental is regulated by the California Department of Managed Health Care (DMHC or the "Department"). If you are dissatisfied with the resolution of your complaint or appeal, the law states that you have the right to submit the grievance to the department for review as follows:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1.800.Cigna24 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

You may file a grievance with the DMHC if Cigna Dental has not completed the complaint or appeal process described above within 30 days of receiving your grievance. You may immediately file an appeal with Cigna Dental and/or the DMHC in a case involving an imminent and serious threat to the health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the DMHC determines that an earlier review is warranted.

D. VOLUNTARY MEDIATION

If you have received an appeal decision from Cigna Dental with which you are not satisfied, you may also request voluntary mediation with us before exercising the right to submit a grievance to the DMHC. In order for mediation to take place, you and Cigna Dental each have to voluntarily agree to the mediation. Cigna Dental will consider each request for mediation on a case-by-case basis. Each side will equally share the expenses of the mediation. To initiate mediation, please submit a written request to the Cigna Dental address listed above. If you request voluntary mediation, you may elect to submit your grievance directly to the DMHC after participating in the voluntary mediation process for at least 30 days.
For more specific information regarding these grievance procedures, please contact our Customer Service Department.

IX. COORDINATION OF BENEFITS

Coordination of benefit rules explain the payment process when you are covered by more than one dental plan. You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Coordination of Benefits should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

The following is a more detailed explanation of the rules used to determine which plan must pay first (your "primary" plan) and which plan must pay second (your "secondary" plan):

A. A customer may be covered as an employee by his/her employer and as a dependent by his/her spouse's employer. The plan that covers the Customer as an employee (the policyholder) is the primary plan.

B. Under most circumstances, if a child is covered as a dependent under both parents' coverage (and parents are not separated or divorced), the plan of the parent with the earliest birthday in the year is the primary plan.

C. If a child of divorced or separated parents is covered as a dependent under at least one of the parents' (or stepparents') coverage, benefits are determined in the following order:

   1. According to a court decree that designates the person financially responsible for the dental care coverage; or without such decree,
   2. The plan of the parent who has custody of the child;
   3. If the parent with custody of the child is remarried, then the stepparent's plan; and finally,
   4. The plan of the parent without custody of the child.

D. The benefits of a plan that covers an active employee (and any dependents) are determined before those of a program which covers an inactive employee (laid-off or retired). However, if one of the plans does not have a provision regarding retired or laid-off employees, this section may not apply. Please contact the Plan at the number below for further instruction.

E. If a Customer is covered under a continuation plan (e.g. COBRA) AND has coverage under another plan, the following determines the order of benefits:

   1. The plan that covers the customer as an employee (or dependent of employee) will be primary;
   2. The continuation plan will be secondary.

However, if the plan that covers the person as an employee does not follow these guidelines and the plans disagree about the order of determining benefits, then this rule may be ignored. Please contact Cigna Dental at the number below for further instructions.

F. If none of the above rules determines the order of benefits, the plan that has been in effect longer is the primary plan. To determine which plan has been in effect longer, we will take into consideration the coverage you had previously with the same employer, even if it was a different plan, as long as there was no drop in eligibility during the transition between plans.

G. WORKERS' COMPENSATION - Should any benefit or service rendered result from a Workers' Compensation Injury Claim, the Customer shall assign his/her right to reimbursement from other sources to Cigna Dental or to the Participating Dentist who rendered the service.

H. When Cigna Dental is primary, we will provide or pay dental benefits without considering any other plan's benefits. When Cigna Dental is secondary, we shall pay the lesser of either the amount that we would have paid in the absence of any other dental coverage, or your total out of pocket cost payable under the primary dental plan for benefits covered by Cigna Dental.

I. Please call Cigna Dental at 1.800.Cigna24 if you have questions about which plan will act as your primary plan or if you have other questions about coordination of benefits.

Additional coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

X. DISENROLLMENT FROM THE DENTAL PLAN - TERMINATION OF BENEFITS

Except for extensions of coverage as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan/termination of benefits and coverages will be as follows:

A. FOR THE GROUP

The Dental Plan is renewable with respect to the Group except as follows:

1. for nonpayment of the required Prepayment Fees;
2. for fraud or other intentional misrepresentation of material fact by the Group;
3. low participation (i.e. less than ten enrollees);
4. if the Dental Plan ceases to provide or arrange for the provision of dental services for new Dental Plans in the state; provided, however, that notice of the decision to cease new or existing dental plans shall be provided as required by law at least 180 days prior to discontinuation of coverage; or
5. if the Dental Plan withdraws a Group Dental Plan from the market; provided, however, that notice of withdrawal shall be provided as required by law at least 90 days prior to the

discontinuation and that any other Dental Plan offered is made available to the Group.

B. FOR YOU AND YOUR ENROLLED DEPENDENTS

The Dental Plan may not be canceled or not renewed except as follows:

1. failure to pay the charge for coverage if you have been notified and billed for the charge and at least 15 days have elapsed since the date of notification.
2. fraud or deception in the use of services or Dental Offices or knowingly permitting such fraud or deception by another.

C. TERMINATION EFFECTIVE DATE

The effective date of the termination shall be as follows:

1. Cigna Dental shall provide written notice of non-receipt of payment on or before the twelfth (12th) day of the month following the month for which Premiums/Prepayment Fees remain due and owing. The Group shall have an additional thirty-one (31) days for the payment of any Premium/Prepayment Fee. The Contract shall remain in full force and effect during this Grace Period. If the Premium/Prepayment Fees are not remitted by the end of the Grace Period, the Contract will terminate on the last day of the Grace Period.
2. in the case of failure to meet eligibility requirements enrollment will be canceled as of the date of termination specified in the written notice, provided that at least 15 days have expired since the date of notification.
3. on the last day of the month after voluntary disenrollment.
4. termination of Benefits due to fraud or deception shall be effective immediately upon receipt of notice of cancellation.

D. EFFECT ON DEPENDENTS

When one of your Dependents disenrolls, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

For you and your Dependents, disenrollment will be effective the last day of the month in which Prepayment Fees are not paid to Cigna Dental. Cigna Dental will provide at least 15 days notice to your Group as to the date your coverage will be discontinued.

E. RIGHT TO REVIEW

If you believe that your termination from the Dental Plan is due to your dental health status or requirements for dental care services, you may request review of the termination by the Director of the Department of Managed Health Care.

F. NOTICE OF TERMINATION

If the Group Contract is terminated for any reason described in this section, the notice of termination of the Group Contract or your coverage under the Group Contract shall be mailed by the Dental Plan to your Group or to you, as applicable. Such notice shall be dated and shall state:

1. the cause for termination, with specific reference to the applicable provision of the Group Contract or Plan Booklet;

2. the cause for termination was not the Subscriber's or a Customer's health status or requirements for health care services;
3. the time the termination is effective;
4. the fact that a Subscriber or Customer alleging that the termination was based on health status or requirements for health care services may request a review of the termination by the Director of the California Department of Managed HealthCare;
5. in instances of termination of the Group Contract for non-payment of fees, that receipt by the Dental Plan of any such past due fees within 15 days following receipt of notice of termination will reinstate the Group Contract as though it had never been terminated; if payment is not made within such 15 day period a new application will be required and the Dental Plan shall refund such payment within 20 business days;
6. any applicable rights you may have under the "Continuation of Benefits" Section.

XI. CONTINUITY OF CARE

If you are receiving care from a Network Dentist who has been terminated from the Cigna Dental network, Cigna Dental will arrange for you to continue to receive care from that dentist if the dental services you are receiving are for one of the following conditions:

(1) an acute condition. An acute condition is a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration. Completion of the covered services shall be provided for the duration of the acute condition.
(2) newborn children between birth and age 36 months. Cigna Dental shall provide for the completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Network Dentist's contract.
(3) performance of a surgery or other procedure that is authorized by Cigna Dental and has been recommended and documented by the terminated dentist to occur within 180 days of the effective date of termination of the dentist's contract.

Cigna Dental is not obligated to arrange for continuation of care with a terminated dentist who has been terminated for medical disciplinary reasons or who has committed fraud or other criminal activities.

In order for the terminated Participating Dentist to continue to care for you, the terminated dentist must comply with the Cigna Dental's contractual and credentialing requirements and must meet the Cigna Dental's standards for utilization review and quality assurance. The terminated dentist must also agree with Cigna Dental to a mutually acceptable rate of payment. If these conditions are not met, Cigna Dental is not required to arrange for continuity of care.

If you meet the necessary requirements for continuity of care as described above, and would like to continue your care with the terminated Dentist, you should call Customer Service.

If you do not meet the requirements for continuity of care or if the terminated dentist refuses to render care or has been determined unacceptable for quality or contractual reasons, Cigna Dental will work with you to accomplish a timely transition to another qualified Network Dentist.

XII. CONTINUATION OF BENEFITS (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Prepayment Fees to the Group. Additional information is available through your Benefits Representative.

XIII. INDIVIDUAL CONTINUATION OF BENEFITS

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within 3 months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- permanent breakdown of the dentist-patient relationship,
- fraud or misuse of dental services and/or Dental Offices,
- nonpayment of Prepayment Fees by the Subscriber,
- selection of alternate dental coverage by your Group, or
- lack of network/service area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at [1.800.Cigna24] to obtain current rates and make arrangements for continuing coverage.

XIV. CONFIDENTIALITY/PRIVACY

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at [1.800.Cigna24], or via the Internet at my.cigna.com

A STATEMENT DESCRIBING CIGNA DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

XV. MISCELLANEOUS

A. PROGRAMS PROMOTING GENERAL HEALTH

As a Cigna Dental plan customer, you may be eligible for various benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at my.cigna.com for details.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for [pregnant women] [for other medical conditions]. Please review your plan enrollment materials for details.

B. ORGAN AND TISSUE DONATION

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. The California Health and Safety Code states that an anatomical gift may be made by one of the following ways:

- a document of gift signed by the donor.
- a document of gift signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the donor and of each other and state that it has been so signed.
- a document of gift orally made by a donor by means of a tape recording in his or her own voice.

One easy way individuals can make themselves eligible for organ donation is through the Department of Motor Vehicles (DMV). Every time a license is renewed or a new one is issued to replace one that was lost, the DMV will automatically send an organ donor card. Individuals may complete the card to indicate that they are willing to have their organs donated upon their death. They will then be given a small dot to stick on their driver's license, indicating they have an organ donor card on file. For more information, contact your local DMV office and request an organ donor card.

C. 911 EMERGENCY RESPONSE SYSTEM

You are encouraged to use appropriately the 911 emergency response system, in areas where the system is established and operating, when you have an emergency medical condition that requires an emergency response.

CALIFORNIA LANGUAGE ASSISTANCE PROGRAM NOTICE

IMPORTANT INFORMATION ABOUT FREE LANGUAGE ASSISTANCE

If you have a limited ability to speak or read English you have the right to the following services at no cost to you:

- Access to an interpreter when you call Cigna's Customer Service

Department.

- Access to an interpreter when you talk to your doctor or health care dentist.
- If you read Spanish or Traditional Chinese, you also have the right to request that we read certain documents that Cigna has mailed to you, in your preferred language. You may also request written translation of these documents.

To inform Cigna of your preferred written and spoken languages, your race and/or ethnicity, or to request assistance from someone who speaks your language, please call us at the telephone number on your Identification (ID) card or your customer service phone number.

We are pleased to assist you in the language you prefer and understand.

INFORMACIÓN IMPORTANTE SOBRE LA ASISTENCIA GRATUITA CON EL IDIOMA

Si su dominio para hablar o leer en inglés es limitado, usted tiene derecho a acceder a los siguientes servicios, sin ningún costo para usted:

- Acceso a un intérprete cuando se comunica con el Departamento de Servicios a los miembros de Cigna.
- Acceso a un intérprete cuando habla con su médico o con el proveedor de atención médica.
- Si usted lee español o chino tradicional, también tiene derecho a solicitar que le leamos ciertos documentos que Cigna le ha enviado a usted por correo, en el idioma que usted prefiera. También puede solicitar la traducción por escrito de estos documentos.

Para informarle a Cigna el idioma escrito u oral que usted prefiere, su raza y/o origen étnico, o para solicitar ayuda de alguien que hable su idioma, por favor, llámenos al teléfono que figura en su Tarjeta de identificación (ID) o al teléfono del servicio de atención al cliente.

Nos complace ayudarle en el idioma que usted prefiere y entiende.

有關免費語言協助的重要訊息

如果您的英語說話或閱讀能力有限，您有權可免費取得下列服務：

- 您打電話給 CIGNA 的會員服務部門時，由口譯員爲您 翻譯。
- 您與您的醫生或醫療保健提供者溝通時，由口譯員爲您翻譯。
- 如果您能閱讀西班牙文或繁體中文，您也有權可要求我們把 CIGNA 郵寄給您的部分文件，用您熟悉的語言 朗讀給您聽。您也可以索取這些文件的書面翻譯。

如果您想告訴 CIGNA 您習慣閱讀和說的語言、您的種族 和 (或) 族裔，或想申請由和您說同樣語言的人來協助您，請您撥您的會員卡上的電話，或撥我們的顧客服務電話與我們聯絡。

我們十分樂意用您熟悉且能清楚瞭解的語言來協助您。

THÔNG TIN QUAN TRỌNG VỀ DỊCH VỤ TRỢ GIÚP NGÔN NGỮ MIỄN PHÍ

Nếu quý vị không nói hoặc đọc tiếng Anh thông thạo, quý vị có quyền được nhận các dịch vụ miễn phí sau đây:

- Có thông dịch viên trợ giúp khi quý vị gọi Ban Dịch Vụ Hội Viên của CIGNA.
- Có thông dịch viên trợ giúp khi quý vị nói chuyện với bác sĩ hoặc nhà cung cấp dịch vụ chăm sóc sức khỏe của quý vị.
- Nếu quý vị biết đọc tiếng Tây ban nha hoặc tiếng Hoa truyền thống, quý vị cũng có quyền yêu cầu chúng tôi đọc một số tài liệu mà CIGNA đã gửi cho quý vị, bằng ngôn ngữ mà quý vị ưa dùng. Quý vị cũng có thể yêu cầu bản chuyển ngữ của các tài liệu này.

Để cho CIGNA biết về các ngôn ngữ viết và nói mà quý vị ưa dùng, sắc tộc và/hoặc chủng tộc của quý vị, hoặc nhờ người nói được ngôn ngữ của quý vị giúp đỡ, xin gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc số điện thoại của ban dịch vụ khách hàng.

Chúng tôi luôn sẵn lòng trợ giúp quý vị bằng ngôn ngữ mà quý vị ưa dùng.

無料言語支援サービスに関する重要情報

英語による読み書きにご不自由を感じるお客様のために、以下のサービスを無料でご提供しています。

- CIGNA会員サービス部に電話をする際の通訳サービス。
- 担当医または医療保険プロバイダとの会話を支援する通訳サービス。
- スペイン語または繁体字中国語をお話しになる方を対象に、CIGNAがお手元にお送りする特定の文書をご希望の言語でお読みするサービス。該当文書の翻訳もご請求いただけます。

CIGNA にご希望言語（書面および会話）、または、該当する人種・民族の通知を行う場合、または、言語サービスをご希望の場合には、お手持ちの身分証明(ID)カード記載の電話番号、または、カスタマー・サービスの電話番号までご連絡ください。

お客様のご希望の言語で、サービスをご提供いたします。

무료 통번역 서비스에 대한 중요 정보 사항

영어로 읽고 말하는데 어려움을 겪는 분이 계시다면 다음의 무료 통번역 서비스를 받으실 수 있습니다:

- CIGNA 고객 서비스 센터에 전화하실 때 통역사 서비스를 받으실 수 있습니다.
- 본인의 의사나 헬스 케어 제공자와 대화하실 때 통역사 서비스를 받으실 수 있습니다.
- 스페인어나 중문 번체를 읽으실 수 있는 분은 CIGNA가 우편으로 보낸 특정 서류에 대해 선호하는 언어로 번역해 줄 것을 요청하실 수 있습니다. 또한 이러한 서류 등에 대해 번역본을 요청하실 수도 있습니다.

CIGNA Dental Companies

Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Delaware, Inc.
Cigna Dental Health of Florida, Inc. (**a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)**
Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska)
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Pennsylvania, Inc.
Cigna Dental Health of Virginia, Inc.
P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective customer has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Customers with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of providers dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled "Disenrollment from the Dental Plan–Termination of Benefits."

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at [1.800.Cigna24] if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

TABLE OF CONTENTS

In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.

I. DEFINITIONS

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

A. be consistent with the symptoms, diagnosis or treatment of the condition present;
B. conform to commonly accepted standards throughout the dental field;
C. not be used primarily for the convenience of the customer or provider of care; and
D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

Contract Fees - the fees contained in the Network Dentist agreement with Cigna Dental.

Covered Services - the dental procedures listed on your Patient Charge Schedule.

Dental Office - your selected office of Network General Dentist(s).

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse;

Your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

(a) less than [19] years old; or
(b) less than [23] years old if he or she is both:
   i. a full-time student enrolled at an accredited educational institution, and
   ii. reliant upon you for maintenance and support; or
(c) any age if he or she is both:
   i. incapable of self-sustaining employment due to mental or physical disability, and

ii. reliant upon you for maintenance and support.

For a dependent child [19] years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category (b) or (c) above, you will need to furnish Cigna Dental evidence of the child's reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of [19] and once a year thereafter for as long as the child is claimed as a Dependent under the Plan.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist – a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to You.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Patient Charge Schedule - list of services covered under your Dental Plan and how much they cost you.

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

Service Area - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

Subscriber/You - the enrolled employee or customer of the Group.

Usual Fee - the customary fee that an individual dentist most frequently charges for a given dental service.

II. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. ELIGIBILITY/WHEN COVERAGE BEGINS

To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.
If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. YOUR CIGNA DENTAL COVERAGE

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. CUSTOMER SERVICE

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at [1.800.Cigna24]. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. PREMIUMS

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

C. OTHER CHARGES - PATIENT CHARGES

Network General Dentists are typically reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. CHOICE OF DENTIST

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when

Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at [1.800.Cigna24] to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at [1.800.Cigna24]. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. YOUR PAYMENT RESPONSIBILITY (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. EMERGENCY DENTAL CARE - REIMBURSEMENT

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average

knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. **Emergency Care Away From Home**
   If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

2. **Emergency Care After Hours**
   There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

G. LIMITATIONS ON COVERED SERVICES

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

  Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations , comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

GENERAL LIMITATIONS DENTAL BENEFITS

- No payment will be made for expenses incurred or services received:
- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state

governmental agency or authority, political subdivision or a public program, other than Medicaid.

- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards..
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not

excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)

- the completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.

- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. APPOINTMENTS

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. BROKEN APPOINTMENTS

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. OFFICE TRANSFERS

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at [1.800.Cigna24]. To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at [1.800.Cigna24].

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. SPECIALTY CARE

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists – children's dentistry.
- Endodontists – root canal treatment.
- Periodontists – treatment of gums and bone.

- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.
When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. SPECIALTY REFERRALS

A. IN GENERAL

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-

Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. ORTHODONTICS (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. Definitions – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:

a. **Orthodontic Treatment Plan and Records –** the preparation of orthodontic records and a treatment plan by the Orthodontist.

b. **Interceptive Orthodontic Treatment –** treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.

c. **Comprehensive Orthodontic Treatment –** treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.

d. **Retention (Post Treatment Stabilization) –** the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient Charges

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

3. Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;

b. orthognathic surgery and associated incremental costs;

c. appliances to guide minor tooth movement;

d. appliances to correct harmful habits; and

e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at [1.800.Cigna24] to find out if you are entitled to any benefit under the Dental Plan.

X. COMPLEX REHABILITATION/MULTIPLE CROWN UNITS

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex Rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. WHAT TO DO IF THERE IS A PROBLEM

For the purposes of this section, any reference to “you” or “your” also refers to a representative or provider designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. START WITH CUSTOMER SERVICE

We are here to listen and to help. If you have a concern about

your Dental Office or the Dental Plan, you can call [1.800.Cigna24] toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

B. APPEALS PROCEDURE

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling 1.800.Cigna24.

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, 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.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

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

2. Level Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, 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. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

3. Independent Review Procedure

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas. Consult your State Rider for more details if applicable.

4. Appeals to the State

You have the right to contact your State's Department of Insurance and/or Department of Health for assistance at any time. **See your State Rider for further details.**

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. DUAL COVERAGE

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an

employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. Cigna Dental coordinates benefits only for specialty care services.

XIII. DISENROLLMENT FROM THE DENTAL PLAN - TERMINATION OF BENEFITS

A. TIME FRAMES FOR DISENROLLMENT/TERMINATION

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to Cigna Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. after voluntary disenrollment.

B. EFFECT ON DEPENDENTS

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

XIV. EXTENSION OF BENEFITS

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.
Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. CONTINUATION OF BENEFITS (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. CONVERSION COVERAGE

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group; or
- Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at [1.800.Cigna24] to obtain current rates and make arrangements for continuing coverage.

XVII. CONFIDENTIALITY/PRIVACY

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at [1.800.Cigna24], or via the Internet at my.cigna.com.

XVIII. MISCELLANEOUS

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at my.cigna.com for details.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

SEE YOUR STATE RIDER FOR ADDITIONAL DETAILS.

REQUIRED FORMS DIRECTORY

This Required Forms Directory is for the Cigna Dental Care Product

Section Number	Section Names	Please refer to the Table of Contents to cross-reference Section Names with the following Titles:
1.	Schedule of Benefits (Who Pays What)	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, E. Your Payment Responsibility
2.	Title Page (Cover Page)	Cigna Dental Care - Cigna Dental Health Plan, Please see page immediately in front of I. Definitions
3.	Contact Us	Please call the toll-free number shown on your ID card.
4.	Table of Contents	Table of Contents
5.	Eligibility	Cigna Dental Care - Cigna Dental Health Plan, III. Eligibility – When Coverage Begins
6.	How to Access Your Services and Obtain Approval of Benefits	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, A. Member Services; D. Choice of Dentist, VIII. Specialty Care, IX. Specialty Referrals
7.	Benefits/Coverage (What is Covered)	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage
8.	Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, G. Limitations on Covered Services, H. Services Not Covered Under Your Dental Plan
9.	Member Payment Responsibility	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, E. Your Payment Responsibility (General Care)
10.	Claims Procedure (How to File a Claim)	Cigna Dental Care - Cigna Dental Health Plan, IV. Your Cigna Dental Coverage, E. Your Payment Responsibility (General Care), F. Emergency Dental Care - Reimbursement
11.	General Policy Provisions	Cigna Dental Care - Cigna Dental Health Plan, XII. Dual Coverage
12.	Termination/Nonrenewal/ Continuation	Cigna Dental Care - Cigna Dental Health Plan, XII Disenrollment from the Dental Plan - Termination of Benefits, A. Timeframes for Disenrollment/Termination, B. Effect on Dependents, XIV. Extension of Benefits, XV. Continuation of Benefits (COBRA), XVII. Conversion Coverage
13.	Appeals and Complaints	Cigna Dental Care - Cigna Dental Health Plan, X1. What to do if there is a Problem
14.	Information on Policy and Rate Changes	Cigna Dental Care - Cigna Dental Health Plan, Please see page immediately in front of I. Definitions
15.	Definitions	Cigna Dental Care - Cigna Dental Health Plan , I. Definitions

STATE RIDER
Cigna Dental Health of Colorado, Inc.

Colorado Residents:

I. DEFINITIONS

Dependent - your lawful spouse, partner in a civil union or domestic partner;

IV. YOUR CIGNA DENTAL HEALTH COVERAGE

D. **CHOICE OF DENTIST**

If you decide to obtain dental services from a non-network dentist at your own cost, you may return to your Network Dentist to receive Covered Services without penalty.

IX. SPECIALTY REFERRALS

If you have a dental emergency which requires Specialty Care, your Network Dentist will contact Cigna Dental for an expedited referral.

Referrals approved by Cigna Dental cannot be retrospectively denied except for fraud or abuse; however, your Cigna Dental coverage must be in effect at the time your Network Specialist begins each procedure.

XI. WHAT TO DO IF THERE IS A PROBLEM

The following is applicable only to Adverse Determinations and is in addition to the Appeals Procedure listed in Sections XI.B.1. and XI.B.2. of your Plan Booklet:

1. **Level One Appeals**: The reviewer will consult with a dentist in the same or similar specialty as the care under consideration. A resolution to your written complaint will be provided to you and your Network Dentist, in writing, within 20 working days of receipt. The written decision will contain the name, title, and qualifying credentials of the reviewer and of any specialist consulted, a statement of the reviewer's understanding of the reason for your appeal, clinical rationale, a reference to the documentation used to make the determination, clinical criteria used, and instructions for requesting the clinical review criteria, and a description of the process for requesting a second level appeal.

2. **Level Two Appeals**: A majority of the Appeals Committee will consist of licensed dentists who have appropriate expertise. The licensed dentists may not have been previously involved in the care or decision under consideration, may not be members of the board of directors or employees of Cigna Dental, and may have no direct financial interest in either the case or its outcome.

   The Appeals Committee will schedule and hold a review within 45 working days of receipt of your request. You will be notified in writing at least 15 working days prior to the review date of your

right to: be present at the review; present your case to the Grievance Committee, in person or in writing; submit supporting documentation; ask questions of the reviewers prior to or at the review; and be represented by a person of your choice. If you wish to be present, the review will be held during regular business hours at a location reasonably accessible to you. If a face-to-face meeting is not practical for geographic reasons, you will have the opportunity to be present by conference call at Cigna Dental's expense. Please notify Cigna Dental within 5 working days prior to the review if you intend to have an attorney present.

The Appeals Committee's decision will include: the names, titles and qualifying credentials of the reviewers; a statement of the reviewers' understanding of the nature of the appeal and the pertinent facts; the rationale for the decision; reference to any documentation used in making the decision; instructions for requesting the clinical rationale, including the review criteria used to make the determination; additional appeal rights, if any; and the right to contact the Department of Insurance, including the address and telephone number of the Commissioner's office.

3. **Expedited Appeals**: Within 1 working day after your request, Cigna Dental will provide reasonable access to the dentist who will perform the expedited review.

The following process replaces Section XI.B.3. of your Plan Booklet, entitled "**Independent Review Procedure**":
If the Appeals Committee upholds a denial based on clinical necessity, and you have exhausted Cigna Dental's Appeal Process, you may request that your appeal be referred to an Independent Review Organization (IRO). In order to request a referral to an IRO, the reason for the denial must be based on a dental necessity determination by Cigna Dental. Administrative, eligibility or benefit coverage limits are not eligible for additional review under this process.

There is no charge for you to initiate this independent review process; however, you must provide written authorization permitting Cigna Dental to release the information to the Independent Reviewer selected. The IRO is composed of persons who are not employed by Cigna Dental or any of its affiliates. Cigna Dental will abide by the decision of the IRO.

To request a referral to an IRO, you must notify the Appeals Coordinator within 60 days of your receipt of the Appeals Committee's level two appeal review denial. Cigna Dental will then forward the file to the Colorado Department of Insurance within 2 working days, or within 1 working day for expedited reviews. We will send you descriptive information on the entity that the Department selects to conduct the review.

The IRO may request additional information to support the request for independent review. Upon receipt of copies of any additional information, Cigna Dental may reconsider its decision. If Cigna Dental provides coverage, the independent review process will end.

The IRO will provide written notice of its decision to you, your provider and Cigna Dental within 30 working days after Cigna Dental receives your request for an independent review. When requested and when a delay would be detrimental to your dental condition as certified by your treating dentist, the IRO will complete the review within 7 working days after Cigna Dental receives your request. The IRO may request another 10 working days, or another 5 working days for expedited requests, to consider additional information.

If the IRO reverses Cigna Dental's adverse decision, we will provide coverage within 1 working day for pre-authorizations and within 5 working days for services already rendered.

XVIII. MISCELLANEOUS

In addition to the information contained in this booklet, Cigna Dental Health maintains a written plan concerning accessibility of Network Dentists, quality management programs, procedures for continuity of care in the event of insolvency, and other administrative matters. Under Colorado law, these materials are available at Cigna Dental Health administrative offices and will be provided to interested parties upon request.

STATE RIDER
Cigna Dental Health of Florida, Inc.

Florida Residents: This State Rider is attached to and made part of your Plan Booklet and contains information that either replaces, or is in addition to, information contained in your Plan Booklet.

I. DEFINITIONS

Dependent - A child born to or adopted by your covered family member may also be considered a dependent if the child is pre-enrolled at the time of birth or adoption.

III. ELIGIBILITY/WHEN COVERAGE BEGINS

There will be at least one open enrollment period of not less than 30 days every 18 months unless Cigna Dental Health and your Group mutually agree to a shorter period of time than 18 months.

If you have family coverage, your newly-born child, or a newly-born child of a covered family member, is automatically covered during the first 31 days of life if the child is pre-enrolled in the Dental Plan at the time of birth. If you wish to continue coverage beyond the first 31 days, you need to begin to pay Premiums, if any additional are due, during that period.

IV. YOUR CIGNA DENTAL COVERAGE

B. PREMIUMS/PREPAYMENT FEES

Your Group Contract has a 31-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the Group Contract will remain in force.

D. CHOICE OF DENTIST

You may receive a description of the process used to analyze the qualifications and credentials of Network Dentists upon request.

XI. WHAT TO DO IF THERE IS A PROBLEM

The following is in addition to the Section XI of your Plan Booklet:

B. APPEALS PROCEDURE

The Appeals Coordinator can be reached at 1-800-Cigna24 (244.6224) or by writing to P.O. Box 188047, Chattanooga, Tennessee 37422.

1. Level One Appeals

Your written complaint will be processed within 60 days of receipt unless the complaint involves the collection of information outside the service area, in which case Cigna Dental Health will have an additional 30 days to process the complaint. You may file a complaint up to 1 year from the date of occurrence.

If a meeting with you is necessary, the location of the meeting shall be at Cigna Dental Health's administrative office or at a location within the service area that is convenient for you.

4. Appeals to the State

You always have the right to file a complaint with or seek assistance from the Department of Insurance, 200 East Gaines Street, Tallahassee, Florida 32399, 1-800-342-2762.

XIII. DISENROLLMENT FROM THE DENTAL PLAN/TERMINATION

A. CAUSES FOR DISENROLLMENT/TERMINATION

3. Permanent breakdown of the dentist-patient relationship, as determined by Cigna Dental Health, is defined as disruptive, unruly, abusive, unlawful, or uncooperative behavior which seriously impairs Cigna Dental Health's ability to provide services to members, after reasonable efforts to resolve the problem and consideration of extenuating circumstances.

Forty-five days notice will be provided to you if Cigna Dental Health terminates enrollment in the dental plan.

XIV. EXTENSION OF BENEFITS

Coverage for all dental procedures in progress, including Orthodontics, is extended for 90 days after disenrollment.

XVI. CONVERTING FROM YOUR GROUP COVERAGE

You and your enrolled Dependent(s) are eligible for conversion coverage unless benefits are discontinued because you or your Dependent no longer reside in a Cigna Dental Health Service Area, or because of fraud or material misrepresentation in applying for benefits.

Unless benefits were terminated as previously listed, conversion coverage is available to your Dependents, only, as follows:

A. A surviving spouse and children at Subscriber's death;
B. A former spouse whose coverage would otherwise end because of annulment or dissolution of marriage; or
C. A spouse or child whose group coverage ended by reason of ceasing to be an eligible family member under the Subscriber's coverage.

Coverage and Benefits for conversion coverage will be similar to those of your Group's Dental Plan. Rates will be at prevailing conversion levels.

In addition the following provisions apply to your plan:

EXPENSES FOR WHICH A THIRD PARTY MAY BE RESPONSIBLE

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.

2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

RIGHT OF REIMBURSEMENT

If a Participant 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 Participant 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.

CIGNA DENTAL HEALTH OF FLORIDA, INC.

BY: Matthew G. Mowder

TITLE: President

Cigna Dental Health of New Jersey, Inc.
P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. Please read the following information so you will know from whom or what group of providers dental care may be obtained. This certificate is subject to the laws of the state of New Jersey.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled "Disenrollment from the Dental Plan–Termination of Benefits."

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at [1.800.Cigna24] if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

TABLE OF CONTENTS

I. DEFINITIONS

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by Cigna Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

A. be consistent with the symptoms, diagnosis or treatment of the condition present;
B. conform to commonly accepted standards throughout the dental field;
C. not be used primarily for the convenience of the customer or provider of care; and
D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

Contract Fees - the fees contained in the Network Dentist agreement with Cigna Dental.

Covered Services - the dental procedures listed on your Patient Charge Schedule.

Dental Office - your selected office of Network General Dentist(s).

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - Your lawful spouse, your unmarried or unpartnered child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement; or, a dependent child acquired through a civil union) who is:

A. less than [19] years old; or
B. less than [23] years old if he or she is both:
    1. a full time student enrolled at an accredited educational institution, and
    2. reliant upon you for maintenance and support; or
C. any age if he or she is both:
    1. incapable of self sustaining employment due to mental or physical disability, and
    2. reliant upon you for maintenance and support.

For a dependent child [19] years of age or older who is a full-time student at an educational institution, coverage will be provided for an

entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category (b) or (c) above, you will need to furnish Cigna Dental evidence of his or her reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of [19] and once a year thereafter during his or her term of coverage.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a Cigna Dental service area is subject to the availability of an approved network where the dependent resides.

This definition of "Dependent" applies unless modified by your Group Contract.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist – a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to You.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Patient Charge Schedule - list of services covered under your Dental Plan and how much they cost you.

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

Service Area - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services.

Subscriber/You - the enrolled employee or customer of the Group.

Usual Fee - the customary fee that an individual dentist most frequently charges for a given dental service.

II. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. ELIGIBILITY/WHEN COVERAGE BEGINS

To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. YOUR CIGNA DENTAL COVERAGE

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. CUSTOMER SERVICE

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at [1.800.Cigna24]. The hearing impaired may

contact the state TTY toll-free relay service number listed in their local telephone directory.

B. PREMIUMS

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

C. OTHER CHARGES - PATIENT CHARGES

Network General Dentists are reimbursed by Cigna Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. CHOICE OF DENTIST

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Customer Service at [1.800.Cigna24] to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist’s office will have primary responsibility for your child’s care. For children 7 years and

older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at [1.800.Cigna24]. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. YOUR PAYMENT RESPONSIBILITY (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the network dentist for any sums owed to the Network Dentist by Cigna Dental.

F. EMERGENCY DENTAL CARE - REIMBURSEMENT

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. **Emergency Care Away From Home**

   If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist’s usual fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed on the front of this booklet.

2. **Emergency Care After Hours**
There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

G. LIMITATIONS ON COVERED SERVICES

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist
- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations , comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

GENERAL LIMITATIONS
DENTAL BENEFITS

No payment will be made for expenses incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost; stolen; or damaged due to patient abuse, misuse or

neglect.

- Surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- the completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
- the completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.

- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.
- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.
Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. APPOINTMENTS

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. BROKEN APPOINTMENTS

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. OFFICE TRANSFERS

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at [1.800.Cigna24]. To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at [1.800.Cigna24].

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. SPECIALTY CARE

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

- Pediatric Dentists – children's dentistry.
- Endodontists – root canal treatment.
- Periodontists – treatment of gums and bone.
- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

There is no coverage for referrals to Prothodontists or other Specialty Dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. SPECIALTY REFERRALS

A. IN GENERAL

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees for no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., *Orthodontics*. Treatment by the Network Specialist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

B. ORTHODONTICS (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. **Definitions** – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
   a. **Orthodontic Treatment Plan and Records –** the preparation of orthodontic records and a treatment plan by the Orthodontist.
   b. **Interceptive Orthodontic Treatment –** treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
   c. **Comprehensive Orthodontic Treatment –** treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
   d. **Retention (Post Treatment Stabilization) –** the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. **Patient Charges**
   The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

   The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

3. **Additional Charges**
   You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:
   a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
   b. orthognathic surgery and associated incremental costs;
   c. appliances to guide minor tooth movement;
   d. appliances to correct harmful habits; and
   e. services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

4. **Orthodontics in Progress**
   If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at [1.800.Cigna24] to find out if you are entitled to any benefit under the Dental Plan.

X. COMPLEX REHABILITATION/MULTIPLE CROWN UNITS

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex Rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. WHAT TO DO IF THERE IS A PROBLEM

For the purposes of this section, any reference to “you” or “your” also refers to a representative or provider designated by you to act on your behalf.

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. START WITH CUSTOMER SERVICE

We are here to listen and to help. If you have a concern about your Dental Office or the Dental Plan, you can call [1.800.Cigna24] toll-free and explain your concern to one of our Customer Service Representatives. You can also express that concern in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 15 working days.

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

B. APPEALS PROCEDURE

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental, P.O. Box 188047, Chattanooga, TN 37422-

8047, within 1 year from the date of the initial Cigna Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Customer Service to register your appeal by calling [1.800.Cigna24].

1. **Level One Appeals**
   Your level one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

   We will respond with a decision within 15 working days after we receive your appeal. If we need more time or information to make the decision, 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.

   You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

   If you are not satisfied with our level one appeal decision, you may request a level two appeal.

2. **Level Two Appeals**
   To initiate a level two appeal, follow the same process required for a level one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review.

   The review will be completed within 15 working days. If we need more time or information to complete the review, 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. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

   You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed

up in writing.

3. **Appeals to the State**
You have the right to contact the New Jersey Department of Insurance and/or Department of Health for assistance at any time.

Cigna Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. DUAL COVERAGE

A. IN GENERAL

"Coordination of benefits" is the procedure used to pay health care expenses when a person is covered by more than one plan. Cigna Dental follows rules established by New Jersey law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow New Jersey coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Cigna Dental pays for dental care when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

B. HOW CIGNA DENTAL PAYS AS PRIMARY PLAN

When you receive care from a Network Specialty Dentist, Cigna Dental pays the Network Specialty Dentist a contracted fee amount less your copayment for the Covered Service. When we are primary, we will pay the full benefit allowed as if you had no other coverage.

C. HOW CIGNA DENTAL PAYS AS SECONDARY PLAN

1. If your primary plan pays on the basis of UCR, Cigna Dental will pay the difference between the provider's billed charges and the benefits paid by the primary plan up to the amount Cigna Dental would have paid if primary. Cigna Dental's payment will first be applied toward satisfaction of your copayment of your primary plan. You will not be liable for any billed charges in excess of the sum of the benefits paid by your primary plan, Cigna Dental as your secondary plan and the copayment you paid under either the primary or secondary plan. When Cigna Dental pays as secondary, you will never be responsible for paying more than your copayment for the Covered Service.
2. When both your primary plan and Cigna Dental pay network

providers on the basis of a contractual fee schedule and the provider is a network provider of both plans, the allowable expense will be considered to be the contractual fee of your primary plan. Your primary plan will pay the benefit it would have paid regardless of any other coverage you may have. Cigna Dental will pay the copayment for the Covered Service for which you are liable up to the amount Cigna Dental would have paid if primary and provided that the total amount received by the provider from the primary plan, Cigna Dental and you does not exceed the contractual fee of the primary plan. You will not be responsible for an amount more than your copayment.

3. When your primary plan pays network providers on a basis of capitation or a contractual fee schedule or pays a benefit on the basis of UCR, and Cigna Dental pays network providers on the basis of capitation and a service or supply is provided by a network provider of Cigna Dental, we will not be obligated to pay to the network provider any amount other than the capitation payment required under the contract between Cigna Dental and the network provider and we shall not be liable for any deductible, coinsurance or copayment imposed by your primary plan. You will not be responsible for the payment of any amount for eligible services.
4. We will pay only for health care expenses that are covered by Cigna Dental.
5. We will pay only if you have followed all of our procedural requirements, including: care is obtained from or arranged by your primary care dentist; coverage in effect when procedures begin; procedures begin within 90 days of referral.

XIII. DISENROLLMENT FROM THE DENTAL PLAN - TERMINATION OF BENEFITS

A. TIME FRAMES FOR DISENROLLMENT/TERMINATION

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to Cigna Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from Cigna Dental due to permanent breakdown of the dentist-patient relationship as determined by Cigna Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from Cigna Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after 60 days notice by Cigna Dental, due to continued lack of a Dental Office in your Service Area.
6. after voluntary disenrollment.

B. EFFECT ON DEPENDENTS

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

XIV. EXTENSION OF BENEFITS

Coverage for completion of a dental procedure which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

XV. CONTINUATION OF BENEFITS (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. CONVERSION COVERAGE

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

1. Permanent breakdown of the dentist-patient relationship,
2. Fraud or misuse of dental services and/or Dental Offices,
3. Nonpayment of Premiums by the Subscriber,
4. Selection of alternate dental coverage by your Group; or
5. Lack of network/Service Area.

Benefits and rates for Cigna Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the Cigna Dental Conversion Department at [1.800.Cigna24] to obtain current rates and make arrangements for continuing coverage.

XVII. CONFIDENTIALITY/PRIVACY

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at [1.800.Cigna24], or via the Internet at my.cigna.com.

XVIII. MISCELLANEOUS

As a Cigna Dental plan customer, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at my.cigna.com for details.

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

STATE RIDER
Cigna Dental Health of Ohio, Inc.

Ohio Residents:

The following is in addition to the information on the first page of your Plan Booklet:

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

III. ELIGIBILITY/WHEN COVERAGE BEGINS

You and your Dependents must live or work in the service area to be eligible for coverage.

Under Ohio law, if you divorce, you cannot terminate coverage for enrolled Dependents until the court determines that you are no longer responsible for providing coverage.

Cigna Dental does not require, make inquiries into, or rely upon genetic screening or testing in processing applications for enrollment or in determining insurability under the Dental Plan.

Section IV is renamed:

IV. YOUR CIGNA DENTAL PLAN

E. YOUR PAYMENT RESPONSIBILITY (General Care)

The following is in addition to the process described in Section IV. E. of your Plan Booklet:

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. There is no additional cost to you.

Cigna Dental is not a member of any Guaranty Fund. In the event of Cigna Dental's insolvency, you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental. However, you may be financially responsible for services rendered by a non-network dentist whether or not Cigna Dental authorizes payment for a referral.

If you are undergoing treatment and the Dental Plan becomes insolvent, Cigna Dental will arrange for the continuation of services until the expiration of your Group Contract.

XI. WHAT TO DO IF THERE IS A PROBLEM

The following is in addition to the process described in Section XI of your Plan Booklet:

A. START WITH MEMBER SERVICES

You can reach Member Services by calling 1.800. Cigna24 or by writing to Cigna Dental Health of Ohio, Inc., P.O. Box 453099, Sunrise, Florida 33345-3099, Attention: Member Services. You may also submit a complaint in person at any Cigna Dental office.

B. APPEALS PROCEDURE

1. Level One Appeals

Cigna Dental will provide a written response to your written complaint.

Within 30 days of receiving a response from Cigna Dental, you may appeal a complaint resolution regarding cancellation, termination or non-renewal of coverage by Cigna Dental to the Ohio Superintendent of Insurance. The Ohio Department of Insurance is located at 50 W. Town Street, Suite 300, Columbus, Ohio 43215, Attention Consumer Services Division. The Department's toll-free number is 1-800-686-1526 or (614) 644-2673.

XII. DUAL COVERAGE

(This section is not applicable when Cigna Dental does not make payments toward specialty care as indicated by your Patient Charge Schedule. For those plans, Cigna Dental is always the primary plan.)

The following supersedes Section XII of your Plan Booklet.

A. COORDINATION OF BENEFITS

"Coordination of benefits" is the procedure used to pay health care expenses when a person is covered by more than one plan. Cigna Dental follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills. Coordination of benefits applies only to Specialty Care.

When you or your family members are covered by another group plan in addition to this one, we will follow Ohio coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Cigna Dental pays for dental care when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

Cigna Dental will not reduce or exclude benefits payable to you or on your behalf because such benefits have also been paid under a supplemental, specified disease or limited plan of coverage for sickness and accident insurance which is entirely paid for by you, your family or guardian.

B. Plans That Do Not Coordinate

Cigna Dental will pay benefits without regard to benefits paid by the following kinds of coverage:

- Medicaid
- Group hospital indemnity plans which pay less than $100 per day
- School accident coverage
- Some supplemental sickness and accident policies

C. How Cigna Dental Pays As Primary Plan

When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

D. How Cigna Dental Pays as Secondary Plan

1. When we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.
2. We will pay only for health care expenses that are covered by Cigna Dental.
3. We will pay only if you have followed all of our procedural requirements, including: care is obtained from or arranged by your primary care dentist; preauthorized referrals are made to network specialists; coverage in effect when procedures begin; procedures begin within 90 days of referral.
4. We will pay no more than the “allowable expenses” for the health care involved. If our allowable expense is lower than the primary plan’s, we will use the primary plan’s allowable expense. That may be less than the actual bill.

E. Which Plan is Primary?

To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following that applies:

1. Non-coordinating Plan

If you have another group plan that does not coordinate benefits, it will always be primary.

2. Employee

The plan that covers you as an employee (neither laid off nor retired) is always primary.

3. Children (Parents Divorced or Separated)

If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, we follow the birthday rule. If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

4. Children & the Birthday Rule

When your children's health care expenses are involved, we follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children.

However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

5. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

F. Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

G. Subrogation

If another source directly reimburses you more than your Patient Charge for Covered Services, you may be required to reimburse Cigna Dental. Where allowed by law, this section will apply to you or your Dependents who:

1. receive benefit payments under this Dental Plan as the result of a sickness or injury; and

2. have a lawful claim against another party or parties for compensation, damages, or other payment because of that same sickness or injury.

In those instances where this section applies, the rights of the Member or Dependent to claim or receive compensation, damages, or

other payment from the other party or parties will be transferred to Cigna Dental, but only to the extent of benefit payments made under this Dental Plan.

XIII. DISENROLLMENT FROM THE DENTAL PLAN/TERMINATION OF BENEFITS

A. CAUSES FOR DISENROLLMENT/TERMINATION

3. Under Ohio law, you will not be terminated from the dental plan due to a permanent breakdown of the dentist-patient relationship. However, your Network Dentist has the right to decline services to a patient because of rude or abusive behavior.

You or your Dependent may appeal any termination action by Cigna Dental by submitting a written complaint as set out in Section XI.

XVI. CONVERSION COVERAGE

You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

A. Nonpayment of Premiums/Prepayment Fees by the Subscriber;
B. Fraud or misuse of dental services and/or Dental Offices;
C. Selection of alternate dental coverage by your Group.

XVIII. MISCELLANEOUS

A. Governing Law

The Group Contract shall be construed for all purposes as a legal document and shall be interpreted and enforced in accordance with pertinent laws and regulations of the State of Ohio. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

B. Availability of Financial Statement

Cigna Dental Health of Ohio, Inc. will make available to you, upon request, its most recent financial statement.

Cigna Dental Health of Texas, Inc.
1640 Dallas Parkway
Plano, Texas 75093

This Certificate of Coverage is intended for your information; and is included as a part of the agreement between Cigna Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also be changed. Please read the following information so you will know from whom or what group of providers dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information – Please Read the Provision Entitled "Disenrollment from the Dental Plan–Termination of Benefits ".

READ YOUR PLAN BOOKLET CAREFULLY

Please call Customer Service at 1.800.Cigna24 if you have any questions.

If you have a hearing or speech disability, please use your state Telecommunications Relay Service to call us. This service makes it easier for people who have hearing or speech disabilities to communicate with people who do not. Check your local telephone directory for your Relay Service's phone number.

If you have a visual disability, you may call Customer Service and request this booklet in a larger print type or Braille.

IMPORTANT NOTICE	AVISO IMPORTANTE
To obtain information or to make a complaint; **You may call Cigna Dental Health's toll-free telephone number for information or to make a complaint at:** **[1.800.Cigna24]** **You may also write to: Cigna Dental Health of Texas, Inc.** **[1640 Dallas Parkway** **Plano, TX 75093]** **You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:** **1-800-252-3439** **You may write the Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104, Fax No. (512) 475-1771.** **Web: http://www.tdi.state.tx.us** **Email: ConsumerProtection@tdi.state.tx.us** **Claim Disputes:** **Should you have a dispute about a claim, you should contact Cigna Dental Health first. If the dispute is not resolved, you may contact the Texas Department of Insurance.** **Attach this Notice to Your Policy:** **This notice is for information only and does not become a part or condition of the attached document.**	**Para obtener informacion o para someter una queja;** **Usted pueda llamar al numero de telefono gratis de Cigna Dental Health para informacion o para someter una queja al:** **[1.800.Cigna24]** **Usted tambien pueda escribir a Cigna Dental Health of Texas, Inc.** **[1640 Dallas Parkway** **Plano, TX 75093]** **Puede communicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:** **1-800-252-3439** **Puede escribir al Departamento de Seguros de Texas, P.O. Box 149104, Austin, TX 78714-9104, Fax No. (512) 475-1771.** **Web: http://www.tdi.state.tx.us** **Email: ConsumerProtection@tdi.state.tx.us** **Disputas Sobre Reclamos:** **Si tiene una disputa concerniente un reclamo, debe comunicarse con el Cigna Dental Health primero. Si no se resuelve la disputa, puede entonces communicarse con el Departamento de Seguros de Texas.** **Una Este Aviso A Su Poliza:** **Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.**

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I. DEFINITIONS

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination – a determination by a utilization review agent that the dental care services provided or proposed to be furnished to you or your Dependents are not medically necessary or are experimental or investigational. To be considered medically necessary, the specialty referral procedure must be reasonable and appropriate and meet the following requirements:

A. be consistent with the symptoms, diagnosis or treatment of the condition present;
B. conform to commonly accepted standards throughout the dental field;
C. not be used primarily for the convenience of the customer or dentist of care; and
D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the customer at the dentist's Usual Fees. A licensed dentist will make any such denial.

Cigna Dental - the Cigna Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

Contract Fees - the fees contained in the Network Dentist agreement with Cigna Dental.

Covered Services - the dental procedures listed on your Patient Charge Schedule.

Dental Office - your selected office of Network General Dentist(s).

Dental Plan - managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dependent - your lawful spouse; your unmarried child (including newborns, adopted children (includes a child who has become the subject of a suit for adoption), stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

A. less than 25 years old; or
B. any age if he or she is both:
    1. incapable of self sustaining employment due to mental or physical disability, and
    2. reliant upon you for maintenance and support.

A Dependent includes your grandchild if the child is your dependent for federal income tax purposes at the time of application or a child for whom you must provide medical support under a court order.

Coverage for dependents living outside a Cigna Dental Service Area is subject to the availability of an approved network where the dependent resides.

This definition of "Dependent" applies unless modified by your Group Contact.

Group - employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

Network Dentist – a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to You.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Patient Charge Schedule - list of services covered under your Dental Plan and how much they cost you.

Premiums - fees that your Group remits to Cigna Dental, on your behalf, during the term of your Group Contract.

Service Area - the geographical area designated by Cigna Dental within which it shall provide benefits and arrange for dental care services, as set out in the attached list of service areas.

Spouse- the individual of the opposite sex with whom You have entered into a marriage relationship which would be considered valid under the Texas Family Code.

Subscriber/You - the enrolled employee or customer of the Group.

Usual Fee - the customary fee that an individual dentist most frequently charges for a given dental service.

II. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes.

III. ELIGIBILITY/WHEN COVERAGE BEGINS

To enroll in the Dental Plan, you and your Dependents must live, work or reside within the Cigna Dental Service Area. Other eligibility requirements are determined by your Group.

If the legal residence of an enrolled Dependent is different from that of the Subscriber, the Dependent must:
A. reside in the Service Area with a person who has temporary or permanent guardianship, including adoptees or children subject to adoption, and the Subscriber must have legal responsibility for that Dependent's health care; or
B. reside in the Service Area, and the Subscriber must have legal responsibility for that Dependent's health care; or
C. reside in the Service Area with the Subscriber's spouse; or
D. reside anywhere in the United States when the Dependent's coverage is required by a medical support order.

If you or your Dependent becomes eligible for Medicare, you may continue coverage so long as you or your Medicare-eligible Dependent meet all other group eligibility requirements.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. YOUR CIGNA DENTAL COVERAGE

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which

services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. CUSTOMER SERVICE

If you have any questions or concerns about the Dental Plan, Customer Service Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Service from any location at [1.800.Cigna24]. The hearing impaired may contact Customer Service through the State Relay Service located in your local telephone directory.

B. PREMIUMS

Your Group sends a monthly fee to Cigna Dental for customers participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group. Your Premium is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Premiums at least 60 days before any change.

In addition to any other premiums for which the Group is liable, the Group shall also be liable for a customer’s premiums from the time the customer is no longer eligible for coverage under the contract until the end of the month in which the Group notifies Cigna Dental that the customer is no longer part of the group eligible for coverage.

C. OTHER CHARGES - PATIENT CHARGES

Cigna Dental typically pays Network General Dentists fixed monthly payments for each covered customer and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees that you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. The Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You must pay the Patient Charge listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. CHOICE OF DENTIST

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent children under age 7 by calling Customer Service at [1.800.Cigna24] to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at [1.800.Cigna24]. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Customer Service.

E. YOUR PAYMENT RESPONSIBILITY (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If on a temporary basis there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between Cigna Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by Cigna Dental.

F. GENERAL CARE – REIMBURSEMENT

Cigna Dental Health will acknowledge your claim for covered services within 15 days and accept, deny, or request additional information within 15 business days of receipt. If Cigna Dental Health accepts your claim, reimbursement for all appropriate covered services will be made within 5 days of acceptance.

G. EMERGENCY DENTAL CARE - REIMBURSEMENT

Emergency dental services are limited to procedures administered in a dental office, dental clinic, or other comparable facility to evaluate and stabilize emergency dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain or acute infection that would lead a prudent layperson with average knowledge of dentistry to believe that immediate care is needed. .

1. **Emergency Care Away From Home** - If you have an emergency while you are out of your Service Area or unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above without restrictions as to where the services are rendered. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge.

   To receive reimbursement, send appropriate reports and X-rays to Cigna Dental at the address listed on the front of this booklet. Cigna Dental Health will acknowledge your claim for emergency services within 15 days and accept, deny, or request additional information within 15 business days of receipt. If Cigna Dental Health accepts your claim, reimbursement for all appropriate emergency services will be made within 5 days of acceptance. Claims for non-emergency services will be processed within the same timeframes as claims for emergency services.

H. LIMITATIONS ON COVERED SERVICES

Listed below are limitations on services when covered by your Dental Plan:

- **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency. If your Network General Dentist certifies to Cigna Dental that, due to medical necessity, you require certain Covered Services more frequently than the limitation allows, Cigna Dental may waive the applicable limitation.
- **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical

reasons may be considered on an individual basis.

- **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Periodontal (gum tissue and supporting bone) Services** – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.
- **Clinical Oral Evaluations** – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- **Surgical Placement of Implant Services** – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- **Prosthesis Over Implant** – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

GENERAL LIMITATIONS
DENTAL BENEFITS
No payment will be made for expenses incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

I. SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
- services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- prescription medications.
- procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when the teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or c. restore the occlusion.
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- procedures or appliances for minor tooth guidance or to control harmful habits.
- hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- services to the extent you or your enrolled Dependent are

compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.

- crowns, bridges and/or implant supported prosthesis used solely for splinting.
- resin bonded retainers and associated pontics.
- consultations and/or evaluations associated with services that are not covered.
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless prognosis.
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- services performed by a prosthodontist.
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- the recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within the timeframe to be incidental to and part of the charges for the initial restoration.
- the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- services to correct congenital malformations, including the replacement of congenitally missing teeth.
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. APPOINTMENTS

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. BROKEN APPOINTMENTS

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients. If you must change your appointment, please contact your dentist at least 24 hours before the scheduled time.

VII. OFFICE TRANSFERS

If you decide to change Dental Offices, we can arrange a transfer at no charge. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Customer Service at [1.800.Cigna24]. To obtain a list of Dental Offices near you, visit our website at my.cigna.com, or call the Dental Office Locator at [1.800.Cigna24].

Your transfer will take about 5 days to process. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

Network Dentists are Independent Contractors. Cigna Dental cannot require that you pay your Patient Charges before processing of your transfer request; however, it is suggested that all Patient Charges owed to your current Dental Office be paid prior to transfer.

VIII. SPECIALTY CARE

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental Network includes the following types of specialty dentists:

Pediatric Dentists – children's dentistry.
Endodontists – root canal treatment.
Periodontists – treatment of gums and bone.
Oral Surgeons – complex extractions and other surgical procedures.
Orthodontists – tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.
You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

Contact your Benefit Administrator for more information.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. SPECIALTY REFERRALS

A. IN GENERAL

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B, *Orthodontics*. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Customer Service.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, you must pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. ORTHODONTICS (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

1. Definitions – If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:

a. **Orthodontic Treatment Plan and Records –** the preparation of orthodontic records and a treatment plan by the Orthodontist.

b. **Interceptive Orthodontic Treatment –** treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.

c. **Comprehensive Orthodontic Treatment –** treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
d. **Retention (Post Treatment Stabilization) –** the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient Charges

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

3. Additional Charges - You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
b. orthognathic surgery and associated incremental costs;
c. appliances to guide minor tooth movement;
d. appliances to correct harmful habits; and
e. services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

4. Orthodontics in Progress - If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Customer Service at [1.800.Cigna24] to find out if you are entitled to any benefit under the Dental Plan.

X. COMPLEX REHABILITATION/MULTIPLE CROWN UNITS

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex Rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

XI. WHAT TO DO IF THERE IS A PROBLEM

For the purposes of this section, any reference to “you” or “your” also refers to a representative or dentist designated by you to act on your behalf.

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. START WITH CUSTOMER SERVICE

We are here to listen and to help. If you have a question about your Dental Office or the Dental Plan, you can call the toll-free number to reach one of our Customer Service Representatives. We will do our best to respond upon your initial contact or get back to you as soon as possible, usually by the end of the next business day. You can call Customer Service at [1.800.Cigna24], or you may write P.O. Box 188047, Chattanooga, TN 37422-8047.

If you are unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the dentist providing you dental care, please contact Cigna at [1.800.Cigna24] and we will assist you in getting the care you need.

B. APPEALS PROCEDURE

1. Problems Concerning Plan Benefits, Quality of Care, or Plan Administration

The Dental Plan has a two-step procedure for complaints and appeals.

a. Level One Review ("Complaint")

For the purposes of this section, a complaint means a written or oral expression of dissatisfaction with any aspect of the Dental Plan's operation. A complaint is not (1) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up a misunderstanding to your satisfaction; nor (2)

you or your dentist’s dissatisfaction or disagreement with an Adverse Determination.

To initiate a complaint, submit a request in writing to the Dental Plan stating the reason why you feel your request should be approved and include any information supporting your request. If you are unable or choose not to write, you may ask Customer Service to register your request by calling the toll-free number.

Within 5 business days of receiving your complaint, we will send you a letter acknowledging the date the complaint was received, a description of the complaint procedure and timeframes for resolving your complaint. For oral complaints, you will be asked to complete a one-page complaint form to confirm the nature of your problem or to provide additional information.

Upon receipt of your written complaint or one-page complaint form, Customer Service will review and/or investigate your problem. Your complaint will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving clinical appropriateness will be considered by a dental professional. A written resolution will be provided to you within 30 calendar days. If applicable, the written resolution will include a statement of the specific dental or contractual reasons for the resolution, the specialization of any dentist consulted, and a description of the appeals process, including the time frames for the appeals process and final decision of the appeal. If you are not satisfied with our decision, you may request an appeal.

b. Level Two Review (“Appeal”)

Cigna Dental will acknowledge your appeal in writing within 5 business days. The acknowledgment will include the name, address, and telephone number of the Appeals Coordinator. The review will be held at Cigna Dental Health's administrative offices or at another location within the Service Area, including the location where you normally receive services, unless you agree to another site.

Additional information may be requested at that time. Second level reviews will be conducted by an Appeals Committee, which will include:
(1) An employee of Cigna Dental Health;
(2) A dentist who will preside over the Appeals Panel; and,
(3) An enrollee who is not an employee of Cigna Dental Health.

Anyone involved in the prior decision may not vote on the Appeals Committee. If specialty care is in dispute, the Committee will include a dentist in the same or similar specialty as the care under consideration, as determined by Cigna Dental. The review will be held and you will be notified in writing of the Committee’s decision within 30

calendar days.

Cigna Dental will identify the committee customers to you and provide copies of any documentation to be used during the review no later than 5 business days before the review, unless you agree otherwise. You, or your designated representative if you are a minor or disabled, may appear in person or by conference call before the Appeals Committee; present expert testimony; and, request the presence of and question any person responsible for making the prior determination that resulted in your appeal. Please advise Cigna Dental 5 days in advance if you or your representative plans to be present. Cigna Dental will pay the expenses of the Appeals Committee; however, you must pay your own expenses, if any, relating to the Appeals process, including any expenses of your designated representative.

The appeal will be heard and you will be notified in writing of the committee's decision within 30 calendar days from the date of your request. Notice of the Appeals Committee's decision will include a statement of the specific clinical determination, the clinical basis and contractual criteria used, and the toll free telephone number and address of the Texas Department of Insurance.

2. Problems Concerning Adverse Determinations

a. Appeals

For the purpose of this section, a complaint concerning an Adverse Determination constitutes an appeal of that determination. You, your designated representative, or your dentist may appeal an Adverse Determination orally or in writing. We will acknowledge the appeal in writing within 5 working days of receipt, confirming the date we received the appeal, outlining the appeals procedure, and requesting any documents you should send us. For oral appeals, we will include a one-page appeal form.

Appeal decisions will be made by a licensed dentist; provided that, if the appeal is denied and your dentist sends us a letter showing good cause, the denial will be reviewed by a specialty dentist in the same or similar specialty as the care under review. The specialty review will be completed within 15 working days of receipt.

We will send you and your dentist a letter explaining the resolution of your appeal as soon as practical but in no case later than 30 calendar days after we receive the request. If the appeal is denied, the letter will include:
(1) the clinical basis and principal reasons for the denial;
(2) the specialty of the dentist making the denial;
(3) a description of the source of the screening criteria used as guidelines in making the adverse determination; and
(4) notice of the rights to seek review of the denial by an independent review

organization and the procedure for obtaining that review.

b. Independent Review Organization

If the appeal of an Adverse Determination is denied, you, your representative, or your dentist have the right to request a review of that decision by an Independent Review Organization ("IRO"). The written denial outlined above will include information on how to appeal the denial to an IRO, and the forms that must be completed and returned to us to begin the independent review process.

In life-threatening situations, you are entitled to an immediate review by an IRO without having to comply with our procedures for internal appeals of Adverse Determinations. Call Customer Service to request the review by the IRO if you have a life-threatening condition and we will provide the required information.

In order to request a referral to an IRO, the reason for the denial must be based on a medical necessity determination by Cigna Dental. Administrative, eligibility or benefit coverage limits are not eligible for additional review under this process.

c. Expedited Appeals

You may request that the above complaint and appeal process be expedited if the timeframes under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary.

Investigation and resolution of expedited complaints and appeals will be concluded in accordance with the clinical immediacy of the case but will not exceed 1 business day from receipt of the complaint. If an expedited appeal involves an ongoing emergency, you may request that the appeal be reviewed by a dental professional in the same or similar specialty as the care under consideration.

d. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may file a complaint in writing with the Texas Department of Insurance at P. O. Box 149091, Austin, Texas 78714-9091, or you may call their toll-free number, 1.800.252.3439.

The Department will investigate a complaint against Cigna Dental to determine compliance with insurance laws within 30 days after the Department receives your complaint and all information necessary for the Department to determine compliance. The Department may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

(1) additional information is needed;
(2) an on-site review is necessary;
(3) we, the physician or dentist, or you do not provide all documentation necessary to complete the investigation; or
(4) other circumstances occur that are beyond the control of the Department.

Cigna Dental cannot retaliate against a Network General Dentist or Network Specialty Dentist for filing a complaint or appealing a decision on your behalf. Cigna Dental will not cancel or refuse to renew coverage because you or your Dependent has filed a complaint or appealed a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a Dentist.

XII. TREATMENT IN PROGRESS

A. Treatment In Progress For Procedures Other Than Orthodontics

If your dental treatment is in progress when your enroll in the Cigna Dental Plan, you should check to make sure your dentist is in the Cigna Dental Plan Network by contacting Customer Service at [1.800.Cigna24]. You can elect a new dentist at this time. If you do not, your treatment expenses will not be covered by the Cigna Dental Plan.

B. Treatment in Progress For Orthodontics

If orthodontic treatment is in progress for you or your Dependent at the time you enroll in this Dental plan, the copays listed on your Patient Charge Schedule do not apply to treatment that is already in progress. This is because your enrollment in this Dental plan does not override any obligation you or your Dependent may have under any agreement with an Orthodontist prior to your enrollment. Cigna may make a quarterly contribution toward the completion of your treatment, even if your Orthodontist does not participate in the Cigna Dental Health network. Cigna’s contribution is based on the Patient Charge Schedule selected by your Employer and the number of months remaining to complete your interceptive or comprehensive treatment, excluding retention. Please call Customer Service at [1.800.Cigna24] to obtain an Orthodontics in Progress Information Form. You and your Orthodontist should complete this form and return it to Cigna to receive confirmation of Cigna’s contribution.

XIII. DISENROLLMENT FROM THE DENTAL PLAN - TERMINATION OF BENEFITS

Except as otherwise provided in the Sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan/termination of benefits and coverages will be as follows:

A. TERMINATION OF YOUR GROUP

1. due to nonpayment of Premiums, coverage shall remain in effect for 30 days after the due date of the Premium. If the late payment is received within the 30-day grace period, a 20% penalty will be

added to the Premium. If payment is not received within the 30 days, coverage will be canceled on the 31st day and the terminated customers will be liable for the cost of services received during the grace period.

2. either the Group or Cigna Dental Health may terminate the Group Contract, effective as of any renewal date of the Group Contract, by providing at least 60 days prior written notice to the other party.

B. TERMINATION OF BENEFITS FOR YOU AND/OR YOUR DEPENDENTS

1. the last day of the month in which Premiums are not paid to Cigna Dental.
2. the last day of the month in which eligibility requirements are no longer met.
3. the last day of the month in which your Group notifies Cigna Dental of your termination from the Dental Plan.
4. the last day of the month after voluntary disenrollment.
5. upon 15 days written notice from Cigna Dental due to fraud or intentional material misrepresentation or fraud in the use of services or dental offices.
6. immediately for misconduct detrimental to safe plan operations and delivery of services.
7. for failure to establish a satisfactory patient-dentist relationship, Cigna Dental will give 30 days written notification that it considers the relationship unsatisfactory and will specify necessary changes. If you fail to make such changes, coverage may be cancelled at the end of the 30-day period.
8. upon 30 days notice, due to neither residing, living nor working in the Service Area. Coverage for a dependent child who is the subject of a medical support order cannot be cancelled solely because the child does not reside, live or work in the Service Area.

When coverage for one of your Dependents ends, you and your other Dependents may continue to be enrolled. When your coverage ends, your Dependents' coverage will also end.

XIV. EXTENSION OF BENEFITS

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. CONTINUATION OF BENEFITS (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

Under Texas law you may also choose continuation coverage for you and your Dependents if coverage is terminated for any reason except your involuntary termination for cause and if you or your Dependent has been continuously covered for 3 consecutive months prior to the termination. You must request continuation coverage from your Group in writing and pay the monthly Premiums, in advance, within 60 days of the date your termination ends or the date your Group notifies you of your rights to continuation. If you elect continuation coverage, it will not end until the earliest of:

A. 9 months after the date you choose continuation coverage if you or your dependents are not eligible for COBRA;
B. 6 months after the date you choose continuation coverage if you or your dependents are eligible for COBRA;
C. the date you and/or your Dependent becomes covered under another dental plan;
D. the last day of the month in which you fail to pay Premiums; or
E. the date the Group Contract ends.

You must pay your Group the amount of Premiums plus 2%, in advance, on a monthly basis. You must make the first premium payment no later than the 45th day following your election for continued coverage. Subsequent premium payments will be considered timely if you make such payments by the 30th day after the date that payment is due.

XVI. CONVERSION COVERAGE

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the Cigna Dental conversion plan. You must enroll within three months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date your Group coverage ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

A. permanent breakdown of the dentist-patient relationship,
B. fraud or misuse of dental services and/or Dental Offices,
C. nonpayment of Premiums by the Subscriber, or
D. selection of alternate dental coverage by your Group.

Benefits for conversion coverage will be based on the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Premiums will be the Cigna Dental conversion premiums in effect at the time of conversion. Conversion premiums may not exceed 200% of Cigna Dental’s premiums charged to groups with similar coverage. Please call the Cigna Dental Conversion Department at

[1.800.Cigna24] to obtain rates and make arrangements for continuing coverage.

XVII. CONFIDENTIALITY/PRIVACY

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your customer plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at [1.800.Cigna24], or via the Internet at my.cigna.com.

XVIII. MISCELLANEOUS

As a Cigna Dental plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your plan enrollment materials for details.

A. **NOTICE**: Any notice required by the Group Contract shall be in writing and mailed with postage fully prepaid and addressed to the entities named in the Group Contract.

B. **INCONTESTABILITY**: All statements made by a Subscriber on the enrollment application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of the Subscriber’s knowledge and belief. A statement may not be used in a contest to void, cancel, or non-renew an enrollee’s coverage or reduce benefits unless it is in a written enrollment application signed by you, and a signed copy of the enrollment application is or has been furnished to you or your personal representative.

   This Certificate of Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.

C. **ENTIRE AGREEMENT**: The Contract, Pre-Contract Application, amendments and attachments thereto represent the entire agreement between Cigna Dental Health and your Group. Any change in the Group Contract must be approved by an officer of Cigna Dental Health and attached thereto; no agent has the authority to change the Group Contract or waive any of its provisions. In the event this Certificate contains any provision not in conformity with the Texas Health Maintenance Organization Act (the "Act") or other applicable laws, this Certificate shall not be rendered invalid but shall be construed and implied as if it were in full compliance with the Act or other applicable laws.

D. **CONFORMITY WITH STATE LAW**: If this Certificate of Coverage contains any provision not in conformity with the Texas Insurance Code Chapter 1271 or other applicable laws, it shall not be rendered invalid but shall be considered and applied as if it were in full compliance with the Texas Insurance Code Chapter 1271 and other applicable laws.

Cigna Dental Health
Texas Service Areas

Fort Worth Area:
Clay
Collin
Cooke
Dallas
Denton
Ellis
Fannin
Grayson
Hill
Hood
Hunt
Jack
Johnson
Kaufman
Montague
Navarro
Parker
Rockwall
Somervell
Tarrant
Wise

Houston-Beaumont Area:
Austin
Brazoria
Chambers
Colorado
Fort Bend
Galveston
Grimes
Hardin
Harris
Jasper
Jefferson
Liberty
Montgomery
Newton
Orange
Polk
San Jacinto
Tyler
Walker
Waller
Washington
Wharton

San Antonio Area:
Atascosa
Bandera
Bexar
Blanco
Comal
Frio
Gonzales
Guadelupe
Karnes
Kendall
Medina
Wilson

Austin Area:
Bastrop
Fayette
Hays
Travis
Williamson

Midland Odessa Area:
Andrews
Crane
Ector
Glasscock
Howard
Loving
Martin
Midland
Reagan
Upton
Ward
Winkler

El Paso Area:
Culberson
El Paso
Hudspeth
Reeves

San Angelo Area:
Coke
Concho
Irion
Menard
Runnels
Schleicher
Sterling
Tom Green

College Station-Bryan Area:
Brazos
Burleson
Madison

Corpus Christi Area:
Bee
Brooks
Duval
Goliad
Jim Wells
Kennedy
Kleberg
Live Oak
McMullen
Nueces
Refugio
San Patricio

Tyler/Longview Area:
Anderson
Cherokee
Camp
Cass
Franklin
Gregg
Harrison
Henderson
Hopkins
Marion
Morris
Panola
Rains
Rusk
Smith
Titus
Upshur
Van Zandt
Wood

Waco Area:
Bell
Bosque
Burnet
Coryell
Falls
Freestone
Lampasas
Limestone
McClennan
Milam
Robertson

Victoria Area:
Bastrop
Calhoun

Cigna Dental Health
Texas Service Areas

De Witt
Jackson
Lavaca
Lee
Matagorda
Victoria

Brownsville, McAllen, Laredo Area:
Cameron
Dimmit
Hidalgo
Jim Hogg
LaSalle
Starr
Webb
Willacy
Zapata

Wichita Falls Area:
Archer
Baylor
Erath
Foard
Hardeman
Haskell
Knox
Palo Pinto
Stephen
Throckmorton
Wichita
Wilbarger
Young

Texarkana Area:
Bowie
Delta
Lamar
Red River

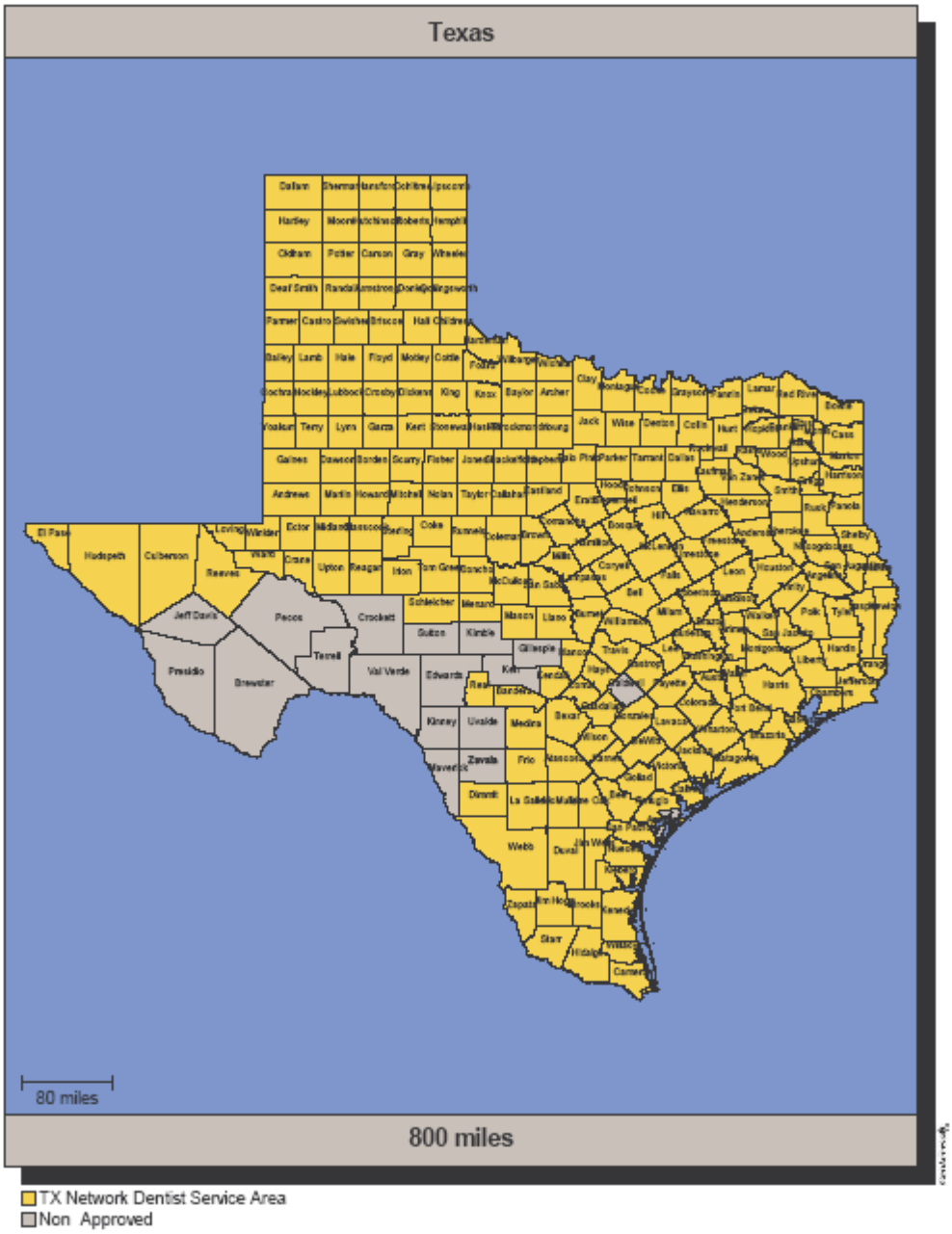
Lubbock Area:
Bailey
Borden
Cochran
Cottle
Crosby
Dawson
Dickens
Floyd
Gaines
Garza
Hale
Hockley
Kent
King
Lamb
Lubbock
Lynn
Motley
Scurry
Stonewall
Terry
Yoakum

Abilene Area:
Brown
Callahan
Coleman
Comanche
Eastland
Fisher
Hamilton
Llano
Jones
Mason
McCulloch
Mills
Mitchell
Nolan
San Saba
Shackelford
Taylor

Amarillo Area:
Armstrong
Briscoe
Carson
Castro
Childress
Collingsworth
Dallam
Deaf Smith
Donley
Gray
Hall
Hansford
Hartley
Hemphill
Hutchinson
Lipscomb
Moore
Ochiltree
Oldham
Parmer
Potter
Randall
Roberts
Sherman
Swisher
Wheeler

Lufkin Area:
Angelina
Houston
Leon
Madison
Nacogdoches
Sabine
San Augustine
Shelby
Trinity

Geographic overview



Cigna Dental Health Plan of Arizona, Inc.
Cigna Dental Health of California, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna HealthCare of Connecticut, Inc.
Cigna Dental Health of Delaware, Inc.
Cigna Dental Health of Florida, Inc.
Cigna Dental Health of Kansas, Inc.
Cigna Dental Health of Kansas, Inc. (Nebraska)
Cigna Dental Health of Kentucky, Inc.
Cigna Dental Health of Kentucky, Inc. (Illinois)
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of Missouri, Inc.
Cigna Dental Health of North Carolina, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Pennsylvania, Inc.
Cigna Dental Health of Texas, Inc.
Cigna Dental Health of Virginia, Inc.

COORDINATION OF SERVICES AND BENEFITS

Applicability. This Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one Plan. ("Plan" is defined below.)

If a Covered Person is covered by this Contract and another Plan, the Order of Benefit Determination Rules described below determine whether this Contract or the other Plan is Primary. The benefits of this Contract:

1. shall not be reduced when, under the Order of Benefit Determination Rules, this Contract is Primary; but

2. may be reduced for the Reasonable Cash Value of any service provided under this Contract that may be recovered from another Plan when, under the Order of Benefit Determination Rules, the other Plan is Primary. (The above reduction is described in the subsection below entitled "Effect on the Benefits of this Plan.")

Definitions. "Plan" means this Contract or any of the following which provides benefits or services for, or because of, dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment or group practice coverage.

2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the United States Social Security Act, as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

3. Dental benefits coverage of all group and group-type contracts.

"Plan" does not include coverage under individual policies or contracts. Each contract or other arrangement for coverage under subparagraphs 1, 2, or 3 above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Primary" means that a Plan's benefits are to be provided or paid without considering any other Plan's benefits. (The Order of Benefit Determination Rules below determine whether a Plan is Primary or Secondary to another Plan.)

"Secondary" means that a Plan's benefits may be reduced and it may recover the Reasonable Cash Value of the services it provided from the Primary Plan. (The Order of Benefit Determination Rules below determine whether a Plan is Primary or Secondary to another Plan.)

"Allowable Expense" means a necessary, reasonable, and customary item of expense for dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

1. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered is an Allowable Expense and a benefit paid.

2. When benefits are reduced under a Primary Plan because a Covered Person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense.

"Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a Covered Person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

"Reasonable Cash Value" means an amount which a duly licensed provider of dental care services usually charges patients and which is within the range of fees usually charged for the same service by other dental care providers located within the immediate geographic area where the dental care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules. When a Covered Person receives services through this Plan or is otherwise entitled to claim benefits under this Plan, and the services or benefits are a basis for a claim under another Plan, this Plan shall be Secondary and the other Plan shall be Primary, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and

2. both the other Plan's rules and this Plan's rules, as stated below, require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its Order of Benefits using the first of the following rules that applies:

1. The Plan under which the Covered Person is an employee shall be Primary.

2. If the Covered Person is not an employee under a Plan, then the Plan which covers the Covered Person's parent (as an employee) whose birthday occurs earlier in a calendar year shall be Primary.

   NOTE: The word "birthday" as used in this subparagraph refers only to month and day in a calendar year, not to the year in which the person was born. To aid in the interpretation of this paragraph, the following example is given: If a Covered Person's mother has a birthday on January 1 and the Covered Person's father has a birthday on January 2, the Plan which covers the Covered Person's mother would be Primary.

3. If two or more Plans cover a Covered Person as a dependent child of divorced or separated parents, benefits for the Covered Person shall be determined in the following order:

   a. First, the Plan of the parent with custody of the child;

   b. Then, the Plan of the spouse of the parent with custody of the child; and

   c. Finally, the Plan of the parent not having custody of the child.

4. Notwithstanding subparagraph 3 above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan shall be Primary. This subparagraph 4 does not apply with respect to any Claim Determination Period or Plan year in which benefits are paid or provided before the entity has that actual knowledge.

5. The benefits of a Plan which covers a Covered Person as an employee (or as that employee's dependent) shall be determined before those of a Plan which covers that Covered Person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this provision and if, as a result, the Plans do not agree on the order of benefit determination, this paragraph shall not apply.

6. If a Covered Person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the benefits of the Plan covering the Covered Person as an employee (or as that employee's dependent) shall be determined before those of a Plan under continuation coverage. If the other Plan does not have this provision and if, as a result, the Plans do not agree on the order of benefit determination, this paragraph shall not apply.

7. If one of the Plans which covers a Covered Person is issued out of the state whose laws govern this Contract and determines the order of benefits based upon the gender of a parent, and as result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

8. If none of the above rules determines the order of benefits, the Plan which has covered the Covered Person for the longer period of time shall be Primary.

Effect on the Benefits of this Plan. This subsection applies when, in accordance with the Order of Benefit Determination Rules, this Plan is

Secondary to one or more other Plans. In that event, the benefits of this Plan may be reduced under this subsection. Such other Plan or Plans are referred to as "the other Plans' in the subparagraphs below.

This Plan may reduce benefits payable or may recover the Reasonable Cash Value of services provided when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Plan, in the absence of this COB provision; and

2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced, or the Reasonable Cash Value of any services provided by this Plan may be recovered from the other Plan, so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Recovery of Excess Benefits. In the event a service or benefit is provided by Cigna Dental Health which is not required by this Contract, or if it has provided a service or benefit which should have been paid by the Primary Plan, that service or benefit shall be considered an excess benefit. Cigna Dental Health shall have the right to recover to the extent of the excess benefit. If the excess benefit is a service, recovery shall be based upon the Reasonable Cash Value for that service. If the excess benefit is a payment, recovery shall be based upon the actual payment made. Recovery may be sought from among one or more of the following, as Cigna Dental Health shall determine: any person to, or for, or with respect to whom, such services were provided or such payments were made; any insurance company; health care plan or other organization. This right of recovery shall be Cigna Dental Health's alone and at its sole discretion. If determined necessary by Cigna Dental Health, the Covered Person (or his or her legal representative if a minor or legally incompetent), upon request, shall execute and deliver to Cigna Dental Health such instruments and papers required and do whatever else is necessary to secure Cigna Dental Health's rights hereunder.

Medicare Benefits. Except as otherwise provided by applicable federal law, the services and benefits under this Plan for Covered Persons aged sixty-five (65) and older, or for Covered Persons otherwise eligible for Medicare payments, shall not duplicate any services or benefits to which such Covered Persons are eligible under Parts A or B of the Medicare Act. Where Medicare is the responsible payor, all amounts payable pursuant to the Medicare program for services and benefits provided hereunder to Covered Persons are payable to and shall be retained by Cigna Dental Health. Covered Persons enrolled in Medicare shall cooperate with and assist Cigna Dental Health in its efforts to obtain reimbursement from Medicare.

Right to Receive and Release Information. Cigna Dental Health may, without consent of or notice to any Covered Person, and to the extent permitted by law, release to or obtain from any person or organization or governmental entity any information with respect to the administering of this Section. A Covered Person shall provide to Cigna Dental Health any information it requests to implement this provision.

CIGNA DENTAL HEALTH
GROUP DENTAL PLAN
PRE-CONTRACT APPLICATION

☐ Cigna Dental Health Plan of Arizona, Inc.
☐ Cigna Dental Health of California, Inc.
☐ Cigna Dental Health of Colorado, Inc.
☐ Cigna HealthCare of Connecticut, Inc.
☐ Cigna Dental Health of Delaware, Inc.
☐ Cigna Dental Health of Florida, Inc.
☐ Cigna Dental Health of Kansas, Inc. (Nebraska)
☐ Cigna Dental Health of Kansas, Inc.
☐ Cigna Dental Health of Kentucky, Inc.
☐ Cigna Dental Health of Kentucky, Inc. (Illinois)
☐ Cigna Dental Health of Maryland, Inc.
☐ Cigna Dental Health of Missouri, Inc.
☐ Cigna Dental Health of North Carolina, Inc.
☐ Cigna Dental Health of New Jersey, Inc.
☐ Cigna Dental Health of Ohio, Inc.
☐ Cigna Dental Health of Pennsylvania, Inc.
☐ Cigna Dental Health of Texas, Inc.
☐ Cigna Dental Health of Virginia, Inc.

FILL IN EVERY LINE – Information must be completed by Applicant.

APPLICANT

A. APPLICANT'S FULL LEGAL NAME: ______
B. ADDRESS: ______ PHONE: ______
C. BILLING ADDRESS, IF DIFFERENT: ______
D. NAME OF CONTACT: ______ TITLE: ______
E. THE APPLICANT IS: ☑ EMPLOYER ☐ LABOR UNION ☐ ASSOCIATION
F. NATURE OF BUSINESS: ______
G. PRIOR DENTAL COVERAGE: ☑ YES ☐ NO
H. ERISA APPLIES: ☑ YES ☐ NO
I. I.R.C. SECTION 125 APPLIES: ☑ YES ☐ NO

ELIGIBILITY

A. TOTAL NO. OF EMPLOYEES: ______ TOTAL NUMBER OF ELIGIBLE EMPLOYEES: ______
B. ALL CLASSES OF FULL-TIME EMPLOYEES WILL BE ELIGIBLE EXCEPT:
EXCLUDED CLASS(ES) ______
C. CURRENT EMPLOYEES WILL BE ELIGIBLE UPON: ______ Months of Service *or* Other ______
D. FUTURE EMPLOYEES WILL BE ELIGIBLE UPON: ______ Months of Service *or* Other __ .
E. AGE LIMITATIONS FOR DEPENDENTS: All unmarried children of Employees are eligible to enroll if (a) less than 19 years of age; or (b) full-time students less than 23 years of age. Please indicate changes, if any, applicable to: (a)______ (b)______

DENTAL PLAN

A. EFFECTIVE DATE: The proposed Effective Date of group coverage is ___________, or the first day of the month after which enrollment information and payment for the first month's coverage are received and accepted by Cigna Dental Health. If this Pre-Contract Application is not accepted by Cigna Dental Health, no coverage will become effective, and any premium advanced by the Applicant will be refunded. Employees who enroll after the Effective Date will be covered: as of the first day of the month after processing of enrollment by Cigna Dental Health *or* Other .
B. CONTRACT TERM: The initial term of the Group Contract shall extend from the Effective Date until the expiration of the initial premium guarantee period shown below. The Group Contract shall be automatically renewed on an annual basis in accordance with the Group Contract, unless terminated in accordance with the Group Contract.
C. PREMIUMS: Cigna Dental Health Premiums will be: 01- _______ 02- _______ 03-______ 04- _______ Composite _____.
Premiums are guaranteed through __________; however, premiums may be adjusted upon 30 days written notice* to the Group if, in Cigna Dental Health's sole opinion, its liability (e.g., for taxes or benefits) is altered by any state or federal law.
D. EMPLOYER CONTRIBUTION: Employee Only _____% Dependents ____%. If no employer contribution, plan must be funded on a pre-tax basis under I.R.C. Section 125.
E. PATIENT CHARGE SCHEDULE:______. The Patient Charge Schedule of the Dental Plan is subject to annual change in accordance with the terms of the Group Contract. Please indicate expiration of guarantee period for the Patient Charge Schedule if other than one year from the Effective Date of coverage:
F. DENTAL OFFICE: Enrolled employees and their enrolled dependents must select a Dental Office. ☐ All family or
☑Each family member may select a different Dental Office.

***North Carolina Groups Only: North Carolina law requires 45-days' notice to group.**

Applicant declares that he/she has read these statements and the answers to these questions are complete and true. Applicant agrees that: (1) this Pre-Contract Application is offered as an inducement for the group coverage applied for; (2) this Pre-Contract Application will form a part of any Group Contract issued; (3) no information given to or acquired by any representative of Cigna Dental Health will bind Cigna Dental Health unless it appears in writing on this Pre-Contract Application; and (4) no waiver or change will bind Cigna Dental Health unless signed by an officer of Cigna Dental Health. Group coverage will only be provided for persons eligible under the Group Contract issued.

APPLICANT: ______________________ TITLE: ______________________ AGENT/BROKER: ______________________
(PRINT NAME OF APPLICANT'S REPRESENTATIVE) (PRINT NAME)

______________________ DATE: ______________ ______________________ DATE: ____________
(SIGNATURE OF REPRESENTATIVE) (SIGNATURE OF AGENT/BROKER)

The following notice is required by Ohio and Kentucky Law:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Statement to be signed by Applicant upon payment of the premium or any part thereof

I HEREBY DECLARE that I have paid to ______________________Agent______________
______________________Dollars for which I hold his or her receipt bearing the same number as this Pre-Contract Application.

Date: __________________ Applicant______________________
No. ______________________

CIGNA DENTAL HEALTH

No.______________________

CONDITIONAL RECEIPT

Received of ________________________/________________________ Dollars to be applied against the first premium on the proposed Group Dental Plan under this Pre-Contract Application. This payment is made and accepted subject to the following conditions. Group coverage at Cigna Dental Health rates applied for will take effect as of the Effective Date requested if the Pre-Contract Application is accepted at the Cigna Dental Health Home Office. If certain persons eligible are to contribute to the cost of the Group Dental Plan, such Group coverage will take effect on the later of: the date the required number have enrolled, or on the Effective Date requested. If the Pre-Contract Application is not accepted, no coverage will become effective. Any premium payment advanced by the Applicant will be refunded upon surrender of this Conditional Receipt.
Date: ________________________Agent

Detach This Receipt When Payment is Made

80085GE2.95

IMPORTANT NOTICE: The group insurance policy in this PDF (the "Policy") is validly issued by Cigna Health and Life Insurance Company in the state identified on the cover page of the Policy (the "Policy Issuance State") and shall be governed by its laws. For your convenience, the Policy is hereby transmitted electronically to you, as representative of the policyholder, in lieu of physical delivery of a paper copy of the Policy in the Policy Issuance State. Your receipt of this electronic transmission constitutes official delivery of the Policy in the Policy Issuance State no less than if a paper copy of the Policy were physically delivered at a policyholder address in the Policy Issuance State. If you prefer, a paper copy of the Policy will be delivered to a policyholder address that you identify in the Policy Issuance State.

This notice is not part of the policy.

Mailing Address: Hartford, Connecticut 06152
Home Office: Bloomfield, Connecticut

CIGNA HEALTH AND LIFE INSURANCE COMPANY

POLICYHOLDER: Sample

ADDRESS: Sample

ACCOUNT/GROUP NUMBER: Sample

Group Insurance Policy and Policy Number	Effective Date	Anniversary Date
CIGNA DENTAL PREFERRED PROVIDER INSURANCE Sample- DPPO	01/01/2017	01/01

This policy is issued in Florida and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain Employees and pay benefits.

The Insurance Company and the Policyholder have agreed to all of the terms of this policy.

POLICY CONTENTS

CERTIFICATE CONTENTS

THE INSURANCE SCHEDULE

The terms set forth herein and in the Certificate(s) listed below describe the insurance underwritten by the Insurance Company. These Certificates are included in and made a part of the policy(ies). Each Certificate is identified by a Certificate Number (CN).

Any reference in the certificate to "you" or "yours" refers to the Employee.

An Employee in any of the classes shown below may be insured but only for the policy(ies) listed for his Employee Class. The Effective Date shown below is the date on which a policy becomes effective for an Employee Class.

An Employee will become eligible and insured in accordance with the terms of the "Eligibility" and "Effective Date" sections of the Certificate.

GROUP POLICY(IES)		EMPLOYEE CLASS	
Certificate Number	Policy(ies)	Eligible Employees	Effective Date
!	!	Each Employee as reported to the insurance company by your Employer	!
	!		

PREMIUMS

PREMIUM PAYMENT. The first premium will be due on the Effective Date. After that, premium will be due monthly unless the Policyholder and the Insurance Company agree on some other method of premium payment. The Policyholder and the Insurance Company may agree to change the method of premium payment from time to time. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

PREMIUM DUE DATE. After the Effective Date, the Premium Due Date will be the first of the month. The Anniversary Date will be the first of the month when the policy becomes effective. If the Policyholder and the Insurance Company agree that premiums will be paid on a quarterly, semiannual or annual basis, the Premium Due Date will be at the appropriate regular interval, quarterly, semiannually or annually. Premiums must be received at the Home Office or by an authorized agent of the Insurance Company on the Premium Due Date or the policy will be cancelled except as set forth in the Grace Period.

MONTHLY STATEMENT DATE. If premiums are to be paid monthly, the Monthly Statement Date will be the same as the Premium Due Date. If premiums are to be paid on a quarterly, semiannual or annual basis, the Monthly Statement Date will be the day in each month with the same number as the Premium Due Date.

MONTHLY PREMIUM STATEMENT. If premiums are due monthly, a Monthly Premium Statement will be prepared as of the Premium Due Date. This Monthly Premium Statement will show the premium due. If premiums are due quarterly, semiannually or annually, a Monthly Premium Statement will be prepared as of the Monthly Statement Date for the time from the Monthly Statement Date to the next Premium Due Date. This Monthly Statement will reflect any pro rata premium charges and credits due to changes in the number of insured persons and changes in insurance amounts that took place in the preceding month.

SIMPLIFIED ACCOUNTING. To simplify the accounting process, premium adjustments will be made on the Monthly Statement Date that is the same as or next follows the date that:

- A person becomes insured.
- The amount of insurance on a person changes, but not due to a revision of The Schedule.
- A person ceases to be insured.

MONTHLY PREMIUM RATE FOR DENTAL INSURANCE. The monthly premium rate for Dental Insurance is determined by written agreement between the Policyholder and Cigna Health and Life Insurance Company.

DENTAL INSURANCE PREMIUM. The monthly premium for Dental Insurance will be calculated as follows:

- Multiply the number of Employees insured on the Premium Due Date in each rate class by the premium rate in effect on that date for that class.
- Add the results.

CHANGE IN METHOD OF PREMIUM PAYMENT. If premiums are to be paid other than monthly, the method of calculation is the same. However, the rate for each class is first changed to quarterly, semiannual or annual rates by multiplying them by 2.9852, 5.9557 or 11.8227, respectively. All results are taken to the nearer cent. If the Policyholder and

the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, a pro rata adjustment will be made in the premium due.

CHANGES IN PREMIUM RATES. Any premium rate may be changed by the Insurance Company from time to time with at least 45 days advance written notice. No such change will be made until 12 months after the Effective Date. An increase will not be made more often than once in a 12-month period. If an increase in premium rates takes place on a date that is not a Premium Due Date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next Premium Due Date. If a decrease in premium rates takes place on a date that is not a Premium Due Date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next Premium Due Date.

The Insurance Company may change rates immediately if, following the latter of the effective date or renewal date, the enrolled population either increases or decreases by 10% or more.

As of any Anniversary Date after the policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine, based on experience. The experience under this policy may be combined with the experience under other contracts issued by the Insurance Company or its affiliates and covering the policyholder or its employees.

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by any change in state or federal law or by a revision in the insurance under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

CANCELLATION OF POLICY

The Policyholder may cancel the policy at any time by giving written notice to the Insurance Company.

The Insurance Company may cancel the policy due to the following reasons only:

- with at least 90 days prior written notice, if the Insurance Company ceases to offer coverage of this type, in accordance with applicable state or federal law;
- as of any Premium Due Date, if the premium is not received at the Home Office or by an authorized agent of the Insurance Company when due;
- immediately, if the Employer has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact;
- as of any Premium Due Date, if the number of insured Employees or if the number of insured Dependents fails to meet the minimum required per group participation rules; or for failure to comply with any other material plan provision relating to Employer contributions or group participation rules;
- if the Insurance Company withdraws from the health insurance market with prior written notice and in accordance with applicable state or federal law;
- in accordance with any applicable state law, if it is determined that the size of the Employer group has changed, making such group eligible for a guaranteed issued small group product;
- in accordance with any applicable state or federal law, if prior notice is given to the Employer;
- as to an Employer member of an association to which this policy is issued, when the Employer's membership in the association ceases, in accordance with applicable state or federal law.

Coverage will cease at midnight on the date on which termination occurs, unless otherwise stated above.

Uniform Modification of Coverage. At renewal, the provisions of this policy may be modified to reflect product revisions which have been uniformly made to this product.

GRACE PERIOD. If, before a Premium Due Date, the Policyholder has not given written notice to the Insurance Company that the policy is to be canceled, a Grace Period of 31 days will be granted for the payment of each premium after the initial premium. The policy will stay in effect during that time. If any premium is not received at the home office or by an authorized agent of the Insurance Company by the end of the Grace Period, the policy will automatically be canceled at the end of the Grace Period; except that, if the Policyholder has given written notice in advance of an earlier date of cancellation, the policy will be canceled as of the earlier date. The Policyholder will be liable to the Insurance Company for any unpaid premium for the time the policy was in force.

MISCELLANEOUS PROVISIONS

EXECUTION OF POLICY. The policy is executed at the Home Office of the Insurance Company. The Post Office address of the Insurance Company is Hartford, Connecticut.

CONSIDERATION. The policy is issued to the Policyholder in consideration of the application and payment of premiums.

INSURANCE DATA. The Policyholder will give the Insurance Company all of the data that it needs to calculate the premium and all other data that it may reasonably require. Failure of the Policyholder to give this data will not void or continue an Employee's insurance. The Insurance Company has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. It also has this right until all rights and obligations under the policy are finally determined.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

PROVISIONS

ENTIRE CONTRACT. The entire contract will be made up of the policy, the application of the Policyholder, a copy of which is attached to the policy and all subsequent versions of the policy, and the applications, if any, of the Employees.

POLICY CHANGES. Changes may be made in the policy only by amendment signed by the Policyholder and by the Insurance Company acting through its President, Vice President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the policy.

STATEMENTS NOT WARRANTIES. All statements made by the Policyholder or by an insured Employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the Employee and a copy is sent to the Policyholder, the Employee or his Beneficiary.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence or start of the loss on which claim is based.

If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

CLAIM FORMS. When the Insurance Company receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to have met the proof of loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS. Written proof of loss must be given to the Insurance Company within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

PHYSICAL EXAMINATION. The Insurance Company, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

LEGAL ACTIONS. No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with the Insurance Company. No action will be brought at all unless brought within 5 years after the time within which proof of loss is required by the policy.

TIME LIMITATIONS. If any time limit set forth in the policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee lives when the policy is issued, then the time limit provided in the policy is extended to agree with the minimum permitted by the law of that state.

CERTIFICATES. The Insurance Company will issue to the Policyholder for delivery to each insured Employee an individual certificate. The Policyholder will be responsible for distributing the certificates to its Employees. The certificate will show the benefits provided under the policy. It will set forth any changes in benefits due to age and to whom benefits will be paid. Nothing in the certificate will change or void the terms of the policy.

NOTICE OF TERMINATION OF ELIGIBILITY. Written notice of the termination of eligibility of any Employee or Dependent must be given to the Insurance Company within (60) days of the loss of eligibility. If such notice is not received by the Insurance Company within (60) days of the date of loss of eligibility for an Employee or Dependent, then the Employer shall be responsible for all claims for that Employee or Dependent incurred through the (60th) day prior to the Insurance Company's receipt of notice of termination of eligibility for the Employee or Dependent.

P2I0X

CIGNA DENTAL CARE® (*DHMO) PATIENT CHARGE SCHEDULE

This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Cigna Dental as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialty Periodontist or Oral Surgeon. You must verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental. Prior authorization is not required for specialty referrals for Pediatric, Orthodontic and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 7 by calling Customer Service at 1.800.Cigna24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 7th birthday.
- Procedures not listed on this Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or nitrous oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- Cigna Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.

Important Highlights (Continued)

- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

Code	Procedure Description	Patient Charge
Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145).		
D9310	Consultation (Diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0.00
D9430	Office visit for observation – No other services performed	$0.00
D9450	Case presentation – Detailed and extensive treatment planning	$0.00
D0120	Periodic oral evaluation – Established patient	$0.00
D0140	Limited oral evaluation – Problem focused	$0.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation – New or established patient	$0.00
D0160	Detailed and extensive oral evaluation – Problem focused, by report *(Limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$0.00
D0170	Reevaluation – Limited, problem focused (Not postoperative visit)	$0.00
D0180	Comprehensive periodontal evaluation – New or established patient	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D0210	X-rays intraoral – Complete series of radiographic images *(Limit 1 every 3 years)*	$0.00
D0220	X-rays intraoral – Periapical – First radiographic image	$0.00
D0230	X-rays intraoral – Periapical – Each additional radiographic image	$0.00
D0240	X-rays intraoral – Occlusal radiographic image	$0.00
D0250	X-rays extraoral – First radiographic image	$0.00
D0260	X-rays extraoral – Each additional radiographic image	$0.00
D0270	X-rays (Bitewing) – Single radiographic image	$0.00
D0272	X-rays (Bitewings) – 2 radiographic images	$0.00
D0273	X-rays (Bitewings) – 3 radiographic images	$0.00
D0274	X-rays (Bitewings) – 4 radiographic images	$0.00
D0277	X-rays (Bitewings, vertical) – 7 to 8 radiographic images	$0.00
D0330	X-rays (Panoramic radiographic image) – *(Limit 1 every 3 years)*	$0.00
D0364	Cone beam CT capture and interpretation with limited field of view – Less than one whole jaw *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$200.00
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – Mandible *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$220.00
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – Maxilla, with or without cranium *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$220.00
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$240.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures *(Limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$240.00
D0350	Oral/facial photographic images	$0.00
D0415	Collection of microorganisms for culture and sensitivity	$0.00
D0425	Caries susceptibility tests	$0.00
D0431	Oral cancer screening using a special light source	$50.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00
D0472	Pathology report – Gross examination of lesion (Only when tooth related)	$0.00
D0473	Pathology report – Microscopic examination of lesion (Only when tooth related)	$0.00
D0474	Pathology report – Microscopic examination of lesion and area (Only when tooth related)	$0.00
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0.00
D1110	Prophylaxis (Cleaning) – Adult (*Limit 2 per calendar year*)	$0.00
	Additional prophylaxis (Cleaning) – In addition to the 2 prophylaxes (Cleanings) allowed per calendar year	$35.00
D1120	Prophylaxis (Cleaning) – Child (*Limit 2 per calendar year*)	$0.00
	Additional prophylaxis (Cleaning) – In addition to the 2 prophylaxes (Cleanings) allowed per calendar year	$25.00
D1206	Topical application of fluoride varnish *(Limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.*	$0.00
	Additional topical application of fluoride varnish – In addition to any combination of two (2) D1206s (Topical application of fluoride varnish) and/or D1208s (Topical application of fluoride) per calendar year.	$15.00
D1208	Topical application of fluoride (*Limit 2 per calendar year*). *There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.*	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
	Additional topical application of fluoride – In addition to any combination of two (2) D1206s (Topical applications of fluoride varnish) and/or D1208s (Topical application of fluoride) per calendar year.	$15.00
D1310	Nutritional counseling for control of dental disease	$0.00
D1320	Tobacco counseling for the control and prevention of oral disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant – Per tooth	$0.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth	$0.00
D1510	Space maintainer – Fixed – Unilateral	$0.00
D1515	Space maintainer – Fixed – Bilateral	$0.00
D1520	Space maintainer – Removable – Unilateral	$0.00
D1525	Space maintainer – Removable – Bilateral	$0.00
D1550	Recementation of space maintainer	$0.00
D1555	Removal of fixed space maintainer	$0.00
Restorative (Fillings, including polishing)		
D2140	Amalgam – 1 surface, primary or permanent	$0.00
D2150	Amalgam – 2 surfaces, primary or permanent	$0.00
D2160	Amalgam – 3 surfaces, primary or permanent	$0.00
D2161	Amalgam – 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite – 1 surface, anterior	$0.00
D2331	Resin-based composite – 2 surfaces, anterior	$0.00
D2332	Resin-based composite – 3 surfaces, anterior	$0.00
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle, anterior	$0.00
D2390	Resin-based composite crown, anterior	$20.00
D2391	Resin-based composite – 1 surface, posterior	$25.00
D2392	Resin-based composite – 2 surfaces, posterior	$30.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D2393	Resin-based composite – 3 surfaces, posterior	$35.00
D2394	Resin-based composite – 4 or more surfaces, posterior	$40.00
Crown and bridge – All charges for crowns and bridges (Fixed partial dentures) are per unit (Each replacement or supporting tooth equals 1 unit). Coverage for replacement of crowns and bridges is limited to 1 every 5 years. For single crowns, retainer ("Abutment") crowns, and pontics: The charges below include the cost of predominantly base metal alloy. You may be charged up to these additional amounts, based on the type of material the dentist uses for your restoration. • No more than $150.00 per tooth for any noble metal alloys, high noble metal alloys, titanium or titanium alloys • No more than $75.00 per tooth for any porcelain fused to metal (Only on molar teeth) • Porcelain/ceramic substrate crowns on molar teeth are not covered		
	In addition, you may be charged up to these additional amounts. • No more than $100.00 per tooth if an indirectly fabricated ("Cast") post and core is made of high noble metal alloy • No more than $150.00 per tooth for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (Ceramic) services. Same day in-office CAD/CAM (Ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine Complex rehabilitation – An additional $125 charge per unit for multiple crown units/complex rehabilitation *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – Ask your dentist for the guidelines)*	
D2510	Inlay – Metallic – 1 surface	$50.00
D2520	Inlay – Metallic – 2 surfaces	$50.00
D2530	Inlay – Metallic – 3 or more surfaces	$50.00
D2542	Onlay – Metallic – 2 surfaces	$50.00
D2543	Onlay – Metallic – 3 surfaces	$50.00
D2544	Onlay – Metallic – 4 or more surfaces	$50.00
D2740	Crown – Porcelain/ceramic substrate	$200.00
D2750	Crown – Porcelain fused to high noble metal	$50.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D2751	Crown – Porcelain fused to predominantly base metal	$50.00
D2752	Crown – Porcelain fused to noble metal	$50.00
D2780	Crown – 3/4 cast high noble metal	$50.00
D2781	Crown – 3/4 cast predominantly base metal	$50.00
D2782	Crown – 3/4 cast noble metal	$50.00
D2783	Crown – 3/4 porcelain/ceramic	$50.00
D2790	Crown – Full cast high noble metal	$50.00
D2791	Crown – Full cast predominantly base metal	$50.00
D2792	Crown – Full cast noble metal	$50.00
D2794	Crown – Titanium	$50.00
D2799	Provisional crown	$100.00
D2610	Inlay – Porcelain/ceramic, 1 surface	$50.00
D2620	Inlay – Porcelain/ceramic, 2 surfaces	$50.00
D2630	Inlay – Porcelain/ceramic, 3 or more surfaces	$50.00
D2642	Onlay – Porcelain/ceramic, 2 surfaces	$50.00
D2643	Onlay – Porcelain/ceramic, 3 surfaces	$50.00
D2644	Onlay – Porcelain/ceramic, 4 or more surfaces	$50.00
D2650	Inlay – Resin-based composite, 1 surface	$50.00
D2651	Inlay – Resin-based composite, 2 surfaces	$50.00
D2652	Inlay – Resin-based composite, 3 or more surfaces	$50.00
D2662	Onlay – Resin-based composite, 2 surfaces	$50.00
D2663	Onlay – Resin-based composite, 3 surfaces	$50.00
D2664	Onlay – Resin-based composite, 4 or more surfaces	$50.00
D2710	Crown – Resin-based composite, indirect	$50.00
D2712	Crown – 3/4 resin-based composite, indirect	$50.00
D2720	Crown – Resin with high noble metal	$50.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D2721	Crown – Resin with predominantly base metal	$50.00
D2722	Crown – Resin with noble metal	$50.00
D2910	Recement inlay – Onlay or partial coverage restoration	$0.00
D2915	Recement cast or prefabricated post and core	$0.00
D2920	Recement crown	$0.00
D2929	Prefabricated porcelain/ceramic crown – Primary tooth	$75.00
D2930	Prefabricated stainless steel crown – Primary tooth	$0.00
D2931	Prefabricated stainless steel crown – Permanent tooth	$0.00
D2932	Prefabricated resin crown	$0.00
D2933	Prefabricated stainless steel crown with resin window	$0.00
D2934	Prefabricated esthetic coated stainless steel crown – Primary tooth	$75.00
D2940	Protective restoration	$0.00
D2950	Core buildup – Including any pins	$15.00
D2951	Pin retention – Per tooth – In addition to restoration	$10.00
D2952	Post and core – In addition to crown, indirectly fabricated	$25.00
D2953	Each additional indirectly prefabricated post – Same tooth	$25.00
D2954	Prefabricated post and core – In addition to crown	$20.00
D2957	Each additional prefabricated post – Same tooth	$15.00
D2960	Labial veneer (Resin laminate) – Chairside	$250.00
D2970	Temporary crown (Fractured tooth)	$0.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$30.00
D2980	Crown repair, necessitated by restorative material failure	$0.00
D6210	Pontic – Cast high noble metal	$50.00
D6211	Pontic – Cast predominantly base metal	$50.00
D6212	Pontic – Cast noble metal	$50.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D6214	Pontic – Titanium	$50.00
D6240	Pontic – Porcelain fused to high noble metal	$50.00
D6241	Pontic – Porcelain fused to predominantly base metal	$50.00
D6242	Pontic – Porcelain fused to noble metal	$50.00
D6245	Pontic – Porcelain/ceramic	$50.00
D6250	Pontic – Resin with high noble metal	$50.00
D6251	Pontic – Resin with predominantly base metal	$50.00
D6252	Pontic – Resin with noble metal	$50.00
D6253	Provisional pontic	$50.00
D6545	Retainer – Cast metal for resin bonded fixed prosthesis	$50.00
D6600	Inlay – Porcelain/ceramic, 2 surfaces	$50.00
D6601	Inlay – Porcelain/ceramic, 3 or more surfaces	$50.00
D6602	Inlay – Cast high noble metal, 2 surfaces	$50.00
D6603	Inlay – Cast high noble metal, 3 or more surfaces	$50.00
D6604	Inlay – Cast predominantly base metal, 2 surfaces	$50.00
D6605	Inlay – Cast predominantly base metal, 3 or more surfaces	$50.00
D6606	Inlay – Cast noble metal, 2 surfaces	$50.00
D6607	Inlay – Cast noble metal, 3 or more surfaces	$50.00
D6608	Onlay – Porcelain/ceramic, 2 surfaces	$50.00
D6609	Onlay – Porcelain/ceramic, 3 or more surfaces	$50.00
D6610	Onlay – Cast high noble metal, 2 surfaces	$50.00
D6611	Onlay – Cast high noble metal, 3 or more surfaces	$50.00
D6612	Onlay – Cast predominantly base metal, 2 surfaces	$50.00
D6613	Onlay – Cast predominantly base metal, 3 or more surfaces	$50.00
D6614	Onlay – Cast noble metal, 2 surfaces	$50.00
D6615	Onlay – Cast noble metal, 3 or more surfaces	$50.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D6624	Inlay – Titanium	$50.00
D6634	Onlay – Titanium	$50.00
D6710	Crown – Indirect resin based composite	$50.00
D6720	Crown – Resin with high noble metal	$50.00
D6721	Crown – Resin with predominantly base metal	$50.00
D6722	Crown – Resin with noble metal	$50.00
D6740	Crown – Porcelain/ceramic	$50.00
D6750	Crown – Porcelain fused to high noble metal	$50.00
D6751	Crown – Porcelain fused to predominantly base metal	$50.00
D6752	Crown – Porcelain fused to noble metal	$50.00
D6780	Crown – 3/4 cast high noble metal	$50.00
D6781	Crown – 3/4 cast predominantly base metal	$50.00
D6782	Crown – 3/4 cast noble metal	$50.00
D6783	Crown – 3/4 porcelain/ceramic	$50.00
D6790	Crown – Full cast high noble metal	$50.00
D6791	Crown – Full cast predominantly base metal	$50.00
D6792	Crown – Full cast noble metal	$50.00
D6794	Crown – Titanium	$50.00
D6930	Recement fixed partial denture	$0.00
D6950	Precision attachment	$195.00
Endodontics (Root canal treatment, excluding final restorations)		
D3110	Pulp cap – Direct (Excluding final restoration)	$0.00
D3120	Pulp cap – Indirect (Excluding final restoration)	$0.00
D3220	Pulpotomy – Removal of pulp, not part of a root canal	$0.00
D3221	Pulpal debridement (Not to be used when root canal is done on the same day)	$10.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D3222	Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development	$17.00
D3230	Pulpal therapy (Resorbable filling) – Anterior, primary tooth (Excluding final restoration)	$0.00
D3240	Pulpal therapy (Resorbable filling) – Posterior, primary tooth (Excluding final restoration)	$10.00
D3310	Anterior root canal – Permanent tooth (Excluding final restoration)	$30.00
D3320	Bicuspid root canal – Permanent tooth (Excluding final restoration)	$45.00
D3330	Molar root canal – Permanent tooth (Excluding final restoration)	$75.00
D3331	Treatment of root canal obstruction – Nonsurgical access	$40.00
D3332	Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth	$35.00
D3333	Internal root repair of perforation defects	$40.00
D3346	Retreatment of previous root canal therapy – Anterior	$45.00
D3347	Retreatment of previous root canal therapy – Bicuspid	$70.00
D3348	Retreatment of previous root canal therapy – Molar	$90.00
D3351	Apexification/recalcification – Initial visit (Apical closure/calcific repair of perforations, root resorption, etc.)	$65.00
D3352	Apexification/recalcification – Interim medication replacement (Apical closure/calcific repair of perforations, root resorption, etc.)	$50.00
D3353	Apexification/recalcification – Final visit (Includes completed root canal therapy – Apical closure/calcific repair of perforations, root resorption, etc.)	$50.00
D3410	Apicoectomy/periradicular surgery – Anterior	$60.00
D3421	Apicoectomy/periradicular surgery – Bicuspid (First root)	$70.00
D3425	Apicoectomy/periradicular surgery – Molar (First root)	$80.00
D3426	Apicoectomy/periradicular surgery (Each additional root)	$50.00
D3430	Retrograde filling – Per root	$10.00
D3450	Root amputation – Per root	$0.00
D3920	Hemisection (Including any root removal), not including root canal therapy	$30.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
Periodontics (Treatment of supporting tissues (Gum and bone) of the teeth) periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. The relevant procedure codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 teeth (or 8 sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.		
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$35.00
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	$30.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$30.00
D4240	Gingival flap (Including root planing) – 4 or more teeth per quadrant	$100.00
D4241	Gingival flap (Including root planing) – 1 to 3 teeth per quadrant	$80.00
D4245	Apically positioned flap	$115.00
D4249	Clinical crown lengthening – Hard tissue	$120.00
D4260	Osseous surgery – 4 or more teeth per quadrant	$160.00
D4261	Osseous surgery – 1 to 3 teeth per quadrant	$125.00
D4263	Bone replacement graft – First site in quadrant	$135.00
D4264	Bone replacement graft – Each additional site in quadrant	$70.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95.00
D4266	Guided tissue regeneration – Resorbable barrier per site	$215.00
D4267	Guided tissue regeneration – Nonresorbable barrier per site (Includes membrane removal)	$255.00
D4270	Pedicle soft tissue graft procedure	$85.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$75.00
D4274	Distal or proximal wedge procedure (When not performed in conjunction with surgical procedures in the same anatomical area)	$45.00
D4275	Soft tissue allograft	$125.00
D4277	Free soft tissue graft procedure (Including donor site surgery), first tooth or edentulous *(missing)* tooth position in graft	$120.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D4278	Free soft tissue graft procedure (Including donor site surgery), each additional contiguous tooth or edentulous *(missing)* tooth position in same graft site	$60.00
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant *(Limit 4 quadrants per consecutive 12 months)*	$15.00
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant *(Limit 4 quadrants per consecutive 12 months)*	$11.00
D4355	Full mouth debridement to allow evaluation and diagnosis *(1 per lifetime)*	$15.00
D4381	Localized delivery of antimicrobial agents per tooth	$60.00
D4910	Periodontal maintenance *(Limit 4 per calendar year) (Only covered after active periodontal therapy)*	$15.00
	Additional periodontal maintenance procedures *(Beyond 4 per calendar year)*	$40.00
	Periodontal charting for planning treatment of periodontal disease	$0.00
	Periodontal hygiene instruction	$0.00
Prosthetics (Removable tooth replacement – Dentures) includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years. Characterization is considered an upgrade with maximum additional charge to the member of $200.00 per denture.		
D5110	Full upper denture	$100.00
D5120	Full lower denture	$100.00
D5130	Immediate full upper denture	$100.00
D5140	Immediate full lower denture	$100.00
D5211	Upper partial denture – Resin base (Including clasps, rests and teeth)	$100.00
D5212	Lower partial denture – Resin base (Including clasps, rests and teeth)	$100.00
D5213	Upper partial denture – Cast metal framework (Including clasps, rests and teeth)	$100.00
D5214	Lower partial denture – Cast metal framework (Including clasps, rests and teeth)	$100.00
D5225	Upper partial denture – Flexible base (Including clasps, rests and teeth)	$165.00
D5226	Lower partial denture – Flexible base (Including clasps, rests and teeth)	$165.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D5281	Removable unilateral partial denture – One piece cast metal including clasps and teeth)	$100.00
D5410	Adjust complete denture – Upper	$0.00
D5411	Adjust complete denture – Lower	$0.00
D5421	Adjust partial denture – Upper	$0.00
D5422	Adjust partial denture – Lower	$0.00
D5850	Tissue conditioning – Upper	$0.00
D5851	Tissue conditioning – Lower	$0.00
D5862	Precision attachment – By report	$160.00
Repairs to prosthetics		
D5510	Repair broken complete denture base	$10.00
D5520	Replace missing or broken teeth – Complete denture (Each tooth)	$10.00
D5610	Repair resin denture base	$10.00
D5620	Repair cast framework	$10.00
D5630	Repair or replace broken clasp	$10.00
D5640	Replace broken teeth – Per tooth	$10.00
D5650	Add tooth to existing partial denture	$10.00
D5660	Add clasp to existing partial denture	$10.00
D5670	Replace all teeth and acrylic on cast metal framework – Upper	$135.00
D5671	Replace all teeth and acrylic on cast metal framework – Lower	$135.00
Denture relining (Limit 1 every 36 months)		
D5710	Rebase complete upper denture	$35.00
D5711	Rebase complete lower denture	$35.00
D5720	Rebase upper partial denture	$35.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D5721	Rebase lower partial denture	$35.00
D5730	Reline complete upper denture – Chairside	$20.00
D5731	Reline complete lower denture – Chairside	$20.00
D5740	Reline upper partial denture – Chairside	$20.00
D5741	Reline lower partial denture – Chairside	$20.00
D5750	Reline complete upper denture – Laboratory	$35.00
D5751	Reline complete lower denture – Laboratory	$35.00
D5760	Reline upper partial denture – Laboratory	$35.00
D5761	Reline lower partial denture – Laboratory	$35.00
Interim dentures (Limit 1 every 5 years)		
D5810	Interim complete denture – Upper	$100.00
D5811	Interim complete denture – Lower	$100.00
D5820	Interim partial denture – Upper	$35.00
D5821	Interim partial denture – Lower	$35.00
Implant services – Surgical placement of implants (D6010, D6012, D6040, and D6050 have a limit of 1 implant per calendar year with a replacement of 1 per 10 years)		
D6010	Surgical placement of implant body – Endosteal implant	$1,025.00
D6012	Surgical placement of interim implant body for transitional prosthesis – Endosteal implant	$365.00
D6040	Surgical placement – Eposteal implant	$870.00
D6050	Surgical placement – Transosteal implant	$850.00
D6055	Connecting bar – Implant supported or abutment supported *(Limit 1 per calendar year)*	$1,085.00
D6056	Prefabricated abutment – Includes modification and placement *(Limit 1 per calendar year)*	$355.00
D6057	Custom fabricated abutment – Includes placement *(Limit 1 per calendar year)*	$455.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis *(Limit 1 per calendar year)*	$60.00
D6090	Repair implant supported prosthesis, by report *(Limit 1 per calendar year)*	$120.00
D6091	Replacement of semi-precision or precision attachment (Male or female component) of implant/abutment supported prosthesis, per attachment *(Limit 1 per calendar year)*	$55.00
D6095	Repair implant abutment, by report *(Limit 1 per calendar year)*	$120.00
D6100	Implant removal, by report *(Limit 1 per calendar year)*	$225.00
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure *(Limit 1 per calendar year)*	$80.00
D6102	Debridement and osseous contouring of a periimplant defect – Includes surface cleaning of exposed implant surfaces and flap entry and closure *(Limit 1 per calendar year)*	$125.00
D6103	Bone graft for repair of periimplant defect – Not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration *(Limit 1 per calendar year)*	$135.00
D6104	Bone graft at time of implant placement *(Limit 1 per calendar year)*	$135.00
D6190	Radiographic/surgical implant index, by report *(Limit 1 per calendar year)*	$150.00

Code	Procedure Description	Patient Charge
	Implant/abutment supported prosthetics – All charges for crowns and bridges (Fixed partial dentures) are per unit (Each replacement on a supporting implant(s) equals 1 unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to 1 every 5 years. For single crowns, retainer ("Abutment") crowns, and pontics: The charges below include the cost of predominantly base metal alloy. You may be charged up to these additional amounts, based on the type of material the dentist uses for your restoration. • No more than $150.00 per tooth for any noble metal alloys, high noble metal alloys, titanium or titanium alloys • No more than $75.00 per tooth for any porcelain fused to metal (Only on molar teeth) • Porcelain/ceramic substrate crowns on molar teeth are not covered	
	In addition, you may be charged up to these additional amounts. • No more than $100.00 per tooth if an indirectly fabricated ("Cast") post and core is made of high noble metal alloy • No more than $150.00 per tooth for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (Ceramic) services. Same day in-office CAD/CAM (Ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine Complex rehabilitation on implant/abutment supported prosthetic procedures – An additional $125 charge per unit for multiple crown units/ complex rehabilitation *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – Ask your dentist for the guidelines)*	
D6053	Implant/abutment supported removable denture for completely edentulous arch	$600.00
D6054	Implant/abutment supported removable denture for partially edentulous arch	$600.00
D6058	Abutment supported porcelain/ceramic crown	$540.00
D6059	Abutment supported porcelain fused to metal crown (High noble metal)	$545.00
D6060	Abutment supported porcelain fused to metal crown (Predominantly base metal)	$395.00
D6061	Abutment supported porcelain fused to metal crown (Noble metal)	$545.00
D6062	Abutment supported cast metal crown (High noble metal)	$500.00
D6063	Abutment supported cast metal crown (Predominantly base metal)	$350.00
D6064	Abutment supported cast metal crown (Noble metal)	$500.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D6065	Implant supported porcelain/ceramic crown	$540.00
D6066	Implant supported porcelain fused to metal crown (Titanium, titanium alloy, high noble metal)	$545.00
D6067	Implant supported metal crown (Titanium, titanium alloy, high noble metal)	$500.00
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	$380.00
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture (High noble metal)	$530.00
D6070	Abutment supported retainer for porcelain fused to metal fixed partial denture (Predominantly base metal)	$380.00
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture (Noble metal)	$530.00
D6072	Abutment supported retainer for cast metal fixed partial denture (High noble metal)	$500.00
D6073	Abutment supported retainer for cast metal fixed partial denture (Predominantly base metal)	$350.00
D6074	Abutment supported retainer for cast metal fixed partial denture (Noble metal)	$500.00
D6075	Implant supported retainer for ceramic fixed partial denture	$380.00
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (Titanium, titanium alloy, high noble metal)	$530.00
D6077	Implant supported retainer for cast metal fixed partial denture (Titanium, titanium alloy, high noble metal)	$500.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch	$600.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch	$600.00
D6092	Recement implant/abutment supported crown	$40.00
D6093	Recement implant/abutment supported fixed partial denture	$40.00
D6094	Abutment supported crown (Titanium)	$500.00
D6194	Abutment supported retainer crown for fixed partial denture (Titanium)	$500.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
Oral surgery (Includes routine postoperative treatment) surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (Disease) exists.		
D7111	Extraction of coronal remnants – Deciduous tooth	$0.00
D7140	Extraction, erupted tooth or exposed root – Elevation and/or forceps removal	$0.00
D7210	Surgical removal of erupted tooth – Removal of bone and/or section of tooth	$5.00
D7220	Removal of impacted tooth – Soft tissue	$10.00
D7230	Removal of impacted tooth – Partially bony	$30.00
D7240	Removal of impacted tooth – Completely bony	$55.00
D7241	Removal of impacted tooth – Completely bony, unusual complications (Narrative required)	$80.00
D7250	Surgical removal of residual tooth roots – Cutting procedure	$0.00
D7251	Coronectomy – Intentional partial tooth removal	$30.00
D7260	Oroantral fistula closure	$60.00
D7261	Primary closure of a sinus perforation	$60.00
D7270	Tooth stabilization of accidentally evulsed or displaced tooth	$15.00
D7280	Surgical access of an unerupted tooth (Excluding wisdom teeth)	$15.00
D7283	Placement of device to facilitate eruption of impacted tooth	$0.00
D7285	Biopsy of oral tissue – Hard (Bone, tooth) (Tooth related – Not allowed when in conjunction with another surgical procedure)	$0.00
D7286	Biopsy of oral tissue – Soft (All others) (Tooth related – Not allowed when in conjunction with another surgical procedure)	$0.00
D7287	Exfoliative cytological sample collection	$50.00
D7288	Brush biopsy – Transepithelial sample collection	$50.00
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$0.00
D7311	Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$0.00
D7321	Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$0.00
D7450	Removal of benign odontogenic cyst or tumor – Up to 1.25 cm	$0.00
D7451	Removal of benign odontogenic cyst or tumor – Greater than 1.25 cm	$0.00
D7471	Removal of lateral exostosis – Maxilla or mandible	$0.00
D7472	Removal of torus palatinus	$0.00
D7473	Removal of torus mandibularis	$0.00
D7485	Surgical reduction of osseous tuberosity	$60.00
D7510	Incision and drainage of abscess – Intraoral soft tissue	$0.00
D7511	Incision and drainage of abscess – Intraoral soft tissue – Complicated	$15.00
D7520	Incision and drainage of abscess – Extraoral soft tissue	$15.00
D7521	Incision and drainage of abscess – Extraoral soft tissue – Complicated (Includes drainage of multiple fascial spaces)	$15.00
D7880	Occlusal orthotic device, by report *(Limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)*	$135.00
D7910	Suture of recent small wounds up to 5 cm	$15.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach *(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$850.00
D7952	Sinus augmentation via a vertical approach *(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$640.00
D7953	Bone replacement graft for ridge preservation – Per site *(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$100.00
D7960	Frenulectomy – Also known as frenectomy or frenotomy – Separate procedure not incidental to another procedure	$0.00
D7963	Frenuloplasty	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
Orthodontics (Tooth movement) orthodontic treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8050	Interceptive orthodontic treatment of the primary dentition – Banding	$370.00
D8060	Interceptive orthodontic treatment of the transitional dentition – Banding	$370.00
D8070	Comprehensive orthodontic treatment of the transitional dentition – Banding	$370.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition – Banding	$370.00
D8090	Comprehensive orthodontic treatment of the adult dentition – Banding	$370.00
D8210	Removable appliance therapy	$0.00
D8220	Fixed appliance therapy	$0.00
D8660	Pre-orthodontic treatment visit	$0.00
D8670	Periodic orthodontic treatment visit – As part of contract	
	Children – Up to 19th birthday:	
	24-month treatment fee	$984.00
	Charge per month for 24 months	$41.00
	Adults:	
	24-month treatment fee	$1,488.00
	Charge per month for 24 months	$62.00
D8680	Orthodontic retention – Removal of appliances, construction and placement of retainer(s)	$250.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0.00
D8999	Unspecified orthodontic procedure – By report (Orthodontic treatment plan and records)	$250.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
General anesthesia/IV sedation – General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or intravenous sedation when used for the purpose of anxiety control or patient management.		
D9211	Regional block anesthesia	$0.00
D9212	Trigeminal division block anesthesia	$0.00
D9215	Local anesthesia	$0.00
D9220	General anesthesia – First 30 minutes	$160.00
D9221	General anesthesia – Each additional 15 minutes	$75.00
D9241	IV conscious sedation – First 30 minutes	$160.00
D9242	IV conscious sedation – Each additional 15 minutes	$75.00
D9610	Therapeutic parenteral drug, single administration	$15.00
D9612	Therapeutic parenteral drugs, 2 or more administrations, different medications	$25.00
D9630	Other drugs and/or medicaments – By report	$15.00
D9910	Application of desensitizing medicament	$15.00
Emergency services		
D9110	Palliative (Emergency) treatment of dental pain – Minor procedure	$0.00
D9120	Fixed partial denture sectioning	$0.00
D9440	Office visit – After regularly scheduled hours	$15.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P2I0X)

Code	Procedure Description	Patient Charge
Miscellaneous services		
D9940	Occlusal guard – By report *(Limit 1 per 24 months)*	$85.00
D9941	Fabrication of athletic mouthguard *(Limit 1 per 12 months)*	$110.00
D9942	Repair and/or reline of occlusal guard	$40.00
D9951	Occlusal adjustment – Limited	$0.00
D9952	Occlusal adjustment – Complete	$0.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays *(All other methods of bleaching are not covered)*	$125.00

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling Cigna Dental at the toll free number listed on your ID card or plan materials. Multiple ways to locate a *DHMO Network General Dentist:

- Online provider directory at **Cigna.com**
- Online provider directory on **myCigna.com**
- Call the number located on your ID card to:
  - Use the Dental Office Locator via Speech Recognition
  - Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

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*The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

CIGNA DENTAL CARE® (*DHMO)
PATIENT CHARGE SCHEDULE

This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Cigna Dental as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialty Periodontist or Oral Surgeon. You must verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental. Prior authorization is not required for specialty referrals for Pediatric, Orthodontic and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 7 by calling Customer Service at 1.800.Cigna24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 7th birthday.
- Procedures not listed on this Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or nitrous oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.

Important Highlights (Continued)

- Cigna Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.
- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

Code	Procedure Description	Patient Charge
Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145).		
D9310	Consultation (Diagnostic service provided by dentist or physician other than requesting dentist or physician)	$7.00
D9430	Office visit for observation – No other services performed	$3.00
D9450	Case presentation – Detailed and extensive treatment planning	$0.00
D0120	Periodic oral evaluation – Established patient	$0.00
D0140	Limited oral evaluation – Problem focused	$0.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation – New or established patient	$0.00
D0160	Detailed and extensive oral evaluation – Problem focused, by report *(Limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D0170	Reevaluation – Limited, problem focused (Not postoperative visit)	$0.00
D0180	Comprehensive periodontal evaluation – New or established patient	$0.00
D0210	X-rays intraoral – Complete series of radiographic images *(Limit 1 every 3 years)*	$0.00
D0220	X-rays intraoral – Periapical – First radiographic image	$0.00
D0230	X-rays intraoral – Periapical – Each additional radiographic image	$0.00
D0240	X-rays intraoral – Occlusal radiographic image	$0.00
D0250	X-rays extraoral – First radiographic image	$0.00
D0260	X-rays extraoral – Each additional radiographic image	$0.00
D0270	X-rays (Bitewing) – Single radiographic image	$0.00
D0272	X-rays (Bitewings) – 2 radiographic images	$0.00
D0273	X-rays (Bitewings) – 3 radiographic images	$0.00
D0274	X-rays (Bitewings) – 4 radiographic images	$0.00
D0277	X-rays (Bitewings, vertical) – 7 to 8 radiographic images	$0.00
D0330	X-rays (Panoramic radiographic image) – *(Limit 1 every 3 years)*	$0.00
D0364	Cone beam CT capture and interpretation with limited field of view – Less than one whole jaw *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$200.00
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – Mandible *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$220.00
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – Maxilla, with or without cranium *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$220.00
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$240.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures *(Limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$240.00
D0350	Oral/facial photographic images	$0.00
D0415	Collection of microorganisms for culture and sensitivity	$0.00
D0425	Caries susceptibility tests	$0.00
D0431	Oral cancer screening using a special light source	$50.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00
D0472	Pathology report – Gross examination of lesion (Only when tooth related)	$0.00
D0473	Pathology report – Microscopic examination of lesion (Only when tooth related)	$0.00
D0474	Pathology report – Microscopic examination of lesion and area (Only when tooth related)	$0.00
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0.00
D1110	Prophylaxis (Cleaning) – Adult (*Limit 2 per calendar year*)	$0.00
	Additional prophylaxis (Cleaning) – In addition to the 2 prophylaxes (Cleanings) allowed per calendar year	$45.00
D1120	Prophylaxis (Cleaning) – Child (*Limit 2 per calendar year*)	$0.00
	Additional prophylaxis (Cleaning) – In addition to the 2 prophylaxes (Cleanings) allowed per calendar year	$35.00
D1206	Topical application of fluoride varnish *(Limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.*	$0.00
	Additional topical application of fluoride varnish – In addition to any combination of two (2) D1206s (Topical application of fluoride varnish) and/or D1208s (Topical application of fluoride) per calendar year.	$15.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D1208	Topical application of fluoride (*Limit 2 per calendar year*). *There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.*	$0.00
	Additional topical application of fluoride – In addition to any combination of two (2) D1206s (Topical applications of fluoride varnish) and/or D1208s (Topical application of fluoride) per calendar year.	$15.00
D1310	Nutritional counseling for control of dental disease	$0.00
D1320	Tobacco counseling for the control and prevention of oral disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant – Per tooth	$7.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth	$7.00
D1510	Space maintainer – Fixed – Unilateral	$17.00
D1515	Space maintainer – Fixed – Bilateral	$17.00
D1520	Space maintainer – Removable – Unilateral	$25.00
D1525	Space maintainer – Removable – Bilateral	$25.00
D1550	Recementation of space maintainer	$3.00
D1555	Removal of fixed space maintainer	$3.00
Restorative (Fillings, including polishing)		
D2140	Amalgam – 1 surface, primary or permanent	$0.00
D2150	Amalgam – 2 surfaces, primary or permanent	$0.00
D2160	Amalgam – 3 surfaces, primary or permanent	$0.00
D2161	Amalgam – 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite – 1 surface, anterior	$0.00
D2331	Resin-based composite – 2 surfaces, anterior	$0.00
D2332	Resin-based composite – 3 surfaces, anterior	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle, anterior	$0.00
D2390	Resin-based composite crown, anterior	$30.00
D2391	Resin-based composite – 1 surface, posterior	$45.00
D2392	Resin-based composite – 2 surfaces, posterior	$55.00
D2393	Resin-based composite – 3 surfaces, posterior	$65.00
D2394	Resin-based composite – 4 or more surfaces, posterior	$70.00
Crown and bridge – All charges for crowns and bridges (Fixed partial dentures) are per unit (Each replacement or supporting tooth equals 1 unit). Coverage for replacement of crowns and bridges is limited to 1 every 5 years. For single crowns, retainer ("Abutment") crowns, and pontics: The charges below include the cost of predominantly base metal alloy. You may be charged up to these additional amounts, based on the type of material the dentist uses for your restoration. • No more than $150.00 per tooth for any noble metal alloys, high noble metal alloys, titanium or titanium alloys • No more than $75.00 per tooth for any porcelain fused to metal (Only on molar teeth) • Porcelain/ceramic substrate crowns on molar teeth are not covered		
	In addition, you may be charged up to these additional amounts. • No more than $100.00 per tooth if an indirectly fabricated ("Cast") post and core is made of high noble metal alloy • No more than $150.00 per tooth for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (Ceramic) services. Same day in-office CAD/CAM (Ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine Complex rehabilitation – An additional $125 charge per unit for multiple crown units/complex rehabilitation *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – Ask your dentist for the guidelines)*	
D2510	Inlay – Metallic – 1 surface	$130.00
D2520	Inlay – Metallic – 2 surfaces	$130.00
D2530	Inlay – Metallic – 3 or more surfaces	$130.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D2542	Onlay – Metallic – 2 surfaces	$130.00
D2543	Onlay – Metallic – 3 surfaces	$130.00
D2544	Onlay – Metallic – 4 or more surfaces	$130.00
D2740	Crown – Porcelain/ceramic substrate	$220.00
D2750	Crown – Porcelain fused to high noble metal	$130.00
D2751	Crown – Porcelain fused to predominantly base metal	$130.00
D2752	Crown – Porcelain fused to noble metal	$130.00
D2780	Crown – 3/4 cast high noble metal	$130.00
D2781	Crown – 3/4 cast predominantly base metal	$130.00
D2782	Crown – 3/4 cast noble metal	$130.00
D2783	Crown – 3/4 porcelain/ceramic	$130.00
D2790	Crown – Full cast high noble metal	$130.00
D2791	Crown – Full cast predominantly base metal	$130.00
D2792	Crown – Full cast noble metal	$130.00
D2794	Crown – Titanium	$130.00
D2799	Provisional crown	$100.00
D2610	Inlay – Porcelain/ceramic, 1 surface	$130.00
D2620	Inlay – Porcelain/ceramic, 2 surfaces	$130.00
D2630	Inlay – Porcelain/ceramic, 3 or more surfaces	$130.00
D2642	Onlay – Porcelain/ceramic, 2 surfaces	$130.00
D2643	Onlay – Porcelain/ceramic, 3 surfaces	$130.00
D2644	Onlay – Porcelain/ceramic, 4 or more surfaces	$130.00
D2650	Inlay – Resin-based composite, 1 surface	$130.00
D2651	Inlay – Resin-based composite, 2 surfaces	$130.00
D2652	Inlay – Resin-based composite, 3 or more surfaces	$130.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D2662	Onlay – Resin-based composite, 2 surfaces	$130.00
D2663	Onlay – Resin-based composite, 3 surfaces	$130.00
D2664	Onlay – Resin-based composite, 4 or more surfaces	$130.00
D2710	Crown – Resin-based composite, indirect	$130.00
D2712	Crown – 3/4 resin-based composite, indirect	$130.00
D2720	Crown – Resin with high noble metal	$130.00
D2721	Crown – Resin with predominantly base metal	$130.00
D2722	Crown – Resin with noble metal	$130.00
D2910	Recement inlay – Onlay or partial coverage restoration	$0.00
D2915	Recement cast or prefabricated post and core	$0.00
D2920	Recement crown	$0.00
D2929	Prefabricated porcelain/ceramic crown – Primary tooth	$95.00
D2930	Prefabricated stainless steel crown – Primary tooth	$17.00
D2931	Prefabricated stainless steel crown – Permanent tooth	$17.00
D2932	Prefabricated resin crown	$25.00
D2933	Prefabricated stainless steel crown with resin window	$25.00
D2934	Prefabricated esthetic coated stainless steel crown – Primary tooth	$95.00
D2940	Protective restoration	$3.00
D2950	Core buildup – Including any pins	$40.00
D2951	Pin retention – Per tooth – In addition to restoration	$10.00
D2952	Post and core – In addition to crown, indirectly fabricated	$45.00
D2953	Each additional indirectly prefabricated post – Same tooth	$45.00
D2954	Prefabricated post and core – In addition to crown	$30.00
D2957	Each additional prefabricated post – Same tooth	$25.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D2960	Labial veneer (Resin laminate) – Chairside	$250.00
D2970	Temporary crown (Fractured tooth)	$3.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$45.00
D2980	Crown repair, necessitated by restorative material failure	$10.00
D6210	Pontic – Cast high noble metal	$130.00
D6211	Pontic – Cast predominantly base metal	$130.00
D6212	Pontic – Cast noble metal	$130.00
D6214	Pontic – Titanium	$130.00
D6240	Pontic – Porcelain fused to high noble metal	$130.00
D6241	Pontic – Porcelain fused to predominantly base metal	$130.00
D6242	Pontic – Porcelain fused to noble metal	$130.00
D6245	Pontic – Porcelain/ceramic	$130.00
D6250	Pontic – Resin with high noble metal	$130.00
D6251	Pontic – Resin with predominantly base metal	$130.00
D6252	Pontic – Resin with noble metal	$130.00
D6253	Provisional pontic	$130.00
D6545	Retainer – Cast metal for resin bonded fixed prosthesis	$130.00
D6600	Inlay – Porcelain/ceramic, 2 surfaces	$130.00
D6601	Inlay – Porcelain/ceramic, 3 or more surfaces	$130.00
D6602	Inlay – Cast high noble metal, 2 surfaces	$130.00
D6603	Inlay – Cast high noble metal, 3 or more surfaces	$130.00
D6604	Inlay – Cast predominantly base metal, 2 surfaces	$130.00
D6605	Inlay – Cast predominantly base metal, 3 or more surfaces	$130.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6606	Inlay – Cast noble metal, 2 surfaces	$130.00
D6607	Inlay – Cast noble metal, 3 or more surfaces	$130.00
D6608	Onlay – Porcelain/ceramic, 2 surfaces	$130.00
D6609	Onlay – Porcelain/ceramic, 3 or more surfaces	$130.00
D6610	Onlay – Cast high noble metal, 2 surfaces	$130.00
D6611	Onlay – Cast high noble metal, 3 or more surfaces	$130.00
D6612	Onlay – Cast predominantly base metal, 2 surfaces	$130.00
D6613	Onlay – Cast predominantly base metal, 3 or more surfaces	$130.00
D6614	Onlay – Cast noble metal, 2 surfaces	$130.00
D6615	Onlay – Cast noble metal, 3 or more surfaces	$130.00
D6624	Inlay – Titanium	$130.00
D6634	Onlay – Titanium	$130.00
D6710	Crown – Indirect resin based composite	$130.00
D6720	Crown – Resin with high noble metal	$130.00
D6721	Crown – Resin with predominantly base metal	$130.00
D6722	Crown – Resin with noble metal	$130.00
D6740	Crown – Porcelain/ceramic	$130.00
D6750	Crown – Porcelain fused to high noble metal	$130.00
D6751	Crown – Porcelain fused to predominantly base metal	$130.00
D6752	Crown – Porcelain fused to noble metal	$130.00
D6780	Crown – 3/4 cast high noble metal	$130.00
D6781	Crown – 3/4 cast predominantly base metal	$130.00
D6782	Crown – 3/4 cast noble metal	$130.00
D6783	Crown – 3/4 porcelain/ceramic	$130.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6790	Crown – Full cast high noble metal	$130.00
D6791	Crown – Full cast predominantly base metal	$130.00
D6792	Crown – Full cast noble metal	$130.00
D6794	Crown – Titanium	$130.00
D6930	Recement fixed partial denture	$0.00
D6950	Precision attachment	$195.00
Endodontics (Root canal treatment, excluding final restorations)		
D3110	Pulp cap – Direct (Excluding final restoration)	$0.00
D3120	Pulp cap – Indirect (Excluding final restoration)	$0.00
D3220	Pulpotomy – Removal of pulp, not part of a root canal	$7.00
D3221	Pulpal debridement (Not to be used when root canal is done on the same day)	$35.00
D3222	Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development	$17.00
D3230	Pulpal therapy (Resorbable filling) – Anterior, primary tooth (Excluding final restoration)	$20.00
D3240	Pulpal therapy (Resorbable filling) – Posterior, primary tooth (Excluding final restoration)	$30.00
D3310	Anterior root canal – Permanent tooth (Excluding final restoration)	$65.00
D3320	Bicuspid root canal – Permanent tooth (Excluding final restoration)	$95.00
D3330	Molar root canal – Permanent tooth (Excluding final restoration)	$195.00
D3331	Treatment of root canal obstruction – Nonsurgical access	$70.00
D3332	Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth	$60.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy – Anterior	$105.00
D3347	Retreatment of previous root canal therapy – Bicuspid	$140.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D3348	Retreatment of previous root canal therapy – Molar	$220.00
D3351	Apexification/recalcification – Initial visit (Apical closure/calcific repair of perforations, root resorption, etc.)	$75.00
D3352	Apexification/recalcification – Interim medication replacement (Apical closure/calcific repair of perforations, root resorption, etc.)	$60.00
D3353	Apexification/recalcification – Final visit (Includes completed root canal therapy – Apical closure/calcific repair of perforations, root resorption, etc.)	$60.00
D3410	Apicoectomy/periradicular surgery – Anterior	$85.00
D3421	Apicoectomy/periradicular surgery – Bicuspid (First root)	$90.00
D3425	Apicoectomy/periradicular surgery – Molar (First root)	$90.00
D3426	Apicoectomy/periradicular surgery (Each additional root)	$60.00
D3430	Retrograde filling – Per root	$45.00
D3450	Root amputation – Per root	$65.00
D3920	Hemisection (Including any root removal), not including root canal therapy	$70.00
Periodontics (Treatment of supporting tissues (Gum and bone) of the teeth) periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. The relevant procedure codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 teeth (or 8 sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.		
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$100.00
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	$65.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$65.00
D4240	Gingival flap (Including root planing) – 4 or more teeth per quadrant	$135.00
D4241	Gingival flap (Including root planing) – 1 to 3 teeth per quadrant	$105.00
D4245	Apically positioned flap	$150.00
D4249	Clinical crown lengthening – Hard tissue	$125.00
D4260	Osseous surgery – 4 or more teeth per quadrant	$250.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D4261	Osseous surgery – 1 to 3 teeth per quadrant	$195.00
D4263	Bone replacement graft – First site in quadrant	$185.00
D4264	Bone replacement graft – Each additional site in quadrant	$90.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95.00
D4266	Guided tissue regeneration – Resorbable barrier per site	$215.00
D4267	Guided tissue regeneration – Nonresorbable barrier per site (Includes membrane removal)	$255.00
D4270	Pedicle soft tissue graft procedure	$195.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$75.00
D4274	Distal or proximal wedge procedure (When not performed in conjunction with surgical procedures in the same anatomical area)	$65.00
D4275	Soft tissue allograft	$295.00
D4277	Free soft tissue graft procedure (Including donor site surgery), first tooth or edentulous *(missing)* tooth position in graft	$205.00
D4278	Free soft tissue graft procedure (Including donor site surgery), each additional contiguous tooth or edentulous *(missing)* tooth position in same graft site	$105.00
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant *(Limit 4 quadrants per consecutive 12 months)*	$35.00
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant *(Limit 4 quadrants per consecutive 12 months)*	$25.00
D4355	Full mouth debridement to allow evaluation and diagnosis *(1 per lifetime)*	$35.00
D4381	Localized delivery of antimicrobial agents per tooth	$60.00
D4910	Periodontal maintenance *(Limit 4 per calendar year) (Only covered after active periodontal therapy)*	$25.00
	Additional periodontal maintenance procedures *(Beyond 4 per calendar year)*	$50.00
	Periodontal charting for planning treatment of periodontal disease	$0.00
	Periodontal hygiene instruction	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
Prosthetics (Removable tooth replacement – Dentures) includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years. Characterization is considered an upgrade with maximum additional charge to the member of $200.00 per denture.		
D5110	Full upper denture	$135.00
D5120	Full lower denture	$135.00
D5130	Immediate full upper denture	$145.00
D5140	Immediate full lower denture	$145.00
D5211	Upper partial denture – Resin base (Including clasps, rests and teeth)	$135.00
D5212	Lower partial denture – Resin base (Including clasps, rests and teeth)	$135.00
D5213	Upper partial denture – Cast metal framework (Including clasps, rests and teeth)	$140.00
D5214	Lower partial denture – Cast metal framework (Including clasps, rests and teeth)	$140.00
D5225	Upper partial denture – Flexible base (Including clasps, rests and teeth)	$165.00
D5226	Lower partial denture – Flexible base (Including clasps, rests and teeth)	$165.00
D5281	Removable unilateral partial denture – One piece cast metal including clasps and teeth)	$135.00
D5410	Adjust complete denture – Upper	$7.00
D5411	Adjust complete denture – Lower	$7.00
D5421	Adjust partial denture – Upper	$7.00
D5422	Adjust partial denture – Lower	$7.00
D5850	Tissue conditioning – Upper	$7.00
D5851	Tissue conditioning – Lower	$7.00
D5862	Precision attachment – By report	$160.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
Repairs to prosthetics		
D5510	Repair broken complete denture base	$25.00
D5520	Replace missing or broken teeth – Complete denture (Each tooth)	$25.00
D5610	Repair resin denture base	$25.00
D5620	Repair cast framework	$25.00
D5630	Repair or replace broken clasp	$30.00
D5640	Replace broken teeth – Per tooth	$25.00
D5650	Add tooth to existing partial denture	$25.00
D5660	Add clasp to existing partial denture	$30.00
D5670	Replace all teeth and acrylic on cast metal framework – Upper	$155.00
D5671	Replace all teeth and acrylic on cast metal framework – Lower	$155.00
Denture relining (Limit 1 every 36 months)		
D5710	Rebase complete upper denture	$55.00
D5711	Rebase complete lower denture	$55.00
D5720	Rebase upper partial denture	$55.00
D5721	Rebase lower partial denture	$55.00
D5730	Reline complete upper denture – Chairside	$30.00
D5731	Reline complete lower denture – Chairside	$30.00
D5740	Reline upper partial denture – Chairside	$30.00
D5741	Reline lower partial denture – Chairside	$30.00
D5750	Reline complete upper denture – Laboratory	$55.00
D5751	Reline complete lower denture – Laboratory	$55.00
D5760	Reline upper partial denture – Laboratory	$55.00
D5761	Reline lower partial denture – Laboratory	$55.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
Interim dentures (Limit 1 every 5 years)		
D5810	Interim complete denture – Upper	$190.00
D5811	Interim complete denture – Lower	$190.00
D5820	Interim partial denture – Upper	$65.00
D5821	Interim partial denture – Lower	$65.00
Implant services – Surgical placement of implants (D6010, D6012, D6040, and D6050 have a limit of 1 implant per calendar year with a replacement of 1 per 10 years)		
D6010	Surgical placement of implant body – Endosteal implant	$1,025.00
D6012	Surgical placement of interim implant body for transitional prosthesis – Endosteal implant	$405.00
D6040	Surgical placement – Eposteal implant	$970.00
D6050	Surgical placement – Transosteal implant	$950.00
D6055	Connecting bar – Implant supported or abutment supported *(Limit 1 per calendar year)*	$1,210.00
D6056	Prefabricated abutment – Includes modification and placement *(Limit 1 per calendar year)*	$355.00
D6057	Custom fabricated abutment – Includes placement *(Limit 1 per calendar year)*	$455.00
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis *(Limit 1 per calendar year)*	$65.00
D6090	Repair implant supported prosthesis, by report *(Limit 1 per calendar year)*	$135.00
D6091	Replacement of semi-precision or precision attachment (Male or female component) of implant/abutment supported prosthesis, per attachment *(Limit 1 per calendar year)*	$60.00
D6095	Repair implant abutment, by report *(Limit 1 per calendar year)*	$130.00
D6100	Implant removal, by report *(Limit 1 per calendar year)*	$255.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure *(Limit 1 per calendar year)*	$105.00
D6102	Debridement and osseous contouring of a periimplant defect – Includes surface cleaning of exposed implant surfaces and flap entry and closure *(Limit 1 per calendar year)*	$195.00
D6103	Bone graft for repair of periimplant defect – Not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration *(Limit 1 per calendar year)*	$185.00
D6104	Bone graft at time of implant placement *(Limit 1 per calendar year)*	$185.00
D6190	Radiographic/surgical implant index, by report *(Limit 1 per calendar year)*	$170.00
Implant/abutment supported prosthetics – All charges for crowns and bridges (Fixed partial dentures) are per unit (Each replacement on a supporting implant(s) equals 1 unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to 1 every 5 years. For single crowns, retainer ("Abutment") crowns, and pontics: The charges below include the cost of predominantly base metal alloy. You may be charged up to these additional amounts, based on the type of material the dentist uses for your restoration. • No more than $150.00 per tooth for any noble metal alloys, high noble metal alloys, titanium or titanium alloys • No more than $75.00 per tooth for any porcelain fused to metal (Only on molar teeth) • Porcelain/ceramic substrate crowns on molar teeth are not covered		
	In addition, you may be charged up to these additional amounts. • No more than $100.00 per tooth if an indirectly fabricated ("Cast") post and core is made of high noble metal alloy • No more than $150.00 per tooth for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (Ceramic) services. Same day in-office CAD/CAM (Ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine Complex rehabilitation on implant/abutment supported prosthetic procedures – An additional $125 charge per unit for multiple crown units/complex rehabilitation *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – Ask your dentist for the guidelines)*	

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6053	Implant/abutment supported removable denture for completely edentulous arch	$635.00
D6054	Implant/abutment supported removable denture for partially edentulous arch	$640.00
D6058	Abutment supported porcelain/ceramic crown	$560.00
D6059	Abutment supported porcelain fused to metal crown (High noble metal)	$625.00
D6060	Abutment supported porcelain fused to metal crown (Predominantly base metal)	$475.00
D6061	Abutment supported porcelain fused to metal crown (Noble metal)	$625.00
D6062	Abutment supported cast metal crown (High noble metal)	$580.00
D6063	Abutment supported cast metal crown (Predominantly base metal)	$430.00
D6064	Abutment supported cast metal crown (Noble metal)	$580.00
D6065	Implant supported porcelain/ceramic crown	$560.00
D6066	Implant supported porcelain fused to metal crown (Titanium, titanium alloy, high noble metal)	$625.00
D6067	Implant supported metal crown (Titanium, titanium alloy, high noble metal)	$580.00
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	$460.00
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture (High noble metal)	$610.00
D6070	Abutment supported retainer for porcelain fused to metal fixed partial denture (Predominantly base metal)	$460.00
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture (Noble metal)	$610.00
D6072	Abutment supported retainer for cast metal fixed partial denture (High noble metal)	$580.00
D6073	Abutment supported retainer for cast metal fixed partial denture (Predominantly base metal)	$430.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D6074	Abutment supported retainer for cast metal fixed partial denture (Noble metal)	$580.00
D6075	Implant supported retainer for ceramic fixed partial denture	$460.00
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (Titanium, titanium alloy, high noble metal)	$610.00
D6077	Implant supported retainer for cast metal fixed partial denture (Titanium, titanium alloy, high noble metal)	$580.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch	$635.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch	$640.00
D6092	Recement implant/abutment supported crown	$40.00
D6093	Recement implant/abutment supported fixed partial denture	$40.00
D6094	Abutment supported crown (Titanium)	$580.00
D6194	Abutment supported retainer crown for fixed partial denture (Titanium)	$580.00
Oral surgery (Includes routine postoperative treatment) surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (Disease) exists.		
D7111	Extraction of coronal remnants – Deciduous tooth	$3.00
D7140	Extraction, erupted tooth or exposed root – Elevation and/or forceps removal	$3.00
D7210	Surgical removal of erupted tooth – Removal of bone and/or section of tooth	$25.00
D7220	Removal of impacted tooth – Soft tissue	$40.00
D7230	Removal of impacted tooth – Partially bony	$60.00
D7240	Removal of impacted tooth – Completely bony	$80.00
D7241	Removal of impacted tooth – Completely bony, unusual complications (Narrative required)	$100.00
D7250	Surgical removal of residual tooth roots – Cutting procedure	$30.00
D7251	Coronectomy – Intentional partial tooth removal	$60.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D7260	Oroantral fistula closure	$90.00
D7261	Primary closure of a sinus perforation	$90.00
D7270	Tooth stabilization of accidentally evulsed or displaced tooth	$65.00
D7280	Surgical access of an unerupted tooth (Excluding wisdom teeth)	$65.00
D7283	Placement of device to facilitate eruption of impacted tooth	$60.00
D7285	Biopsy of oral tissue – Hard (Bone, tooth) (Tooth related – Not allowed when in conjunction with another surgical procedure)	$0.00
D7286	Biopsy of oral tissue – Soft (All others) (Tooth related – Not allowed when in conjunction with another surgical procedure)	$0.00
D7287	Exfoliative cytological sample collection	$50.00
D7288	Brush biopsy – Transepithelial sample collection	$50.00
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$35.00
D7311	Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$35.00
D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$50.00
D7321	Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$50.00
D7450	Removal of benign odontogenic cyst or tumor – Up to 1.25 cm	$0.00
D7451	Removal of benign odontogenic cyst or tumor – Greater than 1.25 cm	$0.00
D7471	Removal of lateral exostosis – Maxilla or mandible	$55.00
D7472	Removal of torus palatinus	$40.00
D7473	Removal of torus mandibularis	$40.00
D7485	Surgical reduction of osseous tuberosity	$60.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D7510	Incision and drainage of abscess – Intraoral soft tissue	$20.00
D7511	Incision and drainage of abscess – Intraoral soft tissue – Complicated	$25.00
D7520	Incision and drainage of abscess – Extraoral soft tissue	$25.00
D7521	Incision and drainage of abscess – Extraoral soft tissue – Complicated (Includes drainage of multiple fascial spaces)	$25.00
D7880	Occlusal orthotic device, by report *(Limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)*	$150.00
D7910	Suture of recent small wounds up to 5 cm	$25.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach *(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$850.00
D7952	Sinus augmentation via a vertical approach *(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$640.00
D7953	Bone replacement graft for ridge preservation – Per site *(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$100.00
D7960	Frenulectomy – Also known as frenectomy or frenotomy – Separate procedure not incidental to another procedure	$30.00
D7963	Frenuloplasty	$30.00
Orthodontics (Tooth movement) orthodontic treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8050	Interceptive orthodontic treatment of the primary dentition – Banding	$390.00
D8060	Interceptive orthodontic treatment of the transitional dentition – Banding	$390.00
D8070	Comprehensive orthodontic treatment of the transitional dentition – Banding	$390.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition – Banding	$390.00
D8090	Comprehensive orthodontic treatment of the adult dentition – Banding	$390.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D8210	Removable appliance therapy	$0.00
D8220	Fixed appliance therapy	$0.00
D8660	Pre-orthodontic treatment visit	$85.00
D8670	Periodic orthodontic treatment visit – As part of contract	
	Children – Up to 19th birthday:	
	24-month treatment fee	$1,224.00
	Charge per month for 24 months	$51.00
	Adults:	
	24-month treatment fee	$1,728.00
	Charge per month for 24 months	$72.00
D8680	Orthodontic retention – Removal of appliances, construction and placement of retainer(s)	$270.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0.00
D8999	Unspecified orthodontic procedure – By report (Orthodontic treatment plan and records)	$265.00
General anesthesia/IV sedation – General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or intravenous sedation when used for the purpose of anxiety control or patient management.		
D9211	Regional block anesthesia	$0.00
D9212	Trigeminal division block anesthesia	$0.00
D9215	Local anesthesia	$0.00
D9220	General anesthesia – First 30 minutes	$160.00
D9221	General anesthesia – Each additional 15 minutes	$75.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P4I0X)

Code	Procedure Description	Patient Charge
D9241	IV conscious sedation – First 30 minutes	$160.00
D9242	IV conscious sedation – Each additional 15 minutes	$75.00
D9610	Therapeutic parenteral drug, single administration	$15.00
D9612	Therapeutic parenteral drugs, 2 or more administrations, different medications	$25.00
D9630	Other drugs and/or medicaments – By report	$15.00
D9910	Application of desensitizing medicament	$15.00
Emergency services		
D9110	Palliative (Emergency) treatment of dental pain – Minor procedure	$3.00
D9120	Fixed partial denture sectioning	$0.00
D9440	Office visit – After regularly scheduled hours	$25.00
Miscellaneous services		
D9940	Occlusal guard – By report *(Limit 1 per 24 months)*	$95.00
D9941	Fabrication of athletic mouthguard *(Limit 1 per 12 months)*	$110.00
D9942	Repair and/or reline of occlusal guard	$40.00
D9951	Occlusal adjustment – Limited	$25.00
D9952	Occlusal adjustment – Complete	$40.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays *(All other methods of bleaching are not covered)*	$125.00

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling Cigna Dental at the toll free number listed on your ID card or plan materials. Multiple ways to locate a *DHMO Network General Dentist:

- Online provider directory at **Cigna.com**
- Online provider directory on **myCigna.com**
- Call the number located on your ID card to:
  - Use the Dental Office Locator via Speech Recognition
  - Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

*The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

CIGNA DENTAL CARE® (*DHMO)
PATIENT CHARGE SCHEDULE

This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Cigna Dental as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialty Periodontist or Oral Surgeon. You must verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental. Prior authorization is not required for specialty referrals for Pediatric, Orthodontic and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 7 by calling Customer Service at 1.800.Cigna24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 7th birthday.
- Procedures not listed on this Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or nitrous oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.

Important Highlights (Continued)

- Cigna Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.
- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

Code	Procedure Description	Patient Charge
Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145).		
D9310	Consultation (Diagnostic service provided by dentist or physician other than requesting dentist or physician)	$10.00
D9430	Office visit for observation – No other services performed	$5.00
D9450	Case presentation – Detailed and extensive treatment planning	$0.00
D0120	Periodic oral evaluation – Established patient	$0.00
D0140	Limited oral evaluation – Problem focused	$0.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation – New or established patient	$0.00
D0160	Detailed and extensive oral evaluation – Problem focused, by report *(Limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D0170	Reevaluation – Limited, problem focused (Not postoperative visit)	$0.00
D0180	Comprehensive periodontal evaluation – New or established patient	$0.00
D0210	X-rays intraoral – Complete series of radiographic images *(Limit 1 every 3 years)*	$0.00
D0220	X-rays intraoral – Periapical – First radiographic image	$0.00
D0230	X-rays intraoral – Periapical – Each additional radiographic image	$0.00
D0240	X-rays intraoral – Occlusal radiographic image	$0.00
D0250	X-rays extraoral – First radiographic image	$0.00
D0260	X-rays extraoral – Each additional radiographic image	$0.00
D0270	X-rays (Bitewing) – Single radiographic image	$0.00
D0272	X-rays (Bitewings) – 2 radiographic images	$0.00
D0273	X-rays (Bitewings) – 3 radiographic images	$0.00
D0274	X-rays (Bitewings) – 4 radiographic images	$0.00
D0277	X-rays (Bitewings, vertical) – 7 to 8 radiographic images	$0.00
D0330	X-rays (Panoramic radiographic image) – *(Limit 1 every 3 years)*	$0.00
D0364	Cone beam CT capture and interpretation with limited field of view – Less than one whole jaw *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$200.00
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – Mandible *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$220.00
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – Maxilla, with or without cranium *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$220.00
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium *(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366 or D0367 per calendar year)*	$240.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures *(Limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)*	$240.00
D0350	Oral/facial photographic images	$0.00
D0415	Collection of microorganisms for culture and sensitivity	$0.00
D0425	Caries susceptibility tests	$0.00
D0431	Oral cancer screening using a special light source	$50.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00
D0472	Pathology report – Gross examination of lesion (Only when tooth related)	$0.00
D0473	Pathology report – Microscopic examination of lesion (Only when tooth related)	$0.00
D0474	Pathology report – Microscopic examination of lesion and area (Only when tooth related)	$0.00
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$0.00
D1110	Prophylaxis (Cleaning) – Adult (*Limit 2 per calendar year*)	$0.00
	Additional prophylaxis (Cleaning) – In addition to the 2 prophylaxes (Cleanings) allowed per calendar year	$45.00
D1120	Prophylaxis (Cleaning) – Child (*Limit 2 per calendar year*)	$0.00
	Additional prophylaxis (Cleaning) – In addition to the 2 prophylaxes (Cleanings) allowed per calendar year	$35.00
D1206	Topical application of fluoride varnish *(Limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.*	$0.00
	Additional topical application of fluoride varnish – In addition to any combination of two (2) D1206s (Topical application of fluoride varnish) and/or D1208s (Topical application of fluoride) per calendar year.	$15.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D1208	Topical application of fluoride (*Limit 2 per calendar year*). *There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.*	$0.00
	Additional topical application of fluoride – In addition to any combination of two (2) D1206s (Topical applications of fluoride varnish) and/or D1208s (Topical application of fluoride) per calendar year.	$15.00
D1310	Nutritional counseling for control of dental disease	$0.00
D1320	Tobacco counseling for the control and prevention of oral disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant – Per tooth	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth	$10.00
D1510	Space maintainer – Fixed – Unilateral	$25.00
D1515	Space maintainer – Fixed – Bilateral	$25.00
D1520	Space maintainer – Removable – Unilateral	$35.00
D1525	Space maintainer – Removable – Bilateral	$35.00
D1550	Recementation of space maintainer	$5.00
D1555	Removal of fixed space maintainer	$5.00
Restorative (Fillings, including polishing)		
D2140	Amalgam – 1 surface, primary or permanent	$0.00
D2150	Amalgam – 2 surfaces, primary or permanent	$0.00
D2160	Amalgam – 3 surfaces, primary or permanent	$0.00
D2161	Amalgam – 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite – 1 surface, anterior	$0.00
D2331	Resin-based composite – 2 surfaces, anterior	$0.00
D2332	Resin-based composite – 3 surfaces, anterior	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle, anterior	$0.00
D2390	Resin-based composite crown, anterior	$35.00
D2391	Resin-based composite – 1 surface, posterior	$55.00
D2392	Resin-based composite – 2 surfaces, posterior	$65.00
D2393	Resin-based composite – 3 surfaces, posterior	$75.00
D2394	Resin-based composite – 4 or more surfaces, posterior	$85.00
	Crown and bridge – All charges for crowns and bridges (Fixed partial dentures) are per unit (Each replacement or supporting tooth equals 1 unit). Coverage for replacement of crowns and bridges is limited to 1 every 5 years. For single crowns, retainer ("Abutment") crowns, and pontics: The charges below include the cost of predominantly base metal alloy. You may be charged up to these additional amounts, based on the type of material the dentist uses for your restoration. • No more than $150.00 per tooth for any noble metal alloys, high noble metal alloys, titanium or titanium alloys • No more than $75.00 per tooth for any porcelain fused to metal (Only on molar teeth) • Porcelain/ceramic substrate crowns on molar teeth are not covered	
	In addition, you may be charged up to these additional amounts. • No more than $100.00 per tooth if an indirectly fabricated ("Cast") post and core is made of high noble metal alloy • No more than $150.00 per tooth for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (Ceramic) services. Same day in-office CAD/CAM (Ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine Complex rehabilitation – An additional $125 charge per unit for multiple crown units/complex rehabilitation *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – Ask your dentist for the guidelines)*	
D2510	Inlay – Metallic – 1 surface	$185.00
D2520	Inlay – Metallic – 2 surfaces	$185.00
D2530	Inlay – Metallic – 3 or more surfaces	$185.00
D2542	Onlay – Metallic – 2 surfaces	$185.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D2543	Onlay – Metallic – 3 surfaces	$185.00
D2544	Onlay – Metallic – 4 or more surfaces	$185.00
D2740	Crown – Porcelain/ceramic substrate	$225.00
D2750	Crown – Porcelain fused to high noble metal	$185.00
D2751	Crown – Porcelain fused to predominantly base metal	$185.00
D2752	Crown – Porcelain fused to noble metal	$185.00
D2780	Crown – 3/4 cast high noble metal	$185.00
D2781	Crown – 3/4 cast predominantly base metal	$185.00
D2782	Crown – 3/4 cast noble metal	$185.00
D2783	Crown – 3/4 porcelain/ceramic	$185.00
D2790	Crown – Full cast high noble metal	$185.00
D2791	Crown – Full cast predominantly base metal	$185.00
D2792	Crown – Full cast noble metal	$185.00
D2794	Crown – Titanium	$185.00
D2799	Provisional crown	$100.00
D2610	Inlay – Porcelain/ceramic, 1 surface	$185.00
D2620	Inlay – Porcelain/ceramic, 2 surfaces	$185.00
D2630	Inlay – Porcelain/ceramic, 3 or more surfaces	$185.00
D2642	Onlay – Porcelain/ceramic, 2 surfaces	$185.00
D2643	Onlay – Porcelain/ceramic, 3 surfaces	$185.00
D2644	Onlay – Porcelain/ceramic, 4 or more surfaces	$185.00
D2650	Inlay – Resin-based composite, 1 surface	$185.00
D2651	Inlay – Resin-based composite, 2 surfaces	$185.00
D2652	Inlay – Resin-based composite, 3 or more surfaces	$185.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D2662	Onlay – Resin-based composite, 2 surfaces	$185.00
D2663	Onlay – Resin-based composite, 3 surfaces	$185.00
D2664	Onlay – Resin-based composite, 4 or more surfaces	$185.00
D2710	Crown – Resin-based composite, indirect	$185.00
D2712	Crown – 3/4 resin-based composite, indirect	$185.00
D2720	Crown – Resin with high noble metal	$185.00
D2721	Crown – Resin with predominantly base metal	$185.00
D2722	Crown – Resin with noble metal	$185.00
D2910	Recement inlay – Onlay or partial coverage restoration	$0.00
D2915	Recement cast or prefabricated post and core	$0.00
D2920	Recement crown	$0.00
D2929	Prefabricated porcelain/ceramic crown – Primary tooth	$105.00
D2930	Prefabricated stainless steel crown – Primary tooth	$25.00
D2931	Prefabricated stainless steel crown – Permanent tooth	$25.00
D2932	Prefabricated resin crown	$35.00
D2933	Prefabricated stainless steel crown with resin window	$35.00
D2934	Prefabricated esthetic coated stainless steel crown – Primary tooth	$105.00
D2940	Protective restoration	$5.00
D2950	Core buildup – Including any pins	$50.00
D2951	Pin retention – Per tooth – In addition to restoration	$10.00
D2952	Post and core – In addition to crown, indirectly fabricated	$50.00
D2953	Each additional indirectly prefabricated post – Same tooth	$50.00
D2954	Prefabricated post and core – In addition to crown	$30.00
D2957	Each additional prefabricated post – Same tooth	$30.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D2960	Labial veneer (Resin laminate) – Chairside	$250.00
D2970	Temporary crown (Fractured tooth)	$5.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$50.00
D2980	Crown repair, necessitated by restorative material failure	$15.00
D6210	Pontic – Cast high noble metal	$185.00
D6211	Pontic – Cast predominantly base metal	$185.00
D6212	Pontic – Cast noble metal	$185.00
D6214	Pontic – Titanium	$185.00
D6240	Pontic – Porcelain fused to high noble metal	$185.00
D6241	Pontic – Porcelain fused to predominantly base metal	$185.00
D6242	Pontic – Porcelain fused to noble metal	$185.00
D6245	Pontic – Porcelain/ceramic	$185.00
D6250	Pontic – Resin with high noble metal	$185.00
D6251	Pontic – Resin with predominantly base metal	$185.00
D6252	Pontic – Resin with noble metal	$185.00
D6253	Provisional pontic	$185.00
D6545	Retainer – Cast metal for resin bonded fixed prosthesis	$185.00
D6600	Inlay – Porcelain/ceramic, 2 surfaces	$185.00
D6601	Inlay – Porcelain/ceramic, 3 or more surfaces	$185.00
D6602	Inlay – Cast high noble metal, 2 surfaces	$185.00
D6603	Inlay – Cast high noble metal, 3 or more surfaces	$185.00
D6604	Inlay – Cast predominantly base metal, 2 surfaces	$185.00
D6605	Inlay – Cast predominantly base metal, 3 or more surfaces	$185.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D6606	Inlay – Cast noble metal, 2 surfaces	$185.00
D6607	Inlay – Cast noble metal, 3 or more surfaces	$185.00
D6608	Onlay – Porcelain/ceramic, 2 surfaces	$185.00
D6609	Onlay – Porcelain/ceramic, 3 or more surfaces	$185.00
D6610	Onlay – Cast high noble metal, 2 surfaces	$185.00
D6611	Onlay – Cast high noble metal, 3 or more surfaces	$185.00
D6612	Onlay – Cast predominantly base metal, 2 surfaces	$185.00
D6613	Onlay – Cast predominantly base metal, 3 or more surfaces	$185.00
D6614	Onlay – Cast noble metal, 2 surfaces	$185.00
D6615	Onlay – Cast noble metal, 3 or more surfaces	$185.00
D6624	Inlay – Titanium	$185.00
D6634	Onlay – Titanium	$185.00
D6710	Crown – Indirect resin based composite	$185.00
D6720	Crown – Resin with high noble metal	$185.00
D6721	Crown – Resin with predominantly base metal	$185.00
D6722	Crown – Resin with noble metal	$185.00
D6740	Crown – Porcelain/ceramic	$185.00
D6750	Crown – Porcelain fused to high noble metal	$185.00
D6751	Crown – Porcelain fused to predominantly base metal	$185.00
D6752	Crown – Porcelain fused to noble metal	$185.00
D6780	Crown – 3/4 cast high noble metal	$185.00
D6781	Crown – 3/4 cast predominantly base metal	$185.00
D6782	Crown – 3/4 cast noble metal	$185.00
D6783	Crown – 3/4 porcelain/ceramic	$185.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D6790	Crown – Full cast high noble metal	$185.00
D6791	Crown – Full cast predominantly base metal	$185.00
D6792	Crown – Full cast noble metal	$185.00
D6794	Crown – Titanium	$185.00
D6930	Recement fixed partial denture	$0.00
D6950	Precision attachment	$195.00
Endodontics (Root canal treatment, excluding final restorations)		
D3110	Pulp cap – Direct (Excluding final restoration)	$0.00
D3120	Pulp cap – Indirect (Excluding final restoration)	$0.00
D3220	Pulpotomy – Removal of pulp, not part of a root canal	$10.00
D3221	Pulpal debridement (Not to be used when root canal is done on the same day)	$45.00
D3222	Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development	$17.00
D3230	Pulpal therapy (Resorbable filling) – Anterior, primary tooth (Excluding final restoration)	$30.00
D3240	Pulpal therapy (Resorbable filling) – Posterior, primary tooth (Excluding final restoration)	$35.00
D3310	Anterior root canal – Permanent tooth (Excluding final restoration)	$80.00
D3320	Bicuspid root canal – Permanent tooth (Excluding final restoration)	$120.00
D3330	Molar root canal – Permanent tooth (Excluding final restoration)	$250.00
D3331	Treatment of root canal obstruction – Nonsurgical access	$85.00
D3332	Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$85.00
D3346	Retreatment of previous root canal therapy – Anterior	$135.00
D3347	Retreatment of previous root canal therapy – Bicuspid	$175.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D3348	Retreatment of previous root canal therapy – Molar	$280.00
D3351	Apexification/recalcification – Initial visit (Apical closure/calcific repair of perforations, root resorption, etc.)	$75.00
D3352	Apexification/recalcification – Interim medication replacement (Apical closure/calcific repair of perforations, root resorption, etc.)	$65.00
D3353	Apexification/recalcification – Final visit (Includes completed root canal therapy – Apical closure/calcific repair of perforations, root resorption, etc.)	$65.00
D3410	Apicoectomy/periradicular surgery – Anterior	$95.00
D3421	Apicoectomy/periradicular surgery – Bicuspid (First root)	$95.00
D3425	Apicoectomy/periradicular surgery – Molar (First root)	$95.00
D3426	Apicoectomy/periradicular surgery (Each additional root)	$60.00
D3430	Retrograde filling – Per root	$60.00
D3450	Root amputation – Per root	$95.00
D3920	Hemisection (Including any root removal), not including root canal therapy	$90.00
Periodontics (Treatment of supporting tissues (Gum and bone) of the teeth) periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. The relevant procedure codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 teeth (or 8 sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.		
D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$130.00
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	$80.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$80.00
D4240	Gingival flap (Including root planing) – 4 or more teeth per quadrant	$150.00
D4241	Gingival flap (Including root planing) – 1 to 3 teeth per quadrant	$115.00
D4245	Apically positioned flap	$165.00
D4249	Clinical crown lengthening – Hard tissue	$125.00
D4260	Osseous surgery – 4 or more teeth per quadrant	$295.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D4261	Osseous surgery – 1 to 3 teeth per quadrant	$225.00
D4263	Bone replacement graft – First site in quadrant	$205.00
D4264	Bone replacement graft – Each additional site in quadrant	$95.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$95.00
D4266	Guided tissue regeneration – Resorbable barrier per site	$215.00
D4267	Guided tissue regeneration – Nonresorbable barrier per site (Includes membrane removal)	$255.00
D4270	Pedicle soft tissue graft procedure	$245.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$75.00
D4274	Distal or proximal wedge procedure (When not performed in conjunction with surgical procedures in the same anatomical area)	$70.00
D4275	Soft tissue allograft	$380.00
D4277	Free soft tissue graft procedure (Including donor site surgery), first tooth or edentulous *(missing)* tooth position in graft	$245.00
D4278	Free soft tissue graft procedure (Including donor site surgery), each additional contiguous tooth or edentulous *(missing)* tooth position in same graft site	$125.00
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant *(Limit 4 quadrants per consecutive 12 months)*	$40.00
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant *(Limit 4 quadrants per consecutive 12 months)*	$30.00
D4355	Full mouth debridement to allow evaluation and diagnosis *(1 per lifetime)*	$40.00
D4381	Localized delivery of antimicrobial agents per tooth	$60.00
D4910	Periodontal maintenance *(Limit 4 per calendar year) (Only covered after active periodontal therapy)*	$30.00
	Additional periodontal maintenance procedures *(Beyond 4 per calendar year)*	$55.00
	Periodontal charting for planning treatment of periodontal disease	$0.00
	Periodontal hygiene instruction	$0.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
Prosthetics (Removable tooth replacement – Dentures) includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years. Characterization is considered an upgrade with maximum additional charge to the member of $200.00 per denture.		
D5110	Full upper denture	$150.00
D5120	Full lower denture	$150.00
D5130	Immediate full upper denture	$165.00
D5140	Immediate full lower denture	$165.00
D5211	Upper partial denture – Resin base (Including clasps, rests and teeth)	$150.00
D5212	Lower partial denture – Resin base (Including clasps, rests and teeth)	$150.00
D5213	Upper partial denture – Cast metal framework (Including clasps, rests and teeth)	$160.00
D5214	Lower partial denture – Cast metal framework (Including clasps, rests and teeth)	$160.00
D5225	Upper partial denture – Flexible base (Including clasps, rests and teeth)	$165.00
D5226	Lower partial denture – Flexible base (Including clasps, rests and teeth)	$165.00
D5281	Removable unilateral partial denture – One piece cast metal including clasps and teeth)	$150.00
D5410	Adjust complete denture – Upper	$10.00
D5411	Adjust complete denture – Lower	$10.00
D5421	Adjust partial denture – Upper	$10.00
D5422	Adjust partial denture – Lower	$10.00
D5850	Tissue conditioning – Upper	$10.00
D5851	Tissue conditioning – Lower	$10.00
D5862	Precision attachment – By report	$160.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
Repairs to prosthetics		
D5510	Repair broken complete denture base	$30.00
D5520	Replace missing or broken teeth – Complete denture (Each tooth)	$30.00
D5610	Repair resin denture base	$30.00
D5620	Repair cast framework	$30.00
D5630	Repair or replace broken clasp	$35.00
D5640	Replace broken teeth – Per tooth	$30.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture	$35.00
D5670	Replace all teeth and acrylic on cast metal framework – Upper	$165.00
D5671	Replace all teeth and acrylic on cast metal framework – Lower	$165.00
Denture relining (Limit 1 every 36 months)		
D5710	Rebase complete upper denture	$60.00
D5711	Rebase complete lower denture	$60.00
D5720	Rebase upper partial denture	$60.00
D5721	Rebase lower partial denture	$60.00
D5730	Reline complete upper denture – Chairside	$35.00
D5731	Reline complete lower denture – Chairside	$35.00
D5740	Reline upper partial denture – Chairside	$35.00
D5741	Reline lower partial denture – Chairside	$35.00
D5750	Reline complete upper denture – Laboratory	$60.00
D5751	Reline complete lower denture – Laboratory	$60.00
D5760	Reline upper partial denture – Laboratory	$60.00
D5761	Reline lower partial denture – Laboratory	$60.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
Interim dentures (Limit 1 every 5 years)		
D5810	Interim complete denture – Upper	$230.00
D5811	Interim complete denture – Lower	$230.00
D5820	Interim partial denture – Upper	$75.00
D5821	Interim partial denture – Lower	$75.00
Implant services – Surgical placement of implants (D6010, D6012, D6040, and D6050 have a limit of 1 implant per calendar year with a replacement of 1 per 10 years)		
D6010	Surgical placement of implant body – Endosteal implant	$1,025.00
D6012	Surgical placement of interim implant body for transitional prosthesis – Endosteal implant	$435.00
D6040	Surgical placement – Eposteal implant	$1,040.00
D6050	Surgical placement – Transosteal implant	$1,015.00
D6055	Connecting bar – Implant supported or abutment supported *(Limit 1 per calendar year)*	$1,295.00
D6056	Prefabricated abutment – Includes modification and placement *(Limit 1 per calendar year)*	$355.00
D6057	Custom fabricated abutment – Includes placement *(Limit 1 per calendar year)*	$455.00
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis *(Limit 1 per calendar year)*	$70.00
D6090	Repair implant supported prosthesis, by report *(Limit 1 per calendar year)*	$145.00
D6091	Replacement of semi-precision or precision attachment (Male or female component) of implant/abutment supported prosthesis, per attachment *(Limit 1 per calendar year)*	$65.00
D6095	Repair implant abutment, by report *(Limit 1 per calendar year)*	$140.00
D6100	Implant removal, by report *(Limit 1 per calendar year)*	$270.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure *(Limit 1 per calendar year)*	$115.00
D6102	Debridement and osseous contouring of a periimplant defect – Includes surface cleaning of exposed implant surfaces and flap entry and closure *(Limit 1 per calendar year)*	$225.00
D6103	Bone graft for repair of periimplant defect – Not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration *(Limit 1 per calendar year)*	$205.00
D6104	Bone graft at time of implant placement *(Limit 1 per calendar year)*	$205.00
D6190	Radiographic/surgical implant index, by report *(Limit 1 per calendar year)*	$180.00
Implant/abutment supported prosthetics – All charges for crowns and bridges (Fixed partial dentures) are per unit (Each replacement on a supporting implant(S) equals 1 unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to 1 every 5 years. For single crowns, retainer ("Abutment") crowns, and pontics: The charges below include the cost of predominantly base metal alloy. You may be charged up to these additional amounts, based on the type of material the dentist uses for your restoration. • No more than $150.00 per tooth for any noble metal alloys, high noble metal alloys, titanium or titanium alloys • No more than $75.00 per tooth for any porcelain fused to metal (Only on molar teeth) • Porcelain/ceramic substrate crowns on molar teeth are not covered		
	In addition, you may be charged up to these additional amounts. • No more than $100.00 per tooth if an indirectly fabricated ("Cast") post and core is made of high noble metal alloy • No more than $150.00 per tooth for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (Ceramic) services. Same day in-office CAD/CAM (Ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine Complex rehabilitation on implant/abutment supported prosthetic procedures – An additional $125 charge per unit for multiple crown units/complex rehabilitation *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – Ask your dentist for the guidelines)*	

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D6053	Implant/abutment supported removable denture for completely edentulous arch	$650.00
D6054	Implant/abutment supported removable denture for partially edentulous arch	$660.00
D6058	Abutment supported porcelain/ceramic crown	$570.00
D6059	Abutment supported porcelain fused to metal crown (High noble metal)	$680.00
D6060	Abutment supported porcelain fused to metal crown (Predominantly base metal)	$530.00
D6061	Abutment supported porcelain fused to metal crown (Noble metal)	$680.00
D6062	Abutment supported cast metal crown (High noble metal)	$635.00
D6063	Abutment supported cast metal crown (Predominantly base metal)	$485.00
D6064	Abutment supported cast metal crown (Noble metal)	$635.00
D6065	Implant supported porcelain/ceramic crown	$570.00
D6066	Implant supported porcelain fused to metal crown (Titanium, titanium alloy, high noble metal)	$680.00
D6067	Implant supported metal crown (Titanium, titanium alloy, high noble metal)	$635.00
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	$515.00
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture (High noble metal)	$665.00
D6070	Abutment supported retainer for porcelain fused to metal fixed partial denture (Predominantly base metal)	$515.00
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture (Noble metal)	$665.00
D6072	Abutment supported retainer for cast metal fixed partial denture (High noble metal)	$635.00
D6073	Abutment supported retainer for cast metal fixed partial denture (Predominantly base metal)	$485.00

Code	Procedure Description	Patient Charge
D6074	Abutment supported retainer for cast metal fixed partial denture (Noble metal)	$635.00
D6075	Implant supported retainer for ceramic fixed partial denture	$515.00
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (Titanium, titanium alloy, high noble metal)	$665.00
D6077	Implant supported retainer for cast metal fixed partial denture (Titanium, titanium alloy, high noble metal)	$635.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch	$650.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch	$660.00
D6092	Recement implant/abutment supported crown	$40.00
D6093	Recement implant/abutment supported fixed partial denture	$40.00
D6094	Abutment supported crown (Titanium)	$635.00
D6194	Abutment supported retainer crown for fixed partial denture (Titanium)	$635.00
Oral surgery (Includes routine postoperative treatment) surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (Disease) exists.		
D7111	Extraction of coronal remnants – Deciduous tooth	$5.00
D7140	Extraction, erupted tooth or exposed root – Elevation and/or forceps removal	$5.00
D7210	Surgical removal of erupted tooth – Removal of bone and/or section of tooth	$30.00
D7220	Removal of impacted tooth – Soft tissue	$50.00
D7230	Removal of impacted tooth – Partially bony	$70.00
D7240	Removal of impacted tooth – Completely bony	$90.00
D7241	Removal of impacted tooth – Completely bony, unusual complications (Narrative required)	$110.00
D7250	Surgical removal of residual tooth roots – Cutting procedure	$40.00
D7251	Coronectomy – Intentional partial tooth removal	$70.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D7260	Oroantral fistula closure	$110.00
D7261	Primary closure of a sinus perforation	$110.00
D7270	Tooth stabilization of accidentally evulsed or displaced tooth	$85.00
D7280	Surgical access of an unerupted tooth (Excluding wisdom teeth)	$90.00
D7283	Placement of device to facilitate eruption of impacted tooth	$90.00
D7285	Biopsy of oral tissue – Hard (Bone, tooth) (Tooth related – Not allowed when in conjunction with another surgical procedure)	$0.00
D7286	Biopsy of oral tissue – Soft (All others) (Tooth related – Not allowed when in conjunction with another surgical procedure)	$0.00
D7287	Exfoliative cytological sample collection	$50.00
D7288	Brush biopsy – Transepithelial sample collection	$50.00
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant	$70.00
D7450	Removal of benign odontogenic cyst or tumor – Up to 1.25 cm	$0.00
D7451	Removal of benign odontogenic cyst or tumor – Greater than 1.25 cm	$0.00
D7471	Removal of lateral exostosis – Maxilla or mandible	$80.00
D7472	Removal of torus palatinus	$60.00
D7473	Removal of torus mandibularis	$60.00
D7485	Surgical reduction of osseous tuberosity	$60.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D7510	Incision and drainage of abscess – Intraoral soft tissue	$30.00
D7511	Incision and drainage of abscess – Intraoral soft tissue – Complicated	$30.00
D7520	Incision and drainage of abscess – Extraoral soft tissue	$30.00
D7521	Incision and drainage of abscess – Extraoral soft tissue – Complicated (Includes drainage of multiple fascial spaces)	$30.00
D7880	Occlusal orthotic device, by report *(Limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)*	$160.00
D7910	Suture of recent small wounds up to 5 cm	$25.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach *(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$850.00
D7952	Sinus augmentation via a vertical approach *(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$640.00
D7953	Bone replacement graft for ridge preservation – Per site *(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)*	$100.00
D7960	Frenulectomy – Also known as frenectomy or frenotomy – Separate procedure not incidental to another procedure	$40.00
D7963	Frenuloplasty	$40.00
Orthodontics (Tooth movement) orthodontic treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8050	Interceptive orthodontic treatment of the primary dentition – Banding	$400.00
D8060	Interceptive orthodontic treatment of the transitional dentition – Banding	$400.00
D8070	Comprehensive orthodontic treatment of the transitional dentition – Banding	$400.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition – Banding	$400.00
D8090	Comprehensive orthodontic treatment of the adult dentition – Banding	$400.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D8210	Removable appliance therapy	$0.00
D8220	Fixed appliance therapy	$0.00
D8660	Pre-orthodontic treatment visit	$125.00
D8670	Periodic orthodontic treatment visit – As part of contract	
	Children – Up to 19th birthday:	
	24-month treatment fee	$1,344.00
	Charge per month for 24 months	$56.00
	Adults:	
	24-month treatment fee	$1,944.00
	Charge per month for 24 months	$81.00
D8680	Orthodontic retention – Removal of appliances, construction and placement of retainer(S)	$275.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	$0.00
D8999	Unspecified orthodontic procedure – By report (Orthodontic treatment plan and records)	$270.00
General anesthesia/IV sedation – General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or intravenous sedation when used for the purpose of anxiety control or patient management.		
D9211	Regional block anesthesia	$0.00
D9212	Trigeminal division block anesthesia	$0.00
D9215	Local anesthesia	$0.00
D9220	General anesthesia – First 30 minutes	$160.00
D9221	General anesthesia – Each additional 15 minutes	$75.00

CIGNA DENTAL CARE®
PATIENT CHARGE SCHEDULE (P5I0X)

Code	Procedure Description	Patient Charge
D9241	IV conscious sedation – First 30 minutes	$160.00
D9242	IV conscious sedation – Each additional 15 minutes	$75.00
D9610	Therapeutic parenteral drug, single administration	$15.00
D9612	Therapeutic parenteral drugs, 2 or more administrations, different medications	$25.00
D9630	Other drugs and/or medicaments – By report	$15.00
D9910	Application of desensitizing medicament	$15.00
Emergency services		
D9110	Palliative (Emergency) treatment of dental pain – Minor procedure	$5.00
D9120	Fixed partial denture sectioning	$0.00
D9440	Office visit – After regularly scheduled hours	$30.00
Miscellaneous services		
D9940	Occlusal guard – By report *(Limit 1 per 24 months)*	$100.00
D9941	Fabrication of athletic mouthguard *(Limit 1 per 12 months)*	$110.00
D9942	Repair and/or reline of occlusal guard	$40.00
D9951	Occlusal adjustment – Limited	$35.00
D9952	Occlusal adjustment – Complete	$55.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays *(All other methods of bleaching are not covered)*	$125.00

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling Cigna Dental at the toll free number listed on your ID card or plan materials. Multiple ways to locate a *DHMO Network General Dentist:

- Online provider directory at **Cigna.com**
- Online provider directory on **myCigna.com**
- Call the number located on your ID card to:
  - Use the Dental Office Locator via Speech Recognition
  - Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

*The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

Cigna Dental Enrollment Form

Employer: Complete Section A
Employee: Complete Sections B, C & D

Insured and/or Administered by
Cigna Health and Life Insurance Company

Cigna.

Please print and thank you for providing this information

A

☐ OPEN ENROLL. ☐ CHANGE ☐ NEW ENROLL. ☐ REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME		EMPLOYER ADDRESS		
CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	DENTAL BENEFIT OPTION

TYPE OF CHANGE:

- ☐ **Add Dependent(s) *** Date: _____
- ☐ **Cancel Employee** Last Date of Coverage: _____
- ☐ **Cancel Dependent(s) *** Last Date of Coverage: _____
  Reason for Cancellation:
  - ☐ Leave employment
  - ☐ Transfer out of Cigna Dental Care area
  - ☐ Transfer to another plan
- ☐ **Address Change**
- ☐ **Transfer to COBRA**
  - ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
- ☐ **Other**_____

*** List Names in Section C**

B

EMPLOYEE NAME *(Last)* *(First)* *(M.I.)*				SOCIAL SECURITY NO.
EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE ( )	WORK PHONE ( )	HOME E-MAIL ADDRESS	EMPLOYEE IDENTIFICATION NUMBER
ADDRESS *(Street)*	*(City)*		*(State)*	*(Zip Code)*

WHAT IS YOUR PRIMARY LANGUAGE? *(optional)*	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? *(optional)* ☐ Yes ☐ No	SELECT PLAN: ☐ Cigna Dental Care® ☐ Cigna Dental EPO ☐ Cigna Dental PPO ☐ Cigna Traditional

C

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	FULL-TIME STUDENT? Yes No	DENTAL OFFICE SELECTION *(for Cigna Dental Care only)*	START DATE OF CONTINUOUS DENTAL COVERAGE *(for Cigna Dental PPO only)* *(Month, Day, Year)*	*(check one)*
Employee			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Spouse			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel

Proof of student or handicapped status for overage dependents may be required.
The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

D

SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE'S SIGNATURE / DATE

NOTE: Not all products are available for all clients or all states. Check your enrollment materials carefully to see what is offered for your group.

DISTRIBUTION: White - Cigna **Canary -** Member **Pink -** Employer

PROVISIONS

- The Cigna Dental Care (DHMO) plan is underwritten or administered by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc. (Kentucky and Illinois), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, the Cigna Dental Care plan is underwritten by Cigna Health and Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc.
- The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.
- The Cigna Dental PPO and EPO plans are underwritten or administered by Cigna Health and Life Insurance Company with network management services provided by Cigna Dental Health, Inc. and certain of its operating subsidiaries. The Cigna Traditional (Indemnity) plan is underwritten and/or administered by Cigna Health and Life Insurance Company.
- I accept the coverage/insurance benefits provided by this group plan and authorize the processing of my enrollment in the coverage as indicated on this form. I authorize deduction from my earnings of the required contributions, if any, toward the cost of the coverage.
- I authorize payment of benefits to the participating provider.
- I authorize any participating office to release records and billing information concerning me or my covered dependents to Cigna Health and Life Insurance Company and/or Cigna Dental Health, Inc. and its subsidiaries and affiliates for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize Cigna Health and Life Insurance Company and/or Cigna Dental Health, Inc. and its subsidiaries and affiliates to release any records or information concerning me or my covered dependents to its designee, for purposes of plan administration and customer service.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Cigna Health and Life Insurance Company and/or Cigna Dental Health, Inc. and its subsidiaries and affiliates do not require such tests in any state as a condition of obtaining dental coverage.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which *is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (In Florida, this is a felony of the third degree. In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation. *In Nebraska, "is" is changed to "may be").

Cigna Dental
PO Box 453099
Sunrise FL 33345-3099

>000001 9150400 001 003071 000 0
SAMPLE, JOHN
456 NOWHERE AVENUE
DALLAS TX 98765-4321

Member Name	Role	Dental Office Assignment	Phone Number
JOHN	EE	XYZ DENTAL GROUP XYZ	555.554.5544
MICHAEL	SP	DENTAL GROUP WHITER	555.554.5544
AKIL	CH	SMILES DENTAL XYZ	555.553.5533
ATIBA	CH	DENTAL GROUP WHITER	555.554.5544
ISAIAH	CH	SMILES DENTAL WHITER	555.553.5533
ZION	CH	SMILES DENTAL WHITER	555.553.5533
AJA	CH	SMILES DENTAL WHITER	555.553.5533
TALIA	CH	SMILES DENTAL	555.553.5533

CLIENT NAME

DENTAL CARE NETWORK (DHMO)

Subscriber ID	Group ID	Coverage	DOI Effective Date
T93104203	19999999	FAMILY	01-01-2004

Plan information, benefits and to locate a network dentist:
Call toll-free: 1.800.Cigna24 (1.800.244.6224)
Account Website: www.accountwebsite.com

T93104203	SAMPLE, ISAIAH	CH
T93104203	SAMPLE, ZION	CH
T93104203	SAMPLE, AJA	CH
T93104203	SAMPLE, TALIA	CH

www.cigna.com or myCigna.com

CLIENT NAME

DENTAL CARE NETWORK (DHMO)

Subscriber ID	Group ID	Coverage	DOI Effective Date
T93104203	19999999	FAMILY	01-01-2004

Plan information, benefits and to locate a network dentist:
Call toll-free: 1.800.Cigna24 (1.800.244.6224)
Account Website: www.accountwebsite.com

T93104203 01
T93104203
T93104203
T93104203

www.cigna.com or myCigna.com

03071 9150400 0000 0000001 0000001 119 6 227

Welcome **to the Cigna Dental Care plan.**
Enclosed is your ID card. Although this card does not guarantee eligibility for benefits, you may present it to a participating dental office to communicate important dental plan information.

If this is not the dental office you chose or no dental office is assigned (or listed), your original selection was not available or not received. If you would like to select another dental office, you may do so by calling the number on this ID Card. You can locate a provider by visiting www.cigna.com.

Your benefit descriptions will be mailed to you under separate cover.

we give you more reasons to smile

This card does not guarantee eligibility for benefits.

If required, mail referral forms to the following Cigna Dental location:
Cigna Dental, P.O. Box 188046, Chattanooga, TN 37422-8046

Cigna Dental refers to the following operating subsidiaries of Cigna Corporation: Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company and Cigna Dental Health, Inc., and its operating subsidiaries and affiliates. The Cigna Dental Care plan is provided by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, the Cigna Dental Care plan is underwritten by Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc.

EDI Submitter No: 62308 Cat # 595882

This card does not guarantee eligibility for benefits.

If required, mail referral forms to the following Cigna Dental location:
Cigna Dental, P.O. Box 188046, Chattanooga, TN 37422-8046

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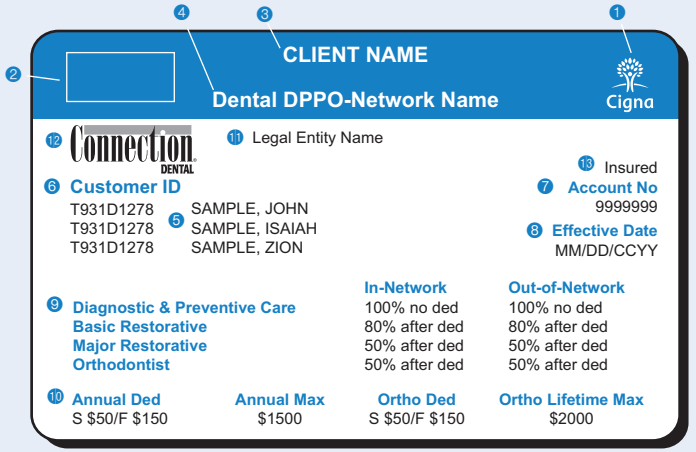
EDI Submitter No: 62308

Dental DPPO-Network (Front)

ID CARD FEATURES

Description of ID card fields:

1. Cigna Dental logo
2. Client logo-will be left blank if the client has elected not to print their logo on the card. (additional charge applies).
3. Client name (optional)
4. Product branding
   - DPPO will be branded as Dental PPO-Network name
5. Customer and or dependent names
   - ID Cards are available as subscriber, member or dependent based
6. Customer ID number
7. Account number
8. Effective date
   - Only appears on GA Situs
9. Covered benefits in-network and out-of-network
   - If the benefit does not apply, the description and amount will not print
   - Amounts must be in whole numbers, no decimals or commas
10. Annual ded and Annual max – dollar amount will vary based on accounts
    - S refers to Single and F refers to Family
11. Legal entity name
12. Third-party logo Connection Dental logo
13. New Hampshire requires the word "insured" displayed on the ID card for non-ASO (fully insured or minimum premium) accounts



Actual size of ID card

GA requirements

- Customer and dependents names on ID cards
- ID number
- Effective date
- Benefits
- Coinsurance amount

Other features

- Font size cannot be altered (made smaller)
- Bar at top of ID card must be of the Cigna Blue color
- Text in that bar should be in "white" so a photo copy of card is easy to read
- Static labels to be in blue color as shown on ID card depiction

Dental DPPO Network (Back)

ID CARD FEATURES

Description of ID card sample:

14. Eligibility disclaimer
15. Mail Claims to
16. For Benefits, Claims, Coverage Information and to locate a Dentist. Website and Call Toll-Free
17. Account Website
18. EDI Submitter No.
19. DPPO Product Disclaimer
20. Catalog number

14 This card does not guarantee eligibility for benefits.

15 Mail Claims To:
Cigna Dental
P.O. Box 188037
Chattanooga, TN 37422-8037

17 Account Website:
www.accountwebsite

18 EDI Submitter No: 62308

16 For Benefits, Claims, Coverage Information and to locate a Dentist:

Website:	www.cigna.com or myCigna.com
Call Toll-Free	1.800.Cigna24 (1.800.244.6224)

19 Cigna Dental refers to the following operating subsidiaries of Cigna Corporation; Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company and Cigna Dental Health, Inc., and its operating subsidiaries. The Cigna Dental PPO is underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company with network management services provided by Cigna Dental Health, Inc., and certain of its operating subsidiaries. In Texas, the Cigna Dental PPO product is referred to as the Cigna Dental Choice Plan. In Arizona and Louisiana, the Cigna Dental PPO product is referred to as the CG Dental PPO.

20 Catalog number

Actual size of ID card

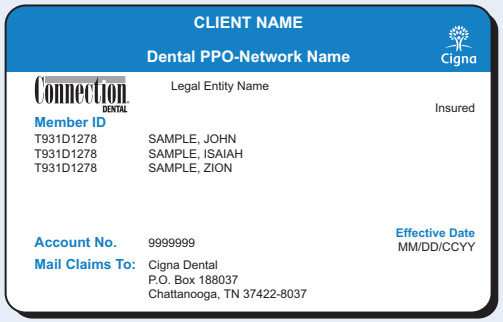
GA Requirements

- Customer and dependents names on ID cards
- ID number
- Effective date
- Benefits
- Coinsurance amount
- Claim address

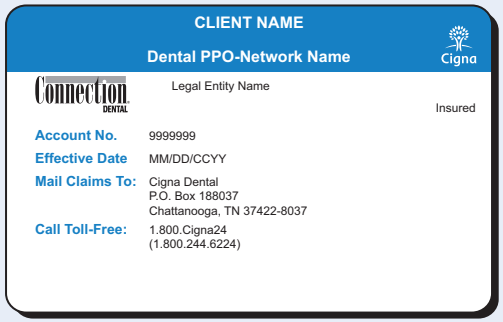
Other features

- Font size cannot be altered (made smaller)
- Static labels **except** product disclaimer to be in teal color as shown on ID card depiction

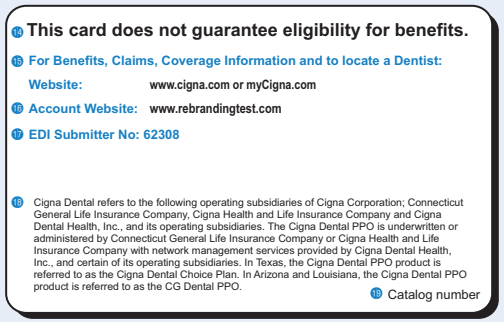
Customer without benefits



Devoid of customer and benefits information – Front



Devoid of customer and benefits information – Back



ADA American Dental Association® Dental Claim Form

Cigna dental plans are insured and/or administered by:
Cigna Health and Life Insurance Company
Connecticut General Life Insurance Company
Cigna Dental Care*
For mailing address, call Customer Service at the telephone number listed on your Cigna ID card.

Cigna

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee $0.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number | 58. Additional Provider ID

J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

IMPORTANT CLAIM NOTICE

Alaska Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona Residents: For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties. The authorization shall remain in effect for the term of your coverage. You or your designated representative is entitled to receive a copy of this claim form.

California Residents: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire Residents: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a **fraud** against an insurer, submits an application or files a **claim** containing a false or deceptive statement is guilty of insurance **fraud**.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Cigna Dental
Cigna Health and Life Insurance Company
P.O. BOX 188037
CHATTANOOGA, TN 37422

As administrator for ABC COMPANY 1234567

THIS IS NOT A BILL

FOR CUSTOMER SERVICE:

1.800.Cigna24 (1.800.244.6224)
or visit www.myCigna.com

Please have your patient ID (U12345678 S0) or the employee's social security number available when calling Customer Service, visiting your health care professional, or writing to us.

YOUR NAME
100 STREET AVENUE
ANY TOWN, MA 02067-2920

Your explanation of dental benefits (for the claim processed on Jul 30, 2014)

Your current account summary

$50 has been applied towards your $50 individual deductible
$100 has been applied towards your $150 family deductible
$240 has been applied towards your $2,000 individual maximum
$0 has been applied towards your $2,500 lifetime ortho maximum

The balances shown above are as of Jul 30, 2014, the day the claim was finalized. However, the balances on the website are updated daily, so the balances shown here may not match those listed on your participant website at myCigna.com.

Your payment summary

Paid to:	I.WELLBEING DDS
Amount:	$125.00

Did you know that your oral health can affect your overall health?

Did you know that your oral health and certain medical conditions are closely linked? The **Cigna Dental Oral Health Integration Program** reimburses eligible customers 100% of their out-of-pocket payment to their dentist for certain dental procedures. To be eligible, customers need to have any of the following medical conditions: Diabetes; Heart Disease; Maternity; Stroke; Head & Neck Cancer Radiation; Organ Transplants; Chronic Kidney Disease. Program participants can also learn how stress, tobacco use and fear of going to the dentist can negatively impact their oral and overall health and what they can do about it. Find out more about the **Cigna Dental Oral Health Integration Program** on ***myCigna.com*** .

"The Cigna Dental Oral Health Integration Program is a registered trademark of Cigna Corporation."

GD5001A 0000687

Rights of review and appeal

If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on the front of this form.

Please follow the steps below to make sure that your appeal is processed in a timely manner.

- If you're not satisfied with this coverage decision, you can start the Appeal process by submitting a written request to the address listed: Cigna Appeals Unit PO Box 188044 Chattanooga, TN 37422 within 180 days of receipt of this EOB (unless a longer time is permitted by your plan).
- Send a copy of this explanation of benefits along with any relevant additional information (e.g. benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include:
  1) Your name,
  2) Account number from the front of this form,
  3) ID Number from the front of this form,
  4) Name of the patient and relationship and
  5) "Attention: Appeals Unit" on all supporting documents
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records, and other information about your claim, free of charge.
- You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision.

Definitions

- **Amount Your Health Care Professional Charged:** Amount charged for the services.
- **Your Health Care Professional's Contracted Amount (if present):** Cigna Dental has negotiated a reduced fee for participating dentists. The negotiated amount is printed in this column if the health care professional is a Cigna Dental participating dentist, otherwise zeros will appear.
- **Amount Eligible for Coverage by Your Plan:** Part of the "Amount Your Health Care Professional Charged" or "Your Health Care Professional's Contracted Amount" (if present) eligible for coverage under your plan. This amount is used to help calculate how much will be paid by your plan.
- **Your Deductible:** Portion of the "Amount Eligible for Coverage by Your Plan" that is applied towards your deductible.
- **Remaining Balance:** "Amount Eligible for Coverage by Your Plan" minus "Your Deductible".
- **Your Plan Covered (%,$):** The amount (percentage and dollar amounts, respectively) of the "Amount Eligible for Coverage by Your Plan" that your plan paid.

Your explanation of dental benefits (for the claim processed on Jul 30, 2014)

THIS IS NOT A BILL

Your claim details

PATIENT NAME: **YOUR NAME** CUSTOMER NAME: YOUR NAME PATIENT ID: U12345678
HEALTH CARE PROFESSIONAL NAME: I.WELLBEING DDS GROUP NAME: ABC COMPANY GROUP #: 1234567
DOCUMENT #: D123456789 CLAIMANT #: 01 CLAIM #: 999 PAYMENT #: 001 POLICY CODE: 02 DIVISION: 018 RECEIVED DATE: Jul 24, 2014
PROCESSED DATE: Jul 30, 2014

AMOUNT YOUR HEALTH CARE PROFESSIONAL CHARGED ($)	YOUR HEALTH CARE PROFESSIONAL'S CONTRACTED AMOUNT ($)	AMOUNT ELIGIBLE FOR COVERAGE BY YOUR PLAN ($)	YOUR DEDUCTIBLE ($)	REMAINING BALANCE ($)	YOUR PLAN COVERED (%)	YOUR PLAN COVERED ($)
For service on Jul 23, 2014: Composite Filling, 2 surfaces* for Tooth#/Quad/Arch: 13 *(see note DB)*						
200.00	175.00	175.00	50.00	125.00	100%	125.00
$200.00	**$175.00**	**$175.00**	**$50.00**	**$125.00**		**$125.00**

Using a preferred health care professional resulted in a total savings of $25.00.

Amount paid by your plan $125.00
Customer's responsibility **$50.00**

Notes

DB - Benefits have been applied toward the deductible.

Additional remarks

Thank you for using a Cigna Dental healthcare professional. The amount eligible for coverage is determined by the Cigna Dental negotiated amount and the customer's benefit plan. The difference between the submitted charges and the negotiated amount is not the patient's responsibility.

GD5007A 0000689

Additional appeal information related to the Patient Protection and Affordable Care Act of 2010

If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, please either contact your Health Care Professional, or go to http://www.cigna.com/privacy/privacy_healthcare_forms.html or call the Customer Service number on the back of your ID card.
If you are not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements.
For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.askebsa.dol.gov. Assistance may also be available through the below consumer assistance or ombudsman program(s):

State	Contact Information
Massachusetts	Massachusetts Consumer Assistance 30 Winter Street Suite 1004 Boston, MA 02108 Telephone: (888)211-6168 Website: www.massconsumerassistance.org

If you have difficulty reading English, we offer language assistance. For help please call the Customer Service number on your ID card.

Si tiene problemas para leer el texto en inglés, le ofrecemos asistencia de idiomas. Para obtener ayuda, por favor, llame al número de Servicio al cliente que figura en su tarjeta de identificación.

Si vous avez des difficultés à lire l'anglais, nous offrons une assistance linguistique. Pour toute aide, veuillez composer le numéro du Service à la clientèle qui se trouve sur votre carte d'identification.

Für den Fall, dass Sie den englischen Text nicht verstehen, bieten wir mehrsprachige Unterstützung an. Rufen Sie in diesem Fall bitte die auf Ihrer Versicherungskarte angegebene Kundenservice-Nummer an.

Kung nahihirapan ka sa pagbabasa ng wikang Ingles, nag-aalok kami ng tulong sa wika. Para sa tulong pakitawagan ang numero ng Serbisyo ng Customer sa iyong ID card.

如果對您來說閱讀英文會有困難，我們可以提供您語言協助。欲取得協助，請撥打會員卡上的客戶服務電話號碼。

Bilagáana Bizaad wólta' nił nanitł'ahgo, saad bee niká'a'doowołígíí hóló. Áká'a'áyeed biniiyé t'áá shǫǫdi áká'anídaalwo'go dabinaanishígíí bich'į' hodíilnih éí naaltsoos bee nee hózinígíí bikáa'gi bibéésh bee hane'é yisdzoh.

If you are the treating dentist and you would like to discuss a clinical question, you may contact Dr.Clay Hedlund, 1640 Dallas Parkway, Plano, TX 75093. Phone: 972.863.5021.

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by your plan, you may contact the Virginia Bureau of Insurance, Office of the Managed Care Ombudsman for assistance. The Managed Care Ombudsman may be reached at P.O. Box 1157, Richmond, VA 23218. Phone: 1.877.310.6560 (toll free) or 1.804.371.9032. E-mail: ombudsman@scc.virginia.gov. Web Page: For information regarding the Ombudsman, http://www.scc.virginia.gov.

SECTION IV – SUBMITTAL REQUIREMENTS

4.2.21 Minority/Women (M/WBE) Participation

If your firm is a certified minority business enterprise as defined by the Florida Small and Minority Business Assistance Act of 1985, provide copies of your certification(s). If your firm is not a certified M/WBE, describe your company's previous efforts, as well as planned efforts in meeting M/WBE procurement goals under Florida Statutes 287.09451.

Diversity is a major initiative and commitment for Cigna, and our diversity program is part of an overall sourcing strategy that includes nationally recognized models for ensuring our commitment to the communities where we work and serve. Our policy is to solicit competitive bids, including those from minority- and women-owned business enterprises (MWBE), to obtain the maximum value when purchasing goods and services. We consistently review corporate and divisional goals and accountabilities for the utilization of MWBE, and we benchmark our progress against those established by the National Minority Supplier Development Council and the Women's Business Enterprise National Council (WBENC). Cigna is a corporate member of both organizations.

Currently, Cigna has two full-time supplier diversity managers: Ginger Anderson, who is the first point of contact for RFPs except those for the Mid-Atlantic region, and Tonya Marksteiner, who handles the Mid-Atlantic accounts. In addition, Tippi Montgomery joined the supplier diversity team to manage the Mentor Protégé Program.

Cigna is truly committed to being the partner of choice for diverse-owned business enterprises. For more information, visit our website at http://www.cigna.com/suppliercommunity/supplier-diversity-program.

BID/PROPOSAL CERTIFICATION

Please Note: If responding to this solicitation through BidSync, the electronic version of the bid response will prevail, unless a paper version is clearly marked by the bidder in some manner to indicate that it will supplant the electronic version. All fields below must be completed. If the field does not apply to you, please note N/A in that field.

If you are a foreign corporation, you may be required to obtain a certificate of authority from the department of state, in accordance with Florida Statute §607.1501 (visit http://www.dos.state.fl.us/).

Company: (Legal Registration) Cigna Health and Life Insurance Company (CHLIC)* EIN (Optional): 59-1031071*

Address: 900 Cottage Grove Road

City: Bloomfield State: CT Zip: 06002

Telephone No. 954.514.6800 FAX No. Not applicable Email: Scott.Evelyn@cigna.com

Delivery: Calendar days after receipt of Purchase Order (section 1.02 of General Conditions): Not applicable

Total Bid Discount (section 1.05 of General Conditions): Not applicable

Does your firm qualify for MBE or WBE status (section 1.09 of General Conditions): MBE No WBE No

ADDENDUM ACKNOWLEDGEMENT - Proposer acknowledges that the following addenda have been received and are included in the proposal:

Addendum No.	Date Issued	Addendum No.	Date Issued	Addendum No.	Date Issued
1	03/24/2017				

VARIANCES: If you take exception or have variances to any term, condition, specification, scope of service, or requirement in this competitive solicitation you must specify such exception or variance in the space provided below or reference in the space provided below all variances contained on other pages within your response. Additional pages may be attached if necessary. No exceptions or variances will be deemed to be part of the response submitted unless such is listed and contained in the space provided below. The City does not, by virtue of submitting a variance, necessarily accept any variances. If no statement is contained in the below space, it is hereby implied that your response is in full compliance with this competitive solicitation. If you do not have variances, simply mark N/A. If submitting your response electronically through BIDSYNC you must also click the "Take Exception" button.

The below signatory hereby agrees to furnish the following article(s) or services at the price(s) and terms stated subject to all instructions, conditions, specifications addenda, legal advertisement, and conditions contained in the bid/proposal. I have read all attachments including the specifications and fully understand what is required. By submitting this signed proposal I will accept a contract if approved by the City and such acceptance covers all terms, conditions, and specifications of this bid/proposal. The below signatory also hereby agrees, by virtue of submitting or attempting to submit a response, that in no event shall the City's liability for respondent's direct, indirect, incidental, consequential, special or exemplary damages, expenses, or lost profits arising out of this competitive solicitation process, including but not limited to public advertisement, bid conferences, site visits, evaluations, oral presentations, or award proceedings exceed the amount of Five Hundred Dollars ($500.00). This limitation shall not apply to claims arising under any provision of indemnification or the City's protest ordinance contained in this competitive solicitation.

Submitted by:

Scott E. Evelyn
Name (printed)

Signature

April 4th, 2016
Date:

Vice President of CHLIC and Authorized Signatory
Title

revised 04/10/15

*The information provided is specific to CHLIC. Due to spacing restrictions, please refer to the attached appendix for information regarding the additional legal entities.

Company: (Legal Registration)

Cigna Dental Health of California, Inc.
Cigna Dental Health of Colorado, Inc.
Cigna Dental Health of Florida, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Texas, Inc.

EIN

Cigna Dental Health of California, Inc.: 592600475
Cigna Dental Health of Colorado, Inc.: 592675861
Cigna Dental Health of Florida, Inc.: 59-1611217
Cigna Dental Health of New Jersey, Inc.: 59-2308062
Cigna Dental Health of Ohio, Inc.: 59-2579774
Cigna Dental Health of Texas, Inc.: 59-2676977

Address, City, State, Zip

Cigna Dental Health of California, Inc.: 400 N. Brand Blvd, Glendale, CA 91203

Cigna Dental Health of Colorado, Inc.; Cigna Dental Health of Florida, Inc.; Cigna Dental Health of New Jersey, Inc.; and Cigna Dental Health of Ohio, Inc.: 1571 Sawgrass Corporate Parkway Suite 140 Sunrise, FL 33323

Cigna Dental Health of Texas, Inc.: 1640 Dallas Parkway, Plano, TX 75093

Not applicable.

NON-COLLUSION STATEMENT:

By signing this offer, the vendor/contractor certifies that this offer is made independently and *free* from collusion. Vendor shall disclose below any City of Fort Lauderdale, FL officer or employee, or any relative of any such officer or employee who is an officer or director of, or has a material interest in, the vendor's business, who is in a position to influence this procurement.

Any City of Fort Lauderdale, FL officer or employee who has any input into the writing of specifications or requirements, solicitation of offers, decision to award, evaluation of offers, or any other activity pertinent to this procurement is presumed, for purposes hereof, to be in a position to influence this procurement.

For purposes hereof, a person has a material interest if they directly or indirectly own more than 5 percent of the total assets or capital stock of any business entity, or if they otherwise stand to personally gain if the contract is awarded to this vendor.

In accordance with City of Fort Lauderdale, FL Policy and Standards Manual, 6.10.8.3,

3.3. City employees may not contract with the City through any corporation or business entity in which they or their immediate family members hold a controlling financial interest (e.g. ownership of five (5) percent or more).

3.4. Immediate family members (spouse, parents and children) are also prohibited from contracting with the City subject to the same general rules.

Failure of a vendor to disclose any relationship described herein shall be reason for debarment in accordance with the provisions of the City Procurement Code.

NAME	RELATIONSHIPS
_____	_____
_____	_____
	_____
	_____

In the event the vendor does not indicate any names, the City shall interpret this to mean that the vendor has indicated that no such relationships exist.

SECTION IV – SUBMITTAL REQUIREMENTS

4.2 Contents of the Proposal

4.2.22 Required Forms

c. Local Business Preference (LBP)

This form is to be completed, if applicable, and inserted in this section.

Per “Question and Answers for Bid #57511928 Group DHMO and DPPO Dental Plan Benefits”, this form is no longer applicable.

Question 9

The RFP references "Local Business Preference (LBP)" under the Required Forms section and states; "This form is to be completed, if applicable, and inserted in this section." Can you please provide this form or provide additional information on what needs to be provided/ (Submitted: Mar 24, 2017 3:57:18 PM EDT)

Answer

The Local Business Preference does not apply to this solicitation. Please disregard Section 4.2.22.c. (Answered: Mar 27, 2017 8:40:18 AM EDT)

CONTRACT PAYMENT METHOD BY P-CARD

THIS FORM MUST BY SUBMITTED WITH YOUR RESPONSE

The City of Fort Lauderdale has implemented a Procurement Card (P-Card) program which changes how payments are remitted to its vendors. The City has transitioned from traditional paper checks to payment by credit card via MasterCard or Visa. This allows you as a vendor of the City of Fort Lauderdale to receive your payment fast and safely. No more waiting for checks to be printed and mailed.

Payments will be made utilizing the City's P-Card (MasterCard or Visa). Accordingly, firms must presently have the ability to accept credit card payment or take whatever steps necessary to implement acceptance of a credit card before the commencement of a contract.

Please indicate which credit card payment you prefer:

_____ **Master Card**

__X__ **Visa Card**

Company Name: Cigna Health and Life Insurance Company (CHLIC)*

Scott E. Evelyn
Name (printed)

Signature

April 4th, 2016
Date:

Vice President of CHLIC and Authorized Signatory
Title

*Additional legal entities include: Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado,Inc., Cigna Dental Health of Florida, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of Ohio, Inc., and Cigna Dental Health of Texas, Inc.

City of Fort Lauderdale • Procurement Services Division
100 N. Andrews Avenue, 619 • Fort Lauderdale, Florida 33301
954-828-5933 Fax 954-828-5576
purchase@fortlauderdale.gov

ADDENDUM NO. 1

RFP No. 575-11928
TITLE: Group DHMO and DPPO Dental Plan Benefits

ISSUED: March 24, 2017

This addendum is being issued to make the following change:

1. **Section 3.6.4 shall now read:**
   Dependent Coverage
   Eligible dependents shall include a covered employee's spouse if not divorced or legally separated or domestic partner and a covered employee's child to the end of the calendar year in which the child reaches age *twenty six (26)*, if the child meets all of the following:

   (a) The child is dependent upon the employee for support and is not married.
   (b) The child is living in the household of the employee, or the child is a full-time or part time student.

   This definition shall apply to any and all plans offered by The City.

All other terms, conditions, and specifications remain unchanged.

AnnDebra Diaz, CPPB
Senior Procurement Specialist

Company Name: Cigna Health and Life Insurance Company*
(please print)

Bidder's Signature: _____

Date: April 4th, 2016

*Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado,Inc., Cigna Dental Health of Florida, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of Ohio, Inc., and Cigna Dental Health of Texas, Inc.

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY) 04/05/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Aon Risk Services Central, Inc.
Philadelphia PA Office
One Liberty Place
1650 Market Street
Suite 1000
Philadelphia PA 19103 USA

CONTACT NAME:
PHONE (A/C. No. Ext): (866) 283-7122 **FAX (A/C. No.):** (800) 363-0105
E-MAIL ADDRESS:

INSURED
Cigna Corporation Et Al
900 Cottage Grove Road
Bloomfield CT 06002 USA

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	ACE American Insurance Company	22667
INSURER B:	Indemnity Insurance Co of North America	43575
INSURER C:	Agri General Insurance Company	42757
INSURER D:	ACE Fire Underwriters Insurance Co.	20702
INSURER E:		
INSURER F:		

COVERAGES **CERTIFICATE NUMBER:** 570066076845 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:			HDOG27853535	07/01/2016	07/01/2017	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$1,000,000 $1,000,000 $5,000 $1,000,000 $3,000,000 $1,000,000
A	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY			ISA H09042982	07/01/2016	07/01/2017	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Medical Payments Lia	$1,000,000 $5,000
	UMBRELLA LIAB OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION						EACH OCCURRENCE AGGREGATE	
B A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		WLRC48606520 (AOS) WLRC48606532 (AZ CA,MA)	07/01/2016 07/01/2016	07/01/2017 07/01/2017	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE-EA EMPLOYEE E.L. DISEASE-POLICY LIMIT	 $1,000,000 $1,000,000 $1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
City of Fort Lauderdale, City of Fort Lauderdale's officials, employees, agents, contractors and consultants are included as Additional Insured in accordance with the policy provisions of the General Liability and Automobile Liability policies.

CERTIFICATE HOLDER

The City of Fort Lauderdale
Attn: Procurement Services Department
100 N. Andrews Avenue, Room 619
Fort Lauderdale FL 33301 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services Central, Inc.

Holder Identifier :

Certificate No : 570066076845

AGENCY CUSTOMER ID: 10042023
LOC #:

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
Aon Risk Services Central, Inc.	Cigna Corporation Et Al
POLICY NUMBER: See Certificate Number: 570066076845	
CARRIER: See Certificate Number: 570066076845 / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: ACORD 25 **FORM TITLE:** Certificate of Liability Insurance

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER	
INSURER	
INSURER	
INSURER	

ADDITIONAL POLICIES If a policy below does not include limit information, refer to the corresponding policy on the ACORD certificate form for policy limits.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS	
	WORKERS COMPENSATION							
D		N/A		SCFC48606507 (WI)	07/01/2016	07/01/2017		
A		N/A		WLRC48606568 (MI - HealthSpring)	07/01/2016	07/01/2017		
A		N/A		WLRC48606544 (NY)	07/01/2016	07/01/2017		
A		N/A		WLRC48606556 (KS)	07/01/2016	07/01/2017		
C		N/A		WLRC48606519 (TN)	07/01/2016	07/01/2017		
A		N/A		WLRC4860657A (MI - ALEGIS)	07/01/2016	07/01/2017		
A		N/A		WLRC48606581 (MI - CIGNA)	07/01/2016	07/01/2017		

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY)
10/04/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

Holder Identifier :

PRODUCER
Aon Risk Services Central, Inc.
Philadelphia PA Office
One Liberty Place
1650 Market Street
Suite 1000
Philadelphia PA 19103 USA

CONTACT NAME:
PHONE (A/C. No. Ext): (866) 283-7122 **FAX (A/C. No.):** (800) 363-0105
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A:	ACE American Insurance Company	22667
INSURER B:		
INSURER C:		
INSURER D:		
INSURER E:		
INSURER F:		

INSURED
Cigna Corporation Et Al
900 Cottage Grove Road
Bloomfield CT 06002 USA

COVERAGES **CERTIFICATE NUMBER:** 570064056261 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	
							MED EXP (Any one person)	
							PERSONAL & ADV INJURY	
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	
	☐ OTHER:							
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	
	☐ ANY AUTO						BODILY INJURY (Per person)	
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	
	☐ **EXCESS LIAB** ☐ CLAIMS-MADE						AGGREGATE	
	☐ DED ☐ RETENTION							
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N / A						E.L. EACH ACCIDENT	
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE-EA EMPLOYEE	
							E.L. DISEASE-POLICY LIMIT	
A	ManageCare Liab			MSP27030543006 Claims Made SIR applies per policy terms & conditions	10/01/2016	10/01/2017	Agg - Claims Made	$15,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
RE: RFP.

Certificate No : 570064056261

CERTIFICATE HOLDER

City of Fort Lauderdale
Attn: Procurement of Services Division
100 N. Andrews Avenue, Room 619
Fort Lauderdale FL 33301 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services Central, Inc.

SCHEDULE OF INSURANCE
INSURERS, COVERAGES, & LIMITS

TYPE OF INSURANCE	INSURANCE CARRIERS	A.M. BEST RATINGS*	POLICY NUMBER	POLICY PERIOD	LIMITS**	
Aviation Liability (Worldwide)	United States Aircraft Insurance Group (USAIG Pool)	N/A	SIHL 1925Z	FEB 1, 2017 – FEB 1, 2018	$300 Million	Per Occurrence
Commercial Auto Liability	ACE American Insurance Company	A+ XV	ISAH 09042982	JUL 1, 2016 – JUL 1, 2017	$1 Million $1 Million	Per Occurrence & Aggregate Per Person
Commercial General Liability	ACE American Insurance Company	A+ XV	HDOG 27853535	JUL 1, 2016 – JUL 1, 2017	$1 Million $3 Million	Per Occurrence Aggregate
Workers' Compensation (All states except CA, MA, OH, WI, WV)	Indemnity Insurance Company of North America	A+ XV	WLRC48606520	JUL 1, 2016 – JUL 1, 2017	Statutory	
Workers' Compensation (CA, MA, WI, KS & NY)	ACE American Insurance Company	A+ XV	WLRC48606532 (CA, AZ, MA) WLRC48606556 (KS) WLRC48606581 (MI) WLRC48606544 (NY) SCFC48606507 (WI)	JUL 1, 2016 – JUL 1, 2017	Statutory	
Umbrella Liability (Worldwide)	American Guarantee & Liability Insurance Company	A+ XV	AUC 967096608	JUL 1, 2016 – JUL 1, 2017	$25 Million $25 Million	Per Occurrence Aggregate
Employment Practices Liability (Worldwide)	Zurich American Insurance Company	A+ XV	EPL9383687-07	APR 30, 2016 – APR 30, 2017	$15 Million	Aggregate
Property *(Worldwide)* - Blanket Policy (Contents) - Business Interruption - Flood, Earthquake & Windstorm	Zurich American Insurance Company	A XV	PRP9320202-02	MAY 1, 2016 - MAY 1, 2017	Various Deductibles and Limits apply. For more information, please email Cigna Global Risk Management.	
Network Liability *(Worldwide)* -Network Security & Privacy (Cyber)	Illinois National Insurance Company (AIG)	A XV	02-306-01-12	OCT 31, 2016 - OCT 31, 2017	$10 Million $10 Million	Per Claim Aggregate
Direct & Vicarious Medical Professional Liability (Worldwide cover is provided via Temple Insurance Company)	Lexington Insurance Company (AIG)	A XV	114-66384 (All States) 114-66385 (PA)	MAR 30, 2016 – MAR 30, 2017	Physician's Professional Liability (All States except PA) $1 Million $3 Million Pennsylvania Physician's Professional Liability $500,000 $1 Million Entity Medical Professional Liability $1 Million $3 Million	Per Claim Aggregate Per Physician Per Claim Aggregate Per Physician Per Claim (Shared Entity Limit) Aggregate (Shared Entity Limit)
Professional Liability Errors & Omissions Insurance (Worldwide) - Managed Care E&O	ACE American Insurance Company	A+ XV	MSP 27030543 006	OCT 1, 2016 - OCT 1, 2017	$15 Million $15 Million	Per Claim/Wrongful Act Aggregate
Global Casualty (Worldwide) - Employer's Liability - Contigent Auto Liability - Various Local Policies (GL & EL)	AIG	A XV	WR 10005928	JUL 1, 2016 – JUL 1, 2017	$1 Million $1 Million $1 Million $1 Million	Per Occurrence ($2 Million Agg.) Per Occurrence & Aggregate Per Occurrence & Aggregate Per Occurrence & Aggregate

*These ratings are under continuous review and subject to change and/or affirmation.To confirm the current rating, please click on the rating or visit the A.M. Best website: www.ambest.com
** Unless otherwise specificed, limits are indicative of primary layer of insurance coverage and are subject to change.

SECRETARY'S CERTIFICATE

CIGNA HEALTH AND LIFE INSURANCE COMPANY
CIGNA DENTAL HEALTH OF FLORIDA, INC.

I, Susan M. Metrow, a duly elected Assistant Secretary of Cigna Health and Life Insurance Company and Cigna Dental Health of Florida, Inc. (the "Companies"), do hereby represent and certify that the following resolution was adopted by the Board of Directors of each Company via Unanimous Written Consent dated February 4, 2009 and March 30, 1990, respectively; and such resolution remains in full force and effect as of the date hereof, not having been amended, modified or rescinded since the date of its adoption:

Execution of Documents

RESOLVED, That the President, any Vice President or any Assistant Vice President of the Company, or the Secretary, or their designees, be, and each of them hereby is, authorized and empowered to enter into, execute, acknowledge and deliver, on behalf of the Company, any and all agreements, contracts, assignments, equipment leases, transfers, powers of attorney, and other written instruments that they, or any of them, may deem necessary or desirable in connection with the regular and ordinary business activities of the Company, including but not limited to entering into contracts and incurring liabilities with respect to the purchase of goods and services on behalf of the Company in the ordinary course of its business; provided, however, that no officer, agent, employee or designee of the Company shall have any power or authority to mortgage or pledge its real property unless such authority is so delegated by specific resolution of the Board of Directors or by a duly authorized Committee of the Board of Directors.

I further certify that Scott E. Evelyn is a Vice President of the Company having been elected by the Board of Directors of the Cigna Health and Life Insurance Company on September 20, 2010 and of Cigna Dental Health of Florida, Inc. on July 5, 2016.

IN WITNESSS WHEREOF, I hereunto set my hand on this 6th day of April, 2017.

Susan M. Metrow

Susan M. Metrow, Assistant Secretary

Cigna has marked-up this sample contract to reflect previously negotiated terms and conditions with the City. Please note, because this is a fully-insured product, Cigna's insurance policy and certificate will be issued. These are filed documents, and there is very little flexibility to change the provisions. In the event of a conflict, the provisions of the insurance policy and certificate shall govern.

AGREEMENT FOR
~~XXXXXXXXXXXXXXXXXXXXX~~
~~SERVICES~~INSURANCE POLICIES

THIS AGREEMENT, made this _____ day of _____ ~~2014~~2017, is by and between the City of Fort Lauderdale, a Florida municipality, ("City"), whose address is 100 North Andrews Avenue, Fort Lauderdale, FL 33301-1016, and Cigna Health and Life Insurance Company, _____, a Connecticut corporation authorized to transact business in the State of Florida ("Contractor" ~~or "Company"~~), whose address and phone number are 900 Cottage Grove Road, Bloomfield, Connecticut 06002_____, _____ Phone: ~~XXX-XXX-XXXX~~954-514-6859, ~~Fax: XXX-XXX-XXXX,~~ Email: .

NOW THEREFORE, for and in consideration of the mutual promises and covenants set forth herein and other good and valuable consideration, the City and the Contractor covenant and agree as follows:

WITNESSETH:

I. DOCUMENTS

The following documents (collectively "Contract Documents") are hereby incorporated into and made part of this Agreement (Form P-0001):

(1) Invitation to Bid / Request for Proposal No. xxx-xxxx, ~~XXXXXXXXXXX Services~~Dental Insurance Policies, including any and all addenda, prepared by the City of Fort Lauderdale, ("RFP/ITB"or "Exhibit A").

(2) The Contractor's response to the ITB/RFP, dated _____, ("Exhibit B").

(3) Dental Insurance Policies and Certificates (collectively, "Exhibit C")

All Contract Documents may also be collectively referred to as the "Documents." In the event of any conflict between or among the Documents or any ambiguity or missing specifications or instruction, the following priority is established:

A. First, specific direction from the City Manager (or designee)
B. Second, Exhibit C~~this Agreement (Form P-0001) dated _____, 2014, and any attachments.~~
C. Third, this Agreement (Form P-0001) dated _____, 2017, and any attachments ~~Exhibit A~~
D. Fourth, Exhibit A ~~B~~
E. Fifth, Exhibit B

II. SCOPE

The Contractor shall perform the Work under the general direction of the City as set forth in the Contract Documents.

Unless otherwise specified herein, the Contractor shall perform all Work identified in this Agreement. The parties agree that the scope of services is a description of Contractor's obligations and responsibilities, and is deemed to include preliminary considerations and prerequisites, and all labor, materials, equipment, and tasks which are such an inseparable part of the work described that exclusion would render performance by Contractor impractical, illogical, or unconscionable.

Contractor acknowledges and agrees that the City's Contract Administrator has no authority to make changes that would increase, decrease, or otherwise modify the Scope of Services to be provided under this Agreement.

By signing this Agreement, the Contractor represents that it thoroughly reviewed the documents incorporated into this Agreement by reference and that it accepts the description of the Work and the conditions under which the Work is to be performed.

III. TERM OF AGREEMENT

The initial contract period shall commence on " DATE" , and shall end on " DATE" . In the event the term of this Agreement extends beyond the end of any fiscal year of City, to wit, September 30th, the continuation of this Agreement beyond the end of such fiscal year shall be subject to both the appropriation and the availability of funds.

IV. COMPENSATION

The Contractor agrees to provide the services and/or materials as specified in the Contract Documents at the cost specified in Exhibit B. It is acknowledged and agreed by Contractor that this amount is the maximum payable and constitutes a limitation upon City's obligation to compensate Contractor for Contractor's services related to this Agreement. This maximum amount, however, does not constitute a limitation of any sort upon Contractor's obligation to perform all items of work required by or which can be reasonably inferred from the Scope of Services. Except as otherwise provided in the solicitation, no amount shall be paid to Contractor to reimburse Contractor's expenses.

V. METHOD OF BILLING AND PAYMENT

Contractor may submit invoices for compensation no more often than monthly, but only after the services for which the invoices are submitted have been completed. An original invoice plus one copy are due within fifteen (15) days of the end of the month except the final invoice which must be received no later than sixty (60) days after this Agreement expires. Invoices shall designate the nature of the services performed and/or the goods provided.

City shall pay Contractor within forty-five (45) days of receipt of Contractor's proper invoice, as provided in the Florida Local Government Prompt Payment Act.

To be deemed proper, all invoices must comply with the requirements set forth in this Agreement and must be submitted on the form and pursuant to instructions prescribed by the City's Contract Administrator. Payment may be withheld for failure of Contractor to comply with a term, condition, or requirement of this Agreement.

Notwithstanding any provision of this Agreement to the contrary, City may withhold, in whole or in part, payment to the extent necessary to protect itself from loss on account of inadequate or defective work that has not been remedied or resolved in a manner satisfactory to the City's Contract Administrator or failure to comply with this Agreement. The amount withheld shall not be subject to payment of interest by City.

VI. GENERAL CONDITIONS

A. Indemnification

Contractor shall protect and defend at Contractor's expense, counsel being subject to the City's approval, and indemnify and hold harmless the City and the City's officers, employees, volunteers, and agents from and against any and all losses, penalties, fines, damages, settlements, judgments, claims, costs, charges, expenses, or liabilities, including any award of attorney fees and any award of costs, in connection with or arising directly or indirectly out of any act or omission by the Contractor or by any officer, employee, agent, invitee, subcontractor, or sublicensee of the Contractor. The provisions and obligations of this section shall survive the expiration or earlier termination of this Agreement. To the extent considered necessary by the City Manager, any sums due Contractor under this Agreement may be retained by City until all of City's claims for indemnification pursuant to this Agreement have been settled or otherwise resolved, and any amount withheld shall not be subject to payment of interest by City.

B. Intellectual Property

Contractor shall protect and defend at Contractor's expense, counsel being subject to the City's approval, and indemnify and hold harmless the City from and against any and all losses, penalties, fines, damages, settlements, judgments, claims, costs, charges, royalties, expenses, or liabilities, including any award of attorney fees and any award of costs, in connection with or arising directly or indirectly out of any infringement or allegation of infringement of any patent, copyright, or other intellectual property right in connection with the Contractor's or the City's use of any copyrighted, patented or un-patented invention, process, article, material, or device that is manufactured, provided, or used pursuant to this Agreement. If the Contractor uses any design, device, or materials covered by letters, patent or copyright, it is mutually agreed and understood without exception that the bid prices shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

C. Termination for Cause

The aggrieved party may terminate this Agreement for cause if the party in breach has not corrected the breach within ten (10) days after written notice from the aggrieved party identifying the breach. The City Manager may also terminate this Agreement upon such notice as the City Manager deems appropriate under the circumstances in the event the City Manager determines that termination is necessary to protect the public health or safety. The parties agree that if the City erroneously, improperly or unjustifiably terminates for cause, such termination shall be deemed a termination for convenience, which shall be effective thirty (30) days after such notice of termination for cause is provided.

This Agreement may be terminated for cause for reasons including, but not limited to, Contractor's repeated (whether negligent or intentional) submission for payment of false or incorrect bills or invoices, failure to perform the Work to the City's satisfaction; or failure to continuously perform the work in a manner calculated to meet or accomplish the objectives as set forth in this Agreement.

D. Termination for Convenience

The City reserves the right, in its best interest as determined by the City, to cancel this contract for convenience by giving written notice to the Contractor at least thirty (30) days prior to the effective date of such cancellation. In the event this Agreement is terminated for convenience, Contractor shall be paid for any services performed to the City's satisfaction pursuant to the Agreement through the termination date specified in the written notice of termination. Contractor acknowledges and agrees that he/she/it has received good, valuable and sufficient consideration from City, the receipt and adequacy of which are hereby acknowledged by Contractor, for City's right to terminate this Agreement for convenience.

E. Cancellation for Unappropriated Funds

The City reserves the right, in its best interest as determined by the City, to cancel this contract for unappropriated funds or unavailability of funds by giving written notice to the Contractor at least thirty (30) days prior to the effective date of such cancellation. The obligation of the City for payment to a Contractor is limited to the availability of funds appropriated in a current fiscal period, and continuation of the contract into a subsequent fiscal period is subject to appropriation of funds, unless otherwise provided by law.

F. Insurance

The Contractor shall furnish proof of insurance requirements as indicated below. The coverage is to remain in force at all times during the contract period. The following minimum insurance coverage is required. The commercial general liability insurance policy shall name the City of Fort Lauderdale, a Florida municipality, as an "additional insured." This MUST be written in the description section of the insurance certificate, even if there is a check-off box on the insurance certificate. Any costs for adding the City as "additional insured" shall be at the Contractor's expense.

The City of Fort Lauderdale shall be given notice 10 days prior to cancellation or modification of any required insurance. The insurance provided shall be endorsed or amended to comply with this notice requirement. In the event that the insurer is unable to accommodate, it shall be the responsibility of the Contractor to provide the proper notice. Such notification will be in writing by registered mail, return receipt requested and addressed to the Procurement Services Division.

The Contractor's insurance must be provided by an A.M. Best's "A-"rated or better insurance company authorized to issue insurance policies in the State of Florida, subject to approval by the City's Risk Manager. Any exclusions or provisions in the insurance maintained by the contractor that excludes coverage for work contemplated in this solicitation shall be deemed unacceptable, and shall be considered breach of contract.

Workers' Compensation and Employers' Liability Insurance

Limits: Workers' Compensation – Per Chapter 440, Florida Statutes
Employers' Liability - $500,000

Any firm performing work on behalf of the City of Fort Lauderdale must provide Workers' Compensation insurance. Exceptions and exemptions will be allowed by the City's Risk Manager, if they are in accordance with Florida Statute. For additional information contact the Department of Financial Services, Workers' Compensation Division at (850) 413-1601 or on the web at www.fldfs.com.

Commercial General Liability Insurance

Covering premises-operations, products-completed operations, independent contractors and contractual liability.

Limits: Combined single limit bodily injury/property damage $1,000,000.

This coverage must include, but not limited to:

a. Coverage for the liability assumed by the contractor under the indemnity provision of the contract.
b. Coverage for Premises/Operations
c. Products/Completed Operations
d. Broad Form Contractual Liability
e. Independent Contractors

Automobile Liability Insurance

Covering all owned, hired and non-owned automobile equipment.

Limits:	Bodily injury	$250,000 each person, $500,000 each occurrence
	Property damage	$100,000 each occurrence

Professional Liability (Errors & Omissions) – "IF REQUIRED IN BID SPECS"

Consultants

Limits: $2,000,000 per ~~occurrence~~claim

Insurance for Electronic Data Theft

The Contractor shall provide proof that it maintains insurance coverage in an amount of not less than $2,000,000 specifically for cyber related crimes relating to the transmission of Protected Health Information over its website that can include but are not limited to criminal activity involving the information technology infrastructure, including illegal access (unauthorized access), illegal interception (by technical means of non-public transmissions of computer data to, from or within a computer system), data interference (unauthorized damaging, deletion, deterioration, alteration or suppression of computer data), systems interference (interfering with the functioning of a computer system by inputting, transmitting, damaging, deleting, deteriorating, altering or suppressing computer data), misuse of devices, forgery (ID theft), and electronic fraud.

Limits: $2,000,000 per occurrence

Certificate holder should be addressed as follows:

City of Fort Lauderdale
Procurement Services Division
100 North Andrews Avenue, Room 619
Fort Lauderdale, FL 33301

G. Environmental, Health and Safety

Contractor shall place the highest priority on health and safety and shall maintain a safe working environment during performance of the Work. Contractor shall comply, and shall secure compliance by its employees, agents, and subcontractors, with all applicable environmental, health, safety and security laws and regulations, and performance conditions in this Agreement. Compliance with such requirements shall represent the minimum standard required of Contractor. Contractor shall be responsible for examining all requirements and determine whether additional or more stringent environmental, health, safety and security provisions are required for the Work. Contractor agrees to utilize protective devices as required by applicable laws, regulations, and any industry or Contractor's health and safety plans and regulations, and to pay the costs and expenses thereof, and warrants that all such persons shall be fit and qualified to carry out the Work.

H. Standard of Care

Contractor represents that he/she/it is qualified to perform the Work, that Contractor and his/her/its subcontractors possess current, valid state and/or local licenses to perform the Work, and that their services shall be performed in a manner consistent with that level of care and skill ordinarily exercised by other qualified contractors under similar circumstances.

I. Rights in Documents and Work

Any and all reports, photographs, surveys, and other data and documents provided or created in connection with this Agreement are and shall remain the property of City; and Contractor disclaims any copyright in such materials. In the event of and upon termination of this Agreement, any reports, photographs, surveys, and other data and documents prepared by Contractor, whether finished or unfinished, shall become the property of City and shall be delivered by Contractor to the City's Contract Administrator within seven (7) days of termination of this Agreement by either party. Any compensation due to Contractor shall be withheld until Contractor delivers all documents to the City as provided herein.

J. Audit Right and Retention of Records

City shall have the right to audit the books, records, and accounts of Contractor and Contractor's subcontractors that are related to this Agreement. Contractor shall keep, and Contractor shall cause Contractor's subcontractors to keep, such books, records, and accounts as may be necessary in order to record complete and correct entries related to this Agreement. All books, records, and accounts of Contractor and Contractor's subcontractors shall be kept in written form, or in a form capable of conversion into written form within a reasonable time, and upon request to do so, Contractor or Contractor's subcontractor, as applicable, shall make same available at no cost to City in written form.

Comment [GB1]: Cigna will provide certain reports to the City to enable them to administer their coverage plans. If termination of the contract occurs, Cigna would transfer information to a designated carrier upon receipt of a suitable confidentiality and hold harmless agreement from that carrier. Any claim or payment data recorded for or otherwise integrated into Cigna's data processing systems during the ordinary course of business, any information which Cigna reasonably deems to be proprietary in nature, or any information which Cigna reasonably believes it cannot divulge due to applicable state and/or federal privacy restrictions will be considered the property of Cigna.

Contractor and Contractor's subcontractors shall preserve and make available, at reasonable times for examination and audit by City in Broward County, Florida, all financial records, supporting documents, statistical records, and any other documents pertinent to this Agreement for the required retention period of the Florida public records law, Chapter 119, Florida Statutes, as may be amended from time to time, if applicable, or, if the Florida Public Records Act is not applicable, for a minimum period of three (3) years after termination of this Agreement. If any audit has been initiated and audit findings have not been resolved at the end of the retention period or three (3) years, whichever is longer, the books, records, and accounts shall be retained until resolution of the audit findings. If the Florida public records law is determined by City to be applicable to Contractor and Contractor's subcontractors' records, Contractor and Contractor's subcontractors shall comply with all requirements thereof; however, Contractor and Contractor's subcontractors shall violate no confidentiality or non-disclosure requirement of either federal or state law. Any incomplete or incorrect entry in such books, records, and accounts shall be a basis for City's disallowance and recovery of any payment upon such entry.

Contractor shall, by written contract, require Contractor's subcontractors to agree to the requirements and obligations of this Section.

The Contractor shall maintain during the term of the contract all books of account, reports and records in accordance with generally accepted accounting practices and standards for records directly related to this contract.

Comment [GB2]: When required by applicable state or federal law and in keeping with the standards of the industry and Cigna's standard audit and review procedures, Cigna shall cooperate with a required audit or review of applicable documents conducted by a duly authorized representative. However, under a fully insured arrangement, Cigna is fully responsible for claims administration and carries all risk associated with such processes therefore, external audits are not permitted. Cigna has an internal claim quality assurance program to monitor internal performance standards to ensure the accuracy of claims payment.

K. Public Entity Crime Act

Contractor represents that the execution of this Agreement will not violate the Public Entity Crime Act, Section 287.133, Florida Statutes, as may be amended from time to time, which essentially provides that a person or affiliate who is a contractor, consultant, or other provider and who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid on a contract to provide any goods or services to City, may not submit a bid on a contract with City for the construction or repair of a public building or public work, may not submit bids on leases of real property to City, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with City, and may not transact any business with City in excess of the threshold amount provided in Section 287.017, Florida Statutes, as may be amended from time to time, for category two purchases for a period of 36 months from the date of being placed on the convicted vendor list. Violation of this section shall result in termination of this Agreement and recovery of all monies paid by City pursuant to this Agreement, and may result in debarment from City's competitive procurement activities.

L. Independent Contractor

Contractor is an independent contractor under this Agreement. Services provided by Contractor pursuant to this Agreement shall be subject to the supervision of the Contractor. In providing such services, neither Contractor nor Contractor's agents shall act as officers, employees, or agents of City. No partnership, joint venture, or other joint relationship is created hereby. City does not extend to Contractor or Contractor's agents any authority of any kind to bind City in any respect whatsoever.

M. Inspection and Non-Waiver

Contractor shall permit the representatives of CITY to inspect and observe the Work at all times.

The failure of the City to insist upon strict performance of any other terms of this Agreement or to exercise any rights conferred by this Agreement shall not be construed by Contractor as a waiver of the City's right to assert or rely on any such terms or rights on any future occasion or as a waiver of any other terms or rights.

N. Assignment and Performance

Neither this Agreement nor any right or interest herein shall be assigned, transferred, or encumbered without the written consent of the other party. In addition, Contractor shall not subcontract any portion of the work required by this Agreement, except as provided in the Schedule of Subcontractor Participation. City may terminate this Agreement, effective immediately, if there is any assignment, or attempted assignment, transfer, or encumbrance, by Contractor of this Agreement or any right or interest herein without City's written consent.

Contractor represents that each person who will render services pursuant to this Agreement is duly qualified to perform such services by all appropriate governmental authorities, where required, and that each such person is reasonably experienced and skilled in the area(s) for which he or she will render his or her services.

Contractor shall perform Contractor's duties, obligations, and services under this Agreement in a skillful and respectable manner. The quality of Contractor's performance and all interim and final product(s) provided to or on behalf of City shall be comparable to the best local and national standards.

In the event Contractor engages any subcontractor in the performance of this Agreement, Contractor shall ensure that all of Contractor 's subcontractors perform in accordance with the terms and conditions of this Agreement. Contractor shall be fully responsible for all of Contractor's subcontractors' performance, and liable for any of Contractor's subcontractors' non-performance and all of Contractor's subcontractors' acts and omissions. Contractor shall defend at Contractor's expense, counsel being subject to City's approval or disapproval, and indemnify and hold City and City's officers, employees, and agents harmless from and against any claim, lawsuit, third party action, fine, penalty, settlement, or judgment, including any award of attorney fees and any award of costs, by or in favor of any of Contractor's subcontractors for payment for work performed for City by any of such subcontractors, and from and against any claim, lawsuit, third party action, fine, penalty, settlement, or judgment, including any award of attorney fees and any award of costs, occasioned by or arising out of any act or omission by any of Contractor 's subcontractors or by any of Contractor's subcontractors' officers, agents, or employees. Contractor's use of subcontractors in connection with this Agreement shall be subject to City's prior written approval, which approval City may revoke at any time.

O. Conflicts

Neither Contractor nor any of Contractor's employees shall have or hold any continuing or frequently recurring employment or contractual relationship that is substantially antagonistic or incompatible with Contractor's loyal and conscientious exercise of judgment and care related to Contractor's performance under this Agreement.

Contractor further agrees that none of Contractor's officers or employees shall, during the term of this Agreement, serve as an expert witness against City in any legal or administrative proceeding in which he, she, or Contractor is not a party, unless compelled by court process. Further, Contractor agrees that such persons shall not give sworn testimony or issue a report or writing, as an expression of his or her expert opinion, which is adverse or prejudicial to the interests of City in connection with any such pending or threatened legal or administrative proceeding unless compelled by court process. The limitations of this section shall not preclude Contractor or any persons in any way from representing themselves, including giving expert testimony in support thereof, in any action or in any administrative or legal proceeding.

In the event Contractor is permitted pursuant to this Agreement to utilize subcontractors to perform any services required by this Agreement, Contractor agrees to require such subcontractors, by written contract, to comply with the provisions of this section to the same extent as Contractor.

P. Schedule and Delays

Time is of the essence in this Agreement. By signing, Contractor affirms that it believes the schedule to be reasonable; provided, however, the parties acknowledge that the schedule might be modified as the City directs.

Q. Materiality and Waiver of Breach

City and Contractor agree that each requirement, duty, and obligation set forth herein was bargained for at arm's-length and is agreed to by the parties in exchange for *quid pro quo*, that each is substantial and important to the formation of this Agreement and that each is, therefore, a material term hereof.

City's failure to enforce any provision of this Agreement shall not be deemed a waiver of such provision or modification of this Agreement. A waiver of any breach of a provision of this Agreement shall not be deemed a waiver of any subsequent breach and shall not be construed to be a modification of the terms of this Agreement.

R. Compliance With Laws

Contractor shall comply with all applicable federal, state, and local laws, codes, ordinances, rules, and regulations in performing Contractor's duties, responsibilities, and obligations pursuant to this Agreement.

S. Severance

In the event a portion of this Agreement is found by a court of competent jurisdiction to be invalid or unenforceable, the provisions not having been found by a court of competent jurisdiction to be invalid or unenforceable shall continue to be effective.

T. Limitation of Liability

The City desires to enter into this Agreement only if in so doing the City can place a limit on the City's liability for any cause of action for money damages due to an alleged breach by the City of this Agreement, so that its liability for any such breach never exceeds the sum of $1,000. Contractor hereby expresses its willingness to enter into this Agreement

with Contractor's recovery from the City for any damage action for breach of contract or for any action or claim arising from this Agreement to be limited to a maximum amount of $1,000 less the amount of all funds actually paid by the City to Contractor pursuant to this Agreement.

Accordingly, and notwithstanding any other term or condition of this Agreement, Contractor hereby agrees that the City shall not be liable to Contractor for damages in an amount in excess of $1,000 which amount shall be reduced by the amount actually paid by the City to Contractor pursuant to this Agreement, for any action for breach of contract or for any action or claim arising out of this Agreement. Nothing contained in this paragraph or elsewhere in this Agreement is in any way intended to be a waiver of the limitation placed upon City's liability as set forth in Section 768.28, Florida Statutes.

U. Jurisdiction, Venue, Waiver, Waiver of Jury Trial

This Agreement shall be interpreted and construed in accordance with and governed by the laws of the State of Florida. Venue for any lawsuit by either party against the other party or otherwise arising out of this Agreement, and for any other legal proceeding, shall be in the Seventeenth Judicial Circuit in and for Broward County, Florida, or in the event of federal jurisdiction, in the Southern District of Florida, Fort Lauderdale Division.

In the event Contractor is a corporation organized under the laws of any province of Canada or is a Canadian federal corporation, the City may enforce in the United States of America or in Canada or in both countries a judgment entered against the Contractor. The Contractor waives any and all defenses to the City's enforcement in Canada of a judgment entered by a court in the United States of America.

V. Amendments

No modification, amendment, or alteration in the terms or conditions contained herein shall be effective unless contained in a written document prepared with the same or similar formality as this Agreement and executed by the Mayor-Commissioner and/or City Manager, as determined by City Charter and Ordinances, and Contractor or others delegated authority to or otherwise authorized to execute same on their behalf.

W. Prior Agreements

This document represents the final and complete understanding of the parties and incorporates or supersedes all prior negotiations, correspondence, conversations, agreements, and understandings applicable to the matters contained herein. The parties agree that there is no commitment, agreement, or understanding concerning the subject matter of this Agreement that is not contained in this written document. Accordingly, the parties agree that no deviation from the terms hereof shall be predicated upon any prior representation or agreement, whether oral or written.

X. Payable Interest

Except as required and provided for by the Florida Local Government Prompt Payment Act, City shall not be liable for interest for any reason, whether as prejudgment interest or for any other purpose, and in furtherance thereof Contractor waives, rejects, disclaims and surrenders any and all entitlement it has or may have to receive interest in connection with a dispute or claim based on or related to this Agreement.

Y. Representation of Authority

Each individual executing this Agreement on behalf of a party hereto hereby represents and warrants that he or she is, on the date he or she signs this Agreement, duly authorized by all necessary and appropriate action to execute this Agreement on behalf of such party and does so with full legal authority.

AA. Uncontrollable Circumstances ("Force Majeure"

The City and Contractor will be excused from the performance of their respective obligations under this agreement when and to the extent that their performance is delayed or prevented by any circumstances beyond their control including, fire, flood, explosion, strikes or other labor disputes, act of God or public emergency, war, riot, civil commotion, malicious damage, act or omission of any governmental authority, delay or failure or shortage of any type of transportation, equipment, or service from a public utility needed for their performance, provided that:

A. The non performing party gives the other party prompt written notice describing the particulars of the Force Majeure including, but not limited to, the nature of the occurrence and its expected duration, and continues to furnish timely reports with respect thereto during the period of the Force Majeure;

B. The excuse of performance is of no greater scope and of no longer duration than is required by the Force Majeure;

C. No obligations of either party that arose before the Force Majeure causing the excuse of performance are excused as a result of the Force Majeure; and

D. The non-performing party uses its best efforts to remedy its inability to perform. Notwithstanding the above, performance shall not be excused under this Section for a period in excess of two (2) months, provided that in extenuating circumstances, the City may excuse performance for a longer term. Economic hardship of the Contractor will not constitute Force Majeure. The term of the agreement shall be extended by a period equal to that during which either party's performance is suspended under this Section.

BB. Scrutinized Companies

Subject to *Odebrecht Construction, Inc., v. Prasad*, 876 F.Supp.2d 1305 (S.D. Fla. 2012), *affirmed*, *Odebrecht Construction, Inc., v. Secretary, Florida Department of Transportation*, 715 F.3d 1268 (11th Cir. 2013),~~—~~with regard to the "Cuba Amendment,"~~this Section applies to any contract for goods or services of $1 million or more:~~ t~~T~~he Contractor certifies that it is not on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List or the Scrutinized Companies that Boycott Israel List created pursuant to Section 215.4725, Florida Statutes (2016), that it is not engaged in a boycott of Israel, and that it does not have business operations in Cuba or Syria as provided in section 287.135, Florida Statutes (2016~~4~~), as may be amended or revised. The City may terminate this ~~Contract~~ Agreement at the City's option if the Contractor is found to have submitted a false certification as provided under subsection (5) of section 287.135, Florida Statutes (2016~~4~~), as may be amended or revised, or been placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List or the Scrutinized

Companies that Boycott Israel List created pursuant to Section 215.4725, Florida Statutes (2016), or is engaged in a boycott of Israel or has been engaged in business operations in Cuba or Syria, as defined in Section 287.135, Florida Statutes (20164), as may be amended or revised.

Comment [GB3]: Updated to reflect the new City terms.

CC. Public Records

Contractor shall:

(a) Keep and maintain public records that ordinarily and necessarily would be required by the City in order to perform the service.

(b) Upon request from the City's custodian of public records, pProvide the ~~public~~ City with a copy of the requested records or allow the records to be inspected or copied within a reasonable time ~~access to public records on the same terms and conditions that the City would provide the records and~~at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes (20164), as may be amended or revised, or as otherwise provided by law.

(c) Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the contract term and following completion of this contract if the Contractor does not transfer the records to the City.

(d) Upon completion of the Contract, ~~Meet all requirements for retaining public records and~~ transfer, at no cost, to the City, all public records in possession of the Cecontractor or keep and maintain public records required by the City to perform the service. If the Contractor transfers all public records to the City upon completion of this Contract, the Contractor shall ~~upon termination of this contract and~~ destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of this Contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the City, upon request from the City's custodian of public records, in a format that is compatible with the information technology systems of the City.

Comment [GB4]: Updated to reflect the new City terms.

IN WITNESS WHEREOF, the City and the Contractor execute this Contract as follows:

CITY OF FORT LAUDERDALE

By: _____
City Manager

Approved as to form:

_____
Senior Assistant City Attorney

ATTEST

~~CONTRACTOR~~CIGNA HEALTH AND LIFE INSURANCE COMPANY

By: _____
Print Name:
Title:

By: _____
Print Name:_____
Title: _____

(CORPORATE SEAL)

STATE OF _____:
COUNTY OF _____:

The foregoing instrument was acknowledged before me this _____ day of _____, 201~~7~~4, by _____ as _____ (title) for _____.

(SEAL)

_____
Notary Public, State of _____
(Signature of Notary Public)

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known ____OR Produced Identification _____
Type of Identification Produced _____

Sample

CIGNA DENTAL PREFERRED
PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2017

DPPO-17
0610433

This document printed in June, 2017 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Sample

GROUP POLICY(S) — COVERAGE

0610433 - DPPO CIGNA DENTAL PREFERRED PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2017

THE BENEFITS IN THIS CERTIFICATE CONTAIN A DEDUCTIBLE PROVISION

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

HC-CER8 04-10
V1

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Important Notices

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with Cigna, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Customer Service/Member Services at the toll-free phone number shown on your ID card, and ask an associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address: Cigna, Nondiscrimination Complaint Coordinator, P.O. Box 188016, Chattanooga, TN 37422.

If you need assistance filing a written grievance, please call the toll-free phone shown on your ID card or send an email to ACAGrievance@cigna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; or by phone at 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT76 10-16

Proficiency of Language Assistance Services

ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1-800-244-6224 (TTY: Dial 711).

Spanish

ATENCIÓN: tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1-800-244-6224 (los usuarios de TTY deben llamar al 711).

Chinese

注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1-800-244-6224（聽障專線：請撥 711）。

Vietnamese

CHÚ Ý: Có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Dành cho khách hàng hiện tại của Cigna, gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1-800-244-6224 (TTY: Quay số 711).

Korean

주의**:** 언어 지원 서비스를 비용없이 이용하실 수 있습니다. 기존 Cigna 가입자의 경우, 가입자 ID 카드 뒷면에 있는 전화번호로 연락해 주십시오. 아니면 1-800-244-6224번으로 연락해 **주십시오**(TTY: 711번으로 전화).

Tagalog

PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1-800-244-6224 (TTY: I-dial ang 711).

Russian

ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1-800-244-6224 (TTY: 711).

Arabic

برجاء الانتباة خدمات الترجمة المجانية متاحة لكم.لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1-800-244-6224(TTY: اتصل ب 711).

French Creole

ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1-800-244-6224 (TTY: Rele 711).

French

ATTENTION: des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1-800-244-6224 (ATS: composez le numéro 711).

Portuguese

ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1-800-244-6224 (Dispositivos TTY: marque 711).

Polish

UWAGA: W celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1-800-244-6224 (TTY: wybierz 711).

Japanese

お知らせ：無料の日本語サポートサービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号におかけ下さい。その他の方は、1-800-244-6224におかけください。（文字電話: 番号711）。

Italian

ATTENZIONE: sono disponibili servizi di assistenza linguistica gratuiti. Per i clientI Cigna attuali, chiamare il numero sul retro della tessera ID. In caso contrario, chiamare il numero 1-800-244-6224 (utenti TTY: chiamare il numero 711).

German

Achtung: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Für gegenwärtige Cigna-Kunden, Bitte rufen Sie die Nummer auf der Rückseite Ihres Personalausweises. Sonst, rufen Sie 1-800-244-6224 (TTY: Wählen Sie 711).

Persian (Farsi)

توجه: خدمات کمکی زبان، رایگان در دسترس شما است. **برای مشتریان فعلی** Cigna، لطفا با شماره ای که در پشت کارت شناسایی شما است تماس بگیرید. **در غیر اینصورت، با شماره** 1-800-244-6224 **تماس بگیرید** (TTY: 711 را شماره گیری کنید).

HC-NOT77 10-16

How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied if it was not reasonably possible to give proof in the time required. Cigna will not reduce or deny the claim for this reason if the proof is submitted as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an

application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HC-CLM13 04-10
V1

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

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

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Employee Group: None.

New Employee Group: The first day of the month following 0 days from date of hire.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form (if required), but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Newborn Children

Coverage for newborn children of an insured employee or the employee’s covered family member begins from the moment of birth.

Coverage for a newborn child of a covered family member terminates when the child is 18 months old.

If notice of birth is given to the company within 30 days there is no premium charge for the initial 30 day period. If timely notice is not given, the insurer may charge additional premium from the time of birth.

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

This policy covers newborn children for the necessary dental care or dental treatment of congenital defects or birth abnormalities of the teeth or gums.

Foster Children, Adoptive Children and Children in Custodial Care

Benefits applicable to children of the insured employee also apply to adoptive children, foster children and children in custodial care. Coverage begins from birth or from the moment of placement in the home. Except in the case of foster children, coverage may not exclude any preexisting condition of the child.

In the case of a newborn adoptive child, coverage begins from the moment of birth if there is a written agreement to adopt the child, whether or not the agreement is enforceable.

Coverage does not extend to an adoptive child who is not ultimately placed in the home of the insured employee.

If notice of the birth or placement of an adopted child is given to the company within 30 days there is no premium charge for the initial 30 day period. If timely notice is not given, the insurer may charge additional premium from the time of birth or placement.

If notice is given within 60 days of the birth or placement of an adopted child, the insurer may not deny coverage for the child due to the failure of the insured to timely notify the insurer of the birth or placement of the child.

If any family member of the insured employee is covered as a dependent, then benefits applicable to children are covered with respect to foster child or other child in court-ordered temporary custody or other custody of the insured employee.

HC-ELG16 04-10
V1

Late Entrant Limit

Coverage for late entrants:

- Class I and Class II services are paid at the amounts set forth in The Schedule.
- All other classes of service are paid at 50% of the amounts set forth in The Schedule.
- After a person has been continuously insured for 12 months, this limit no longer applies.

HC-LEL1 04-10
V2

Cigna Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes two options. When you select a Participating Provider, this plan pays a greater share of the cost than if you were to select a non-Participating Provider.

Emergency Services

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

Deductibles

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

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Cigna. Based on the provider's Contracted Fee, a higher level of plan payment may be made to a Participating Provider resulting in a lower payment responsibility for you. To determine how your Participating Provider compares refer to your provider directory.
Provider information may change annually; refer to your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.com.

Non-Participating Provider Payment

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 90th percentile of all provider charges in the geographic area.

Simultaneous Accumulation of Amounts

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

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III Combined Calendar Year Maximum	Unlimited	
Calendar Year Deductible		
Individual	$150 per person	
Family Maximum	$650 per family	
Class I		
Preventive Care	100% after plan deductible	80% after plan deductible

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Class II		
Basic Restorative	100% after plan deductible	80%
Class III		
Major Restorative (Includes coverage for implants)	100%	80%

Covered Dental Expense

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 $200.

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

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

HC-DEN1 04-10
V1

Dental PPO – Participating and Non-Participating Providers

Plan payment for a covered service delivered by a Participating Provider is the Contracted Fee for that procedure, 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.

Plan payment for a covered service delivered by a non-Participating Provider is the Maximum Reimbursable Charge for that procedure, 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 non-Participating Provider's actual charge.

HC-DEN179 07-14
V1

Class I Services – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

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

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

HC-DEN3 04-10
V5

Class II Services – Basic Restorations, Periodontics, Endodontics, Oral Surgery, Prosthodontic Maintenance

Amalgam Filling

Composite/Resin Filling

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

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

HC-DEN163 04-10
V3

Class III Services - Major Restorations, Dentures and Bridgework

Crowns

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

HC-DEN172 07-14
V1

Expenses Not Covered

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

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- orthodontic treatment;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

Dental Benefits

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

- for services related to an Injury or Sickness paid and/or received under workers' compensation, occupational disease or similar laws;
- 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.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical or dental care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits

provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination,

the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

HC-COB6 04-10
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Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Right Of Reimbursement

If a Participant 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 Participant 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.

Lien Of The Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;

- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

HC-SUB2 04-10
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Payment of Benefits

To Whom Payable

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

HC-POB4 04-10
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Miscellaneous

As a Cigna Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the

purpose of promoting your general health and well being. Please visit our website at www.cigna.com for details.

If you are a Cigna Dental plan member you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

HC-POB5 04-10
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Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: stops paying premium for you; or otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels your insurance.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM3 04-10
V1

Continuation

Special Continuation of Dental Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: the Florida National Guard; or the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance. In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare;
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

Reinstatement of Dental Insurance Employees and Dependents

Upon completion of your active military duty in: the Florida National Guard; or the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: any new waiting periods; or the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and

- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

HC-TRM29 04-10
V1

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease, for any reason other than the person's failure to pay premiums, will be deemed to be incurred while he is insured if:

- the course of treatment was recommended in writing by the physician and began while the person was insured for dental benefits; and
- the Dental Service is other than a routine examination, prophylaxis, x-ray, or sealants;
- and the Dental Service is performed within 90 days after his insurance ceases.

The terms of this Dental Benefits Extension will not apply to a person who becomes insured under another group policy for similar dental benefits.

HC-BEX23 04-10
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Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of dental practitioners, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the 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 child.

HC-FED4 10-10

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning

no later than the day immediately following the last day of the original coverage.

HC-FED70 12-14

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 .09-14

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 .10-10

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED17 .10-10

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18 .10-10

Claim Determination Procedures under ERISA

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

You or your authorized representative (typically, your health care professional) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, if applicable; 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 claim, 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; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED83 03-13

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;

- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

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ERISA Required Information

The name of the Plan is:

Sample

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Sample
Sample, Sample
Sample, Sample Sample
Sample

Employer Identification Number (EIN):	Plan Number:
Sample	Sample

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4 04-10
V1

The Following Will Apply To Residents Of Florida

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you", "your" or "Member" 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 or address that appears on your Benefit Identification card, 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 Florida

You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

The Statewide Provider and Subscriber Assistance Panel
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456 or 850-921-5458

The Agency for Health Care Administration
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456

The Department of Insurance
State Treasurer's Office
State Capitol, Plaza Level Eleven
Tallahassee, FL 32308
1-800-342-2762

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; 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; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); 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.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

HC-APL48 4-10
V1

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1 04-10
V1

Coinsurance

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

HC-DFS122 04-10
V1

Contracted Fee

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

HC-DFS123 04-10
V1

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a provider operating within the scope of his license when he performs any of the Dental Services described in the policy.

HC-DFS125 04-10
V3

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than

once a year, Cigna may require proof of the continuation of such condition and dependence.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

- a stepchild;
- a child born to an insured Dependent child of yours until such child is 18 months old.

If your Domestic Partner has a child, that child will also be included as a Dependent.

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

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

HC-DFS218 04-10
V2

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

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

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

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

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

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS47 04-10
V1

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than hours a week for the Employer.

HC-DFS7 04-10
V3

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Maximum Reimbursable Charge - Dental

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

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

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

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

HC-DFS752 07-14
V5

Medicaid

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

HC-DFS16 04-10
V1

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HC-DFS17 04-10
V1

Participating Provider

The term Participating Provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

HC-DFS136 04-10
V1