Performance Guarantee Agreement

By and Between

Pinellas County Board of County Commissioners

"Sponsor"

And

Cigna Health and Life Insurance Company

And Applicable Affiliates

Collectively "CHLIC"

Effective Date: January 1, 2017

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EXHIBIT A –Performance Guarantees and Penalties

DENTAL HMO IMPLEMENTATION

Implementation 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 0.20 % of Premium
Implementation 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 0.20 % of Premium
Implementation ID Card Timeliness 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 0.20 % of 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 0.20 % of Premium
Network Access DHMO Network Access. Measured for the Term of the Agreement, Access Standard will meet or exceed: 80% of dental office accepting new patients based on National Results.	Amount at Risk 0.20 % of Premium

DPPO SERVICE

Claim Time-to-Process Dental Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 98% of Claims processed w/in 20 Business Days. Results measured at the Account Level.	Amount At Risk $1,000.00
Financial Accuracy Dental Financial Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 99% of total audited claim dollars are correctly paid. Results measured at Office Level.	Amount At Risk $1,000.00
Payment Accuracy Dental Payment Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 97% of total audited claims are correctly paid. Results measured at Office Level.	Amount At Risk $1,000.00

DPPO SERVICE

	Amount At Risk
Average Speed of Answer Dental ASA. Measured for the Term of the Agreement, results will not exceed: 45 seconds to answer a phone call. Results measured at Special Account Queue.	$1,000.00
Call Abandonment Rate Dental Call Abandonment Rate. Measured for the Term of the Agreement, results will not exceed: 3% of calls received by Call Center(s) terminated. Results measured at Special Account Queue.	$1,000.00
Call Activity Closure Dental Call Activity Closure. 98% of calls closed in 10 Business Days. Results measured at Book of Business Level.	$1,000.00
Call Activity Closure Dental Same Day Call Activity Closure. 90% of inquiries related to the Plan are closed in the same Business Day they are received. Results measured at Book of Business Level.	$1,000.00
CSA Quality Dental CSA Quality. 95% quality standard. Results measured at Office Level.	$1,000.00
Automated Maintenance Eligibility Processing Dental Auto Eligibility Processing. Measured for the Term of the Agreement, results will meet or exceed: 99% files processed in 2 Business Days after the receipt of clean eligibility. Results measured at the Account Level.	$1,000.00
Account Management Dental Account Management. Composite Score (all categories) of 3.0 or better on the Account Management Report Card based on four (4) quarterly scorecards. Results measured at Account Level.	$1,000.00

DENTAL HMO SERVICE

	Amount At Risk.
Average Speed of Answer Dental HMO ASA. Measured for the Term of the Agreement, results will not exceed: 45 seconds to answer a phone call. Results measured at Special Account Queue.	0.20 % of Premium
Call Abandonment Rate Dental HMO Call Abandonment Rate. Measured for the Term of the Agreement, results will not exceed: 3% of calls received by Call Center(s) terminated. Results measured at the Special Account Queue.	0.20 % of Premium

DENTAL HMO SERVICE

Member Satisfaction	Amount At Risk
Dental HMO Member Satisfaction. Measured for the Term of the Agreement, results will meet or exceed: a member satisfaction level of 75% or greater with Cigna Dental overall. Results measured at Book of Business Level.	0.20 % of Premium

Post Enrollment Measure	Amount At Risk
Dental HMO 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.	0.20 % of Premium

Time to Process – Specialty Referral Claim Rate	Amount At Risk
Dental HMO Time to Process. Measured for the Term of the Agreement, result will meet or exceed: 98% within 15 Business Days. Results measured at Office Level.	0.20 % of Premium

This Performance Guarantee Agreement ("**Agreement**") is between Cigna Health and Life Insurance Company and applicable affiliates (collectively "**CHLIC**") and Pinellas County Board of County Commissioners ("**Sponsor**") which term is used throughout for ease of reference only but with acknowledgement that Sponsor, rather the Employer, may be a more accurate term) and is effective on January 1, 2017 ("**Effective Date**").

WHEREAS, in connection with certain services and programs that CHLIC is providing to Sponsor in connection with one or more employee welfare benefit plans sponsored by Sponsor (the "**Plan(s)**") under the applicable agreements between the parties (individually or collectively, the "**Service Agreements and/or Policies**"), CHLIC and Sponsor desire to implement the performance guarantees identified in Exhibit A attached hereto, according to the terms set forth below.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, CHLIC and Sponsor hereby agree as follows:

Section 1. – Term and Termination

1.1. This Agreement is effective on the Effective Date and shall remain in effect for five (5) years or such other period specified in the applicable Exhibit B (the "**Term**") unless terminated sooner upon the earliest of the following dates:

1.1.1. The date when CHLIC ceases to administer the Plan(s) (other than run-out claim administration) or when the applicable Service Agreements and/or Policies are terminated or suspended;

1.1.2. The date when any state or other applicable jurisdiction prohibits the activities of the parties under this Agreement;

1.1.3. The Effective Date, in the event that any condition precedent listed in Section 3 or in the applicable Exhibit B is not satisfied.

1.2. This Agreement is not renewable unless otherwise specified in the applicable Exhibit B.

Section 2. – Definitions

2.1. The following terms used in this Agreement are defined as follows. Additional definitions applicable to a specific Performance Guarantee may be included in Exhibit B. Terms not defined in this section, the applicable Exhibit B, or otherwise in this Agreement shall be deemed to reflect the commonly understood industry meaning.

2.2. Account Level – means that performance shall be measured based upon performance with respect to the Sponsor's Plan(s) to which the Performance Guarantee applies.

2.2.1. Benefit Profile – means the benefits offered under a Plan, including plan design and structure.

2.2.2. Book of Business Level – means that performance shall be measured based upon all plans insured and or administered by CHLIC and its affiliates as determined by CHLIC.

2.2.3. Business Days – means the days of the week that CHLIC is open to the public for conducting business.

2.2.4. Employee – means a person who is an employee or retiree of the Sponsor and covered under the Plan(s).

2.2.5. Guarantee Period – means the period during which CHLIC's performance that is the subject of the Performance Guarantee will be measured, which shall five (5) years from the Effective Date, unless otherwise specified in the applicable Exhibit B.

2.2.6. Payment Amount – means the amount payable, as determined by CHLIC under the criteria set forth in this Agreement, pursuant to the terms of a Performance Guarantee.

2.2.7. Performance Guarantees – means the guarantees identified in Exhibit A pursuant to which CHLIC commits to achieving specified levels of performance in connection with the applicable Service Agreements and/or Policies.

2.2.8. Plan Participants – means eligible persons enrolled in the applicable Plan(s) to which the specific Performance Guarantee applies.

2.2.9. Projected Population – means the number of Employees that Sponsor estimated would be enrolled in the applicable Plan(s) to which the specific Performance Guarantee applies on the Effective Date which is 3,090 dental PPO enrolled Employees and 1,060 dental HMO enrolled Employees.

Section 3. – Conditions Precedent

3.1. Sponsor acknowledges and agrees that the following conditions precedent must be met in order for any Performance Guarantee set forth in this Agreement to be in effect, otherwise such Performance Guarantee is null and void:

3.1.1. This Agreement is signed by both parties within three (3) months of the Effective Date;

3.1.2. Sponsor does not make a material change in Benefit Profile during the Term that, as reasonably determined by CHLIC, affects the performance being measured in the applicable Performance Guarantee;

3.1.3. CHLIC continuously administers the services to which the applicable Performance Guarantee applies for the entire Term;

3.1.4. Sponsor must be an active client of CHLIC for the type of coverage(s) to which this Agreement relates (e.g. Medical, Dental, Pharmacy, Vision, etc.) at the time any Payment Amount is otherwise payable by CHLIC under this Agreement;

3.1.5. This Agreement remains continuously in effect for the entire Term;

3.1.6. The Plan(s) applicable to a specific Performance Guarantee remains in effect throughout the Term;

3.1.7. The applicable Service Agreements and/or Policies to which the Performance Guarantee relates remains in effect throughout the Term of this Agreement, or the Sponsor treats the applicable Service Agreements and/or Policies as being in effect by materially performing its duties and obligations under the applicable Service Agreements and/or Policies throughout the Term of this Agreement;

3.1.8. The conditions precedent set forth in Exhibit B of a specific Performance Guarantee are met.

Section 4. – Evaluation of Performance and Payment Amounts

4.1. Performance Guarantees and the applicable levels of measurement and Payment Amounts are listed in Exhibit A. Any additional terms, conditions precedent and definitions, if applicable, for any Performance

Guarantee, are listed in the applicable Exhibit B. In the event of a conflict between terms in the Agreement, the terms of the applicable Exhibit B shall control.

4.2. CHLIC will report to Sponsor on each Performance Guarantee (the "**Performance Reports**") within the specific time frame listed in the applicable Exhibit B for each specific Performance Guarantee.

4.3. Sponsor shall notify CHLIC in writing within sixty (60) days of receiving the Performance Report of any dispute concerning the Performance Report.

4.4. CHLIC or Sponsor, as applicable, shall pay any Payment Amount due under the Performance Report after the Guarantee Period. Upon prior written notice to Sponsor, CHLIC may offset the Payment Amount against any payments owed by Sponsor to CHLIC.

4.5. In the event that Sponsor fails to perform any of its obligations under the applicable Service Agreements and/or Policies in a way that affects CHLIC's ability to perform a function being measured in a Performance Guarantee, CHLIC reserves the right to adjust the Payment Amount, if any, to account for Sponsor's act or omission.

4.6. Performance Reports measure results for the entire Guarantee Period. Any quarterly or other periodic results shared with Sponsor are for informational purposes only.

4.7. No third party audit results will be used to measure performance under a Performance Guarantee.

4.8. Payment Amounts are based on the Projected Population and/or total amount of fees expected to be paid by Sponsor to CHLIC under the applicable Service Agreements and/or Policies. Payment Amounts are subject to change by CHLIC in the event that the Projected Population and/or total amount of fees paid by Sponsor under the applicable Service Agreements and/or Policies during the Guarantee Period changes.

Section 5. – Measurement Methodology/Changes

5.1. CHLIC shall apply its standard methodology, consistent with applicable industry standards, to measure its performance under a Performance Guarantee. Additional information about methodology for specific Performance Guarantees, if applicable, is detailed in the applicable Exhibit B. Industry standard codes, including but not limited to CPT, ICD-10, NDC and CDT codes, that are set by the industry or a government agency are subject to update/change. Any such updates/changes occurring after the Effective Date will be deemed incorporated into this Agreement without further action required by the parties.

5.2. CHLIC may replace or modify Performance Guarantees if necessitated by a change in the way CHLIC systematically tracks or measures the applicable performance guaranteed. Any substitute Performance Guarantee will, to the extent reasonably possible, attempt to reflect the same underlying objective and performance level reflected in the original Performance Guarantee, consistent with its new measurement/tracking methodology. CHLIC shall explain the reasons for the change of a Performance Guarantee and the specifics of the substitute Performance Guarantee in writing at least 30 days prior to such change.

Section 6. – Agreement Modification

This Agreement constitutes the entire contract between the parties relating to the subject matter herein and no modification or amendment hereto shall be valid unless it is in writing and signed by an officer of Sponsor and by CHLIC's Regional Financial Officer.

Section 7. – Laws Governing Contract

This Agreement shall be construed in accordance with the laws of the State of Florida without regard to conflict of law rules, and both parties consent to the venue and jurisdiction of its courts.

Section 8. - Resolution of Disputes

8.1. It is understood and agreed that any dispute between the parties arising from or relating to the performance or interpretation of this Agreement ("**Controversy**") shall be resolved exclusively pursuant to the following mandatory dispute resolution procedures:

8.1.1. Any Controversy shall first be referred to an executive level employee of each party who shall meet and confer with his/her counterpart to attempt to resolve the dispute ("**Executive Review**") as follows: The disputing party shall initiate Executive Review by giving the other party written notice of the Controversy and shall specifically request Executive Review of said Controversy in such notice. Within twenty (20) calendar days of any party's written request for Executive Review, the receiving party shall submit a written response. Both the notice and response shall include a statement of each party's position and a summary of the evidence and arguments supporting its position. Within thirty (30) calendar days of any party's request for Executive Review, an executive level employee of each party shall be designated by the party to meet and confer with his/her counterpart to attempt to resolve the dispute. Each representative shall have full authority to resolve the dispute.

8.1.2. In the event that a Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 8.1.1., above, the disputing party shall initiate mediation by providing written notice to the other party, which shall be conducted in Pinellas County, Florida, in accordance with the American Arbitration Association Commercial Mediation Rules ("**Mediation**"). Each party shall assume its own costs and attorneys' fees, and the compensation and expenses of the mediator and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the parties.

8.1.3. This Section 8 shall survive the termination of this Agreement.

Section 9. – Third Party Beneficiaries

This Agreement is for the exclusive benefit of Sponsor and CHLIC. It shall not be construed to create any legal relationship between CHLIC and any other party.

Section 10. – Assignment and Subcontracting

No assignment of rights or interests hereunder shall be binding unless approved in writing by a duly authorized officer of each of the parties.

Section 11. – Nondisclosure

Information CHLIC reports to Sponsor in connection with this Agreement, including the Performance Guarantee Reports and the Payment Amounts, are proprietary and confidential. Sponsor shall maintain the confidentiality of such information provided to Sponsor pursuant to this Agreement and shall not disclose information to any other party without the express written consent of CHLIC unless otherwise required by law or as required by applicable law

Contractor acknowledges that information and data it manages as part of the services may be public records in accordance with Chapter 119, Florida Statutes and Pinellas County public records policies. Contractor agrees that prior to providing services it will implement policies and procedures to maintain, produce, secure, and retain public records in accordance with applicable laws, regulations, and County policies, including but not limited to the Section 119.0701, Florida Statutes. Notwithstanding any other provision of this Agreement relating to compensation, the Contractor agrees to charge the County, and/or any third parties requesting public records only such fees allowed by Section 119.07, Florida Statutes, and County policy for locating and producing public records during the term of this Agreement.

If the contractor has questions regarding the application of Chapter 119, Florida Statues, to the Contractor's duty to provide public records relating to this contract, contact the Pinellas County Board of County Commissioners, Purchasing Department, Operations Manager custodian of public records at 727-464-3311, purchase@pinellascounty.org, Pinellas County Government, Purchasing Department, Operations Manager, 400 S. Ft. Harrison Ave, 6th Floor, Clearwater, FL 33756.

Section 12. – Waivers

No course of dealing or failure of either party to strictly enforce any term, right or condition of this Agreement shall be construed as a waiver of such term, right or condition. Waiver by either party of any default shall not be deemed a waiver of any other default.

Section 13. – Headings

Article, section, or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

Section 14. – Survival

Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

Section 15. – Force Majeure

CHLIC shall not be liable for any failure to meet any of the obligations required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of CHLIC, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by CHLIC, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations.

Section 16. – Notices

Except as otherwise provided, all notices or other communications hereunder shall be in writing and shall be deemed to have been duly made when (a) delivered in person, (b) delivered to an agent, such as an overnight or similar delivery service, (c) delivered electronically, or (d) deposited in the United States mail, postage prepaid, and addressed as follows:

To CHLIC:
Cigna Health and Life Insurance Company
1571 Sawgrass Corporate Parkway
Suite #140
Sunrise, FL 33323
Attention: Beth Porcelan, Operations Director

To Sponsor:
Pinellas County Board of County Commissioners
Attn: Employee Benefits Manager
400 South Fort Harrison Avenue
4th Floor
Clearwater, FL 33756
Attention: Ken Burke, Clerk of the Circuit Court

The address to which notices or communications may be given by either party may be changed by written notice given by such party to the other pursuant to this Section.

Section 17. – Entire Agreement

This Agreement constitutes the entire Agreement between the parties on the subject matter herein. Any and all other Performance Guarantee Agreements between the parties relating to the subject matter of this Agreement, if not already terminated, are terminated as of the Effective Date of this Agreement.

Signatures

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in duplicate and signed by their respective officers duly authorized to do so as of the dates given below.

Cigna Health and Life Insurance Company

By: Victoria A. Sirica

Printed Name: Victoria A. Sirica

Title: Contractual Agreement Unit Manager
Duly Authorized

Date: December 9, 2016

Pinellas County Board of County Commissioners

Charlie Justice, Chairman

By: Maria D. Kay
Deputy Clerk

for Printed Name: Ken Burke

Title: Clerk of the Circuit Court
Duly Authorized

Date: 12-13-2016

APPROVED AS TO FORM
OFFICE OF COUNTY ATTORNEY

By: _____
Attorney

EXHIBIT B1 - IMPLEMENTATION

1. **Additional Definitions**

1.1. Commitment Dates – means the dates by which CHLIC must perform specific implementation services, as set forth in the Implementation Calendar.

1.2. Implementation Calendar – means the schedule that sets out the mutually agreed upon obligations for Sponsor and CHLIC in connection with the implementation of the Plan.

1.3. Service Center(s) – means a claim processing office of CHLIC that processes Claims and receives and responds to Plan Participant telephone calls.

2. **Additional Conditions Precedent**

2.1. Benefit Profiles must be finalized and provided to CHLIC by Sponsor at least 60 days prior to the Effective Date or CHLIC confirms that the non-standard design and structure can be reasonably implemented at least 30 days prior to the Effective Date.

2.2. Sponsor or its designated agent must provide to CHLIC eligibility information for Plan Participants that is accurate, complete, accessible, and timely under the predetermined schedule.

2.3. The Implementation Calendar must be finalized and approved by Sponsor and CHLIC prior to the Effective Date.

2.4. Sponsor must fulfill its obligations in the Implementation Calendar, including timely, accurate and complete Plan Participant eligibility information and Benefit Profiles.

2.5. Sponsor must return the completed Account Implementation Survey within sixty (60) days of receipt, in accordance with paragraph 4.4.1. below.

3. **Additional Terms**

3.1. The Guarantee Period for the Implementation Performance Guarantees is six (6) months beginning on the Effective Date.

3.2. Implementation Performance Guarantees set forth in this Exhibit shall be measured solely based on the timely, complete and accurate information provided by Sponsor or its designee to CHLIC as of the due dates set forth in the Implementation Calendar.

4. **Implementation Performance Evaluation Measures**

4.1. **Identification Card Delivery**

4.1.1. Identification Card Delivery – will be determined by whether CHLIC mailed identification cards to Plan Participants by the dates indicated in the Implementation Calendar.

4.2. **Claim Readiness**

4.2.1. Claim Readiness - will be determined by whether all complete and accurate Benefit Profile and eligibility information for each eligible Plan Participant under the Plan was loaded on CHLIC's claims processing system as of the Commitment Date set forth in the approved Implementation Calendar.

4.3. **Call Readiness**

4.3.1. Call Readiness Performance – will be determined by whether Plan specifications were loaded into the applicable inquiry system with the Service Center(s) ready to respond to Plan Participant inquiries as of the Commitment Date set forth in the approved Implementation Calendar.

4.4. **Overall Satisfaction with Implementation Services**

4.4.1. Overall Satisfaction with Implementation Services - will be determined by whether Sponsor is satisfied with the implementation process, as reflected by a score of no less than "3" on Statement 1 of an Account Implementation Survey to be distributed to the Sponsor by CHLIC. Statement 1 recites that the overall implementation of the account or account changes met the Sponsor's needs. A score of "3" will mean that the Sponsor neither agrees nor disagrees with this statement. The Account Implementation Survey shall be provided to the Sponsor within sixty (60) calendar days after the Effective Date; the Sponsor shall return the completed Account Implementation Survey results to CHLIC within sixty (60) days of receipt.

5. **Evaluation of Performance and Payment Amounts**

5.1. Within four (4) months of completion of Implementation, CHLIC shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and any payments owed and make this information available to the Sponsor in a Performance Report.

EXHIBIT B2 - SERVICE

1. **Additional Definitions**

1.1. Average Speed to Answer – means the sum of the total elapsed time between the moment when a telephone call is queued and the time the call is responded to.

1.2. Call – means a telephone call received by a Call Center from a Plan Participant about a Claim or benefit provided by the Plan.

1.3. Call Center – means the member service center of CHLIC that receives and responds to Plan Participant telephone calls.

1.4. Claim – means a claim received by CHLIC for benefits under the Plan(s). If the term "claim" is used without a capital c, it refers to a claim received by CHLIC for benefits whether under the Sponsor's Plan(s) or under other plans.

1.5. CHLIC's Standard Quality Assurance Audit Methodology – means the method by which CHLIC objectively measures claim quality by auditing claims to measure claim accuracy through identification of claim payment or processing errors that are based on data available to the claim processor at the time/day the claim was paid, that caused incorrect payment or correspondence, that has a customer impact and that results in correctional work by CHLIC.

1.6. Customer Service Advocate ("CSA") – means a person whose job it is to respond to callers to a Call Center.

1.7. Inquiry – means an activity generated as a result of a Call received by a Call Center about a Claim or benefit matter. One Call may result in one or more activities.

1.8. Maintenance Eligibility – means additions, deletions and changes in eligibility that are processed during the Guarantee Period.

1.9. Maintenance ID Cards – means ID Cards issued during the Guarantee Period for changes in member address, changes in enrollment, etc.

1.10. Office Level – means the performance is measured using a random sample of all the claims processed for the Service Center(s) on the same claim engine that processes Sponsor's Claims.

1.11. Processed – means that CHLIC has made a determination as to whether expenses for which a Claim/claim is made are covered and, if covered, determined the amount of reimbursement or determined that the Claim/claim is missing critical data which must be requested from an external source.

1.12. Service Center(s) – means a claim processing office of CHLIC that processes Claims and receives and responds to Plan Participant telephone calls.

1.13. Special Account Queue – means a defined group of CHLIC associates that handle a specific block of business with similar Average Speed of Answer and Abandonment Rate requirements. For measurement purposes, results are derived by compiling combined results for all accounts with this requirement.

2. **Performance Guarantee Metrics**

2.1. **Claim Time-to-Process (TTP)**

2.1.1. Claim Time-to-Process - will be calculated by counting the number of Business Days or calendar days (as appropriate as determined by CHLIC) from the day that a Claim is received by CHLIC to and including the day the Claim is Processed. The day that the Claim is received will not be included in this calculation.

2.2. **Claim Quality**

2.2.1. **Financial Accuracy**

2.2.1.1. Financial Accuracy - will be determined by applying CHLIC's Standard Quality Assurance Audit Methodology to a statistically valid sample of Claims (Account Level) or claims (Office Level) processed during the Guarantee Period.

Financial Accuracy represents the sum of the absolute value of total dollars overpaid and the total dollars underpaid subtracted from the total dollars paid, divided by the total dollars paid, expressed as a percentage. Overpayments and underpayments are determined from auditing a statistically valid sample of Claims/claims paid during the Guarantee Period.

2.2.2. **Claim Payment Accuracy**

2.2.2.1. Claim Payment Accuracy - will be determined by applying CHLIC's Standard Quality Assurance Audit Methodology to a statistically valid sample of paid Claims (Account Level) or claims (Office Level) processed during the Guarantee Period.

Claim Payment Accuracy represents the total number of Claims/claims processed without any payment errors, divided by the total Claims/claims processed, expressed as a percentage. The calculation of Claims/claims paid with financial error is determined by CHLIC from auditing a statistically valid sample of Claims/claims paid during the Guarantee Period.

2.3. **Inquiry**

2.3.1. **Average Speed of Answer (ASA)**

2.3.1.1. ASA - will be determined by measuring the sum of the total elapsed time between the moment when a telephone call is queued and the time the call is responded to for all answered calls, and then dividing that number by the total number of telephone calls answered during the Guarantee Period.

The calculation of ASA is based on all calls received during the hours of operation of the Service Center during the Guarantee Period that are serviced in the Special Account Queue.

2.3.2. **Call Abandonment Rate**

2.3.2.1. Call Abandonment Rate - will be determined by dividing the total number of calls received during the Guarantee Period that result in the caller terminating the call after it is queued to a CSA, by the total number of telephone calls received during the Guarantee Period, expressed as a percentage.

The calculation of Call Abandonment Rate is based on all calls received during the hours of operation of the Service Center during the Guarantee Period that are serviced in the Special Account Queue.

2.3.3. **Call Activity Closure Rate**

2.3.3.1. Call Activity Closure Rate - will be determined by dividing the number of Inquiries closed within the Guarantee Period by the total number of Inquiries received during the Guarantee Period, expressed as a percentage. An Inquiry will be considered closed when CHLIC gives it a closed status on its Inquiry Tracking System(s). The Call Activity Closure Rate will be calculated by counting the number of Business Days from the Business Day that the Inquiry is received, to and including the Business Day that the Inquiry is closed. For purposes of this calculation, the Business Day that the Inquiry is received will not be included in the calculation.

2.3.4. **CSA Quality**

2.3.4.1. CSA Quality Rate - will be determined by averaging the quality scores of randomly monitored answered calls for Sponsor or Office during the Guarantee Period, expressed as a percentage. The average quality score of randomly monitored answered calls for Sponsor or Office during the Guarantee Period shall achieve CHLIC's quality standards.

2.4. **Sponsor Service**

2.4.1. **Automated Maintenance Eligibility Processing***

*This Performance Guarantee shall not apply if Sponsor is using the Enrollment Maintenance Tool.

2.4.1.1. Additional Condition Precedent - This Maintenance Eligibility Processing Performance Guarantee is contingent upon the submission by Sponsor (or Sponsor's agent) of full electronic eligibility files containing no more than two (2) percent erroneous records. An "erroneous record" means any Plan Participant record lacking any of the accurate information necessary to correctly administer benefits, such as: correct spelling of the Plan Participant's name; applicable Social Security Number; date of birth; account number; division (if any); branch number; information to correctly identify plan and benefit structure, such as benefit option code, benefit structure, plan code, plan type, network ID (if the Plan uses provider networks); effective date of coverage; termination date; HIPAA privacy information (if any); member address and any other demographic data.

2.4.1.2. Maintenance Eligibility Processing - will be determined by dividing the number of eligibility files that met the performance standard during the Guarantee Period by the total number of eligibility files processed during the Guarantee Period, expressed as a percentage. Whether the performance standard has been met will be determined by counting the number of Business Days from the Business Day that the file is received by CHLIC to and including the Business Day the file is entered into the CHLIC eligibility system. The Business Day the file is received will not be included in this calculation.

2.5. **Account Management**

2.5.1. Account Management Performance Guarantee – will be met if CHLIC's Account Management Sales Team provides services to Sponsor of such quality that the designated Account Management Composite Score based upon four (4) quarterly scorecards during the Guarantee Period is met on the Account Management Report Card (sample available upon request).

2.5.2. Account Management Condition Precedent – This commitment is contingent on Sponsor completing its obligations in the "Evaluation of Account Management" subsection below, on a quarterly basis.

2.5.3. Evaluation of Account Management - At the beginning of the Term, Sponsor shall designate individuals on its benefits staff who will receive and complete the Account Management Report Card on a quarterly basis.

The Account Management Report Card will be distributed to Sponsor's designated staff members on a quarterly basis, shall be completed, signed and dated by them, and all returned to CHLIC by Sponsor within three (3) weeks of the distribution date. Failure of Sponsor to meet its obligations in this subparagraph and the subparagraph above shall nullify the Account Management Performance Guarantee.

Following the end of the Guarantee Period and receipt of the fourth (4^{th}) quarterly survey from Sponsor, CHLIC will calculate the composite score in each performance assessment category by averaging the scores for the four (4) quarters of the Guarantee Period. The assessments of each of the designated staff members and each of the performance assessment categories will be weighted equally. The Account Management Performance Guarantee will be deemed fulfilled if the average of the composite scores in each category ("**Account Management Composite Score**") is equal to or greater than the Account Management Composite Score indicated on Exhibit A.

2.5.4. Reservation of Right – CHLIC reserves the right to make changes during the Term in its staff/personnel assigned to provide Account Management services to Sponsor.

3. **Evaluation of Performance and Payment Amounts**

3.1. Within four (4) months after the end of the Term, CHLIC shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each Performance Guarantee set forth in this Agreement and make this information available to Sponsor in a Performance Report.

The Payment Amounts in Exhibit A have been established in relationship to the Projected Population. In the event that the actual number of Employees enrolled on the Effective Date is greater than one-hundred and fifteen percent (115%) of the Projected Population, the Sponsor reserves the right to increase the Payment Amounts in proportion to the variation between the actual and projected number of enrolled Employees. Correspondingly, CHLIC reserves the right to decrease the Payment Amounts in proportion to the variation between the actual and projected number of enrolled Employees in the event that the actual number of Employees enrolled on the Effective Date is less than eighty-five percent (85%) of the Projected Population.

EXHIBIT B3 - DENTAL HMO

1. **Additional Definitions**

1.1. Book of Business Level – means that the performance commitment is measured based on the total Cigna Dental HMO book of business.

1.2. Call Center – means the member service center of Cigna Dental that receives and responds to Plan Participant telephone calls.

1.3. Customer Service Advocate ("CSA") – means a person responding to callers at a Call Center.

1.4. Inquiry – means an answered call, received at a Call Center, about the services Cigna Dental provides to the Plan(s).

1.5. Office Level – means that the performance commitment is measured using a random sample of all the claims processed on the same claim engine that processes Sponsor's claims for the Service Center(s) or calls received in Call Center(s) that answer Sponsor's calls.

1.6. Special Account Queue – means a defined group of Customer Service Advocates that handle a specific block of business with similar ASA and abandonment rate requirements. For measurement purposes, results are derived by compiling combined results for all accounts with these requirements.

1.7. Specialty Referral Claim – means requests submitted by the Network Specialty Dentist for a care treatment plan for payment authorization, except for Pediatrics, Orthodontics and Endodontics, where prior authorization is not required.

2. **Additional Conditions Precedent**

2.1. The Service Agreements and/or Policies to which these Performance Guarantees relate must be in full force and effect at the time a payment is due, regardless of whether the Guarantee Period specified herein ended prior to or at the same time as termination of such Service Agreements and/or Policies, except to the extent that the Agreements and/or Policies have ended due to reaching their full term in which case any Performance Guarantee payments due remain due.

3. **Additional Terms**

3.1. The Payment Amount due under this Performance Guarantee will be calculated based on the average number of enrolled Employees during the Guarantee Period, not the Projected Population.

4. **Performance Evaluation Metrics**

4.1. Average Speed of Answer (ASA) - is determined by dividing the sum of the total elapsed time between the moment when a telephone call is queued to the Call Center(s) and the time the call is responded to for all answered calls to the Call Center(s) during the Guarantee Period by the total number of telephone calls answered in the Call Center(s) during the Guarantee Period.

4.2. Call Abandonment Rate - will be determined by dividing the total number of calls received during the Guarantee Period that result in the caller terminating the call after it is queued to a CSA by the total number of telephone calls received by the Call Center(s) during the Guarantee Period, expressed as a percent.

4.3. Member Satisfaction – will be determined through evaluation of member surveys, transfer patterns and member complaint/grievance information. Member satisfaction surveys are conducted on a continuous basis, and are designed to measure Cigna Dental's performance and to assess member satisfaction with the services provided. Performance measures include, but are not limited to: Services rendered at the dental office, staff's attitudes, communication of expenses, management of patient discomfort, office environment, perception of treatment outcome and patient waiting time.

4.4. Provision of Post-Enrollment Materials Performance – will be determined by whether Post-enrollment materials were mailed to the Sponsor and/or Plan Participants within the designated number of weeks following receipt of the eligibility files from the Sponsor. The electronic file must be received from Sponsor in order to release this eligibility file to the ID card vendor.

Additional Condition Precedent – this Post-enrollment Performance Guarantee is contingent upon the timely submission by Sponsor (or Sponsor's agent) of full electronic eligibility files containing no more than two percent (2%) erroneous records. An "erroneous record" is defined as a Plan Participant record lacking any of the accurate information necessary to correctly administer benefits, such as: Correct spelling of the Plan Participant's name, applicable Social Security Number, date of birth, account number, division (if any), branch number, information to correctly identify plan and benefit structure, such as benefit option code, benefit structure, plan code, plan type, effective date of coverage, termination date, HIPAA privacy information (if any), member address and any other demographical information.

4.5. Time to Process - Specialty Referral Claims Rate – will be determined by dividing the number of Business Days from when the Specialty Referral Claim is received, to and including the Business Day that the Specialty Referral Claim is closed, for all Specialty Referral Claims received during the Guarantee Period by the number of Specialty Referral Claims received during the Guarantee Period, expressed as a percent. For purposes of this calculation, the Business Day that the Specialty Referral Claim is received will not be included in this calculation.

5. **Evaluation of Performance and Payment Amounts**

5.1. Within four (4) months after the end of the Guarantee Period, CHLIC shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and make this information available to the Sponsor in a Performance Report.

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: Pinellas County Board of County Commissioners
B. ADDRESS: 400 South Ft. Harrison, 4th Floor, Clearwater, FL 33756 PHONE: 727.464.3316
C. BILLING ADDRESS, IF DIFFERENT: _____
D. NAME OF CONTACT: David Blasewitz 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: 1140 TOTAL NUMBER OF ELIGIBLE EMPLOYEES: 1140
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) 25* (b) 25*
*End of calendar year in which age 25 is reached

DENTAL PLAN

A. EFFECTIVE DATE: The proposed Effective Date of group coverage is January 1, 2017, 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- 7.17 02- 10.26 03- 14.38 04- _____ Composite ____. Premiums are guaranteed through December 31, 2019; 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: PSXV9. 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: December 31, 2019
F. DENTAL OFFICE: Enrolled employees and their enrolled dependents must select a Dental Office. All family members must use the same Dental Office *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: CHARLIE JUSTICE (PRINT NAME OF APPLICANT'S REPRESENTATIVE) TITLE: CHAIRMAN AGENT/BROKER: _____ (PRINT NAME)

_____ (SIGNATURE OF APPLICANT'S REPRESENTATIVE) DATE: 12/13/16 _____ (SIGNATURE OF AGENT/BROKER) DATE: _____

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

ATTEST: KEN BURKE, CLERK
By: _____
Deputy Clerk

APPROVED AS TO FORM
OFFICE OF COUNTY ATTORNEY
By: _____
Attorney

10/26/2016

October 26, 2016

Mr. David Blasewitz
Pinellas County Board of County Commissioners
400 South Ft. Harrison
4th Floor
Clearwater, FL 33756

Dear Mr. Blasewitz:

We wish to take this opportunity to welcome your organization to the Cigna Dental Health family.

Enclosed please find a binder containing your Cigna Dental Health Group Contract, Patient Charge Schedule(s) and Pre-Contract Application. These documents cover employees located in Florida. Under the terms of the Group Contract, it is not necessary for you to execute the Contract when an executed Pre-Contract Application is on file. Because it is essential that both the Group and Cigna Dental Health maintain a signed copy of the Pre-Contract Application, we would appreciate you returning the executed Application at your earliest convenience. Once the Pre-Contract Application has been signed and returned, you should retain the enclosed documents in your file.

Please note that your organization will be deemed to have accepted the terms of the Group Contract unless you advise us to the contrary within twenty (20) days from the date of receipt.

You may also receive other policies or participation agreements from Connecticut General Life Insurance Company to reflect dental health coverage in other states or additional out-of-network coverage that you may have purchased.

If you have any questions, please feel free to call Contracts Administration at 954.514.6600. Thank you again for selecting Cigna Dental Health.

Sincerely,

Vallorie Miller-Joseph

Vallorie Miller-Joseph
Contracts Support Specialist
CIGNA DENTAL HEALTH, INC.

Enclosures: Group Contract
Patient Charge Schedule
Pre-Contract Application
Return Envelope

Group Contract

Pinellas County Board of County Commissioners
and
Cigna Dental Health

Member Services 1.800.Cigna24
(Reaches all Regional locations)

Cigna Dental Health of Florida, Inc. (**a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)**
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.

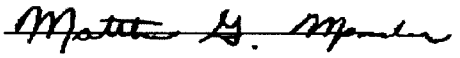
N. GOVERNING LAW

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 OF FLORIDA, INC.

BY: 

TITLE: President

DATE: January 1, 2017

08/11/05

EXHIBITS

Cigna Dental Companies

Cigna Dental Health of Florida, Inc. (a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes)
P.O. Box 453099
Sunrise, Florida 33345-3099

This Plan Booklet 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.

PBSD09 12.01.12

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In some cases, 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.

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 which represent a discount from the Network Dentist's Usual Fees.

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 [or your domestic partner];

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:
  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.

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 State Rider or Group Contract.

The following definition of Domestic Partner applies:

A. A person of the same or opposite sex who:

1. shares your permanent residence;
2. has resided with you for no less than one year;
3. is no less than eighteen years of age;
4. 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, common 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 durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;
5. is not your blood relative any closer than would be prohibited for a legal marriage; and
6. has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental Health which shall be made available to Cigna Dental Health upon request; or

B. A person of the same or opposite sex who has registered jointly with you as Domestic Partners with a governmental entity pursuant to a state or local law authorizing such registration and signed jointly with you a notarized affidavit of such registration which can be made available to Cigna Dental Health upon request.

The above definition applies so long as neither you nor your Domestic Partner hereunder:

A. has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;

B. is currently legally married to another person; or

C. has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.

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 at the Contract Fees.

Patient Charge - The amount you owe your Network General 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 for procedures performed by a Network General Dentist.

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 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 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, 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 General 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 Network General Dentist. 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 by your Network General Dentist.

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.

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 by your Network General Dentist, 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 General Dentist. You will pay the non-Network General Dentist the applicable Patient

Charge for Covered Services. Cigna Dental will pay the non-Network General 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.

- **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.

- **Specialty Care** - Payment for care received from a Network Specialty Dentist is not provided by this Plan. You will be responsible for Contract Fees for care received from a Network Specialty Dentist.

- **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 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); or 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 General 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. (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 General Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number (Social Security number or Employee ID number) and will check your eligibility.

VI. BROKEN APPOINTMENTS

The time your Network General 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 break 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 five 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. If you need specialty care, you may seek treatment from a Network Specialty Dentist at a discounted rate. 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.

Discounted rates are not available at prosthodontists or other specialty dentists not listed above.

X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

IX. SPECIALTY REFERRALS

A. IN GENERAL

Upon referral from a Network General Dentist, you are entitled to receive a discount for services listed on your Patient Charge Schedule when rendered by a Network Specialty Dentist. **If you see a Network Specialty Dentist, you will be responsible for paying total Contract Fees, which are a discount from the dentist's Usual Fees, to the Network Specialty Dentist.** The dollar amounts listed on your Patient Charge Schedule are not applicable to treatment performed by Network Specialty Dentists. Under your plan, preauthorization from Cigna Dental is not necessary for care received from a Network Specialty Dentist. **Cigna Dental will not make payments toward specialty care.**

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment.

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. **Payment**

   Your payment for your entire orthodontic case, including retention, will be based upon the Orthodontist's Contract Fee 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 Contract Fee may apply.

   Your 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 payment 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.

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 crown 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 (plus any additional charge that may apply) 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 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. Level two appeals will be conducted by an Appeals Committee consisting of at least 3 people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the Appeals Committee will include at least one dentist. If specialty care is in dispute, the Appeals Committee will consult with a dentist in the same or similar specialty as the care under review.

Cigna Dental will acknowledge your appeal in writing within 5 business days and schedule an Appeals Committee review. The acknowledgment letter will include the name, address, and telephone number of the Appeals Coordinator. We may request additional information at that time. If your appeal concerns a denied pre-authorization, the Appeals Committee review will be completed within 15 calendar days. For appeals concerning all other coverage issues, the Appeals Committee review will be completed within 30 calendar 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 by the Appeals Committee to complete the review.

You may present your appeal to the Appeals Committee in person or by conference call. You must advise Cigna Dental 5 days in advance if you or your representative plan to attend in person. You will be notified in writing of the Appeals Committee's decision within 5 business days after the meeting. 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, 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.

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.

Coverage for orthodontic treatment, when performed by your Network General Dentist, 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 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.

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.
Domestic Partner definition is replaces as follows:
The following definition of Domestic Partner applies:

A. A person of the same or opposite sex who:

1. shares your permanent residence;
2. is no less than eighteen years of age;
3. 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, common 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 durable power of attorney or health care power of attorney, or such other proof as is considered by Cigna Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;
4. is not your blood relative any closer than would be prohibited for a legal marriage; and
5. has signed jointly with you a notarized affidavit in form and content satisfactory to Cigna Dental Health which shall be made available to Cigna Dental Health upon request; or

The above definition applies so long as neither you nor your Domestic Partner hereunder:

A. has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;

B. is currently legally married to another person; or

C. has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.]

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. Manders

TITLE: President

EXHIBIT B

Cigna Dental Health of Florida, 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.