

**Maricopa County
CIGNA Dental Care (*DHMO)
Patient Charge Schedule**

This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network General Dentist, unless otherwise authorized by CIGNA Dental as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.
- The dollar amounts listed on the Patient Charge Schedule are **only** applicable to treatment performed by your selected Network General Dentist. If you receive care from a Network Specialty Dentist, you are responsible to pay for that care. You are entitled to pay at the Contract Fees negotiated by CIGNA Dental rather than the Network Specialty Dentists' usual fees. Under this plan, referrals and preauthorization for payment by CIGNA Dental are not necessary for care received at a Network Specialty Dentist. CIGNA Dental will not make payments toward this treatment.
- CIGNA Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.
- Procedures **NOT** listed on this Patient Charge Schedule are NOT covered and are the patient's responsibility at the dentist's usual fees.
- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.



Code	Procedure Description	MC-V7
OFFICE VISIT FEE (Per Patient, Per Office Visit in Addition to Any Other Applicable Patient Charges)		
	Office Visit Fee	\$3.00
DIAGNOSTIC/PREVENTIVE - Oral Evaluations are Limited to a Combined Total of 4 of the Following Evaluations During a 12 Consecutive Month Period: Periodic Oral Evaluations (D0120), Comprehensive Oral Evaluations, (D0150), and Comprehensive Periodontal Evaluations, (D0180).		
D9430	Office Visit for Observation - No Other Services Performed	\$0.00
D0120	Periodic Oral Evaluation - Established Patient	\$0.00
D0140	Limited Oral Evaluation - Problem Focused	\$12.00
D0145	Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver	\$0.00
D0150	Comprehensive Oral Evaluation - New or Established Patient	\$0.00
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, By Report	\$55.00
D0170	Re-evaluation - Limited, Problem Focused (Not Post-Operative Visit)	\$15.00
D0210	X-Rays Intraoral - Complete Series (Including Bitewings) <i>(Limit 1 Every 3 Years)</i>	\$0.00
D0220	X-Rays Intraoral Periapical, First Film	\$0.00
D0230	X-Rays Intraoral Periapical, Each Additional Film	\$0.00
D0240	X-Rays Intraoral - Occlusal Film	\$0.00
D0270	X-Rays (Bitewing) - Single Film	\$0.00
D0272	X-Rays (Bitewings) - Two Films	\$0.00
D0273	X-Rays (Bitewings) - Three films	\$0.00
D0274	X-Rays (Bitewings) - Four Films	\$0.00
D0330	X-Rays (Panoramic Film) - <i>(Limit 1 Every 3 years)</i>	\$0.00
D0460	Pulp Vitality Tests	\$0.00
D0470	Diagnostic Casts	\$10.00
D1110	Prophylaxis (Cleaning) - Adult <i>(Limit 2 Per Calendar Year)</i>	\$0.00

Code	Procedure Description	MC-V7
D1120	Prophylaxis (Cleaning) - Child <i>(Limit 2 Per Calendar Year)</i>	\$0.00
D1203	Topical Application of Fluoride - Child <i>(Up to 19th Birthday) (Limited to 2 Per Calendar Year). There is a Combined Limit of a Total of Two D1203s and/or D1206s Per Calendar Year.</i>	\$0.00
D1204	Topical Application of Fluoride (excluding Prophylaxis) Adult	\$0.00
D1310	Nutritional Counseling for Control of Dental Disease	\$0.00
D1330	Oral Hygiene Instructions	\$0.00
D1351	Sealant - Per Tooth	\$12.00
D1510	Space Maintainer - Fixed Unilateral	\$20.00
D1515	Space Maintainer - Fixed Bilateral	\$20.00
D1520	Space Maintainer - Removable - Unilateral	\$20.00
D1525	Space Maintainer - Removable - Bilateral	\$20.00
D1550	Recementation of space maintainer	\$20.00
D1555	Removal of Fixed Space Maintainer	\$25.00
<u>RESTORATIVE (Fillings)</u>		
D2140	Amalgam - One Surface, Primary or Permanent	\$9.00
D2150	Amalgam - Two Surfaces, Primary or Permanent	\$13.00
D2160	Amalgam - Three Surfaces, Primary or Permanent	\$17.00
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	\$21.00
D2330	Resin-Based Composite - One Surface, Anterior	\$22.00
D2331	Resin-Based Composite - Two Surfaces, Anterior	\$28.00
D2332	Resin-Based Composite - Three Surfaces, Anterior	\$40.00
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	\$52.00
D2390	Resin-Based Composite Crown, Anterior	\$70.00
D2391	Resin-Based Composite - One Surface, Posterior	\$22.00

Code	Procedure Description	MC-V7
D2392	Resin-Based Composite - Two Surfaces, Posterior	\$28.00
D2393	Resin-Based Composite - Three Surfaces, Posterior	\$44.00
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	\$44.00
<p>CROWN AND BRIDGE All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals one unit) - Replacement limit 1 every 5 years. The charges below include the cost of base metal. Noble metal and high noble metal (precious) or titanium metal, if used, will be charged to the member at an additional maximum amount of \$150.00 per tooth. If a cast post and core is made of high noble metal, an additional fee up to \$100.00 per tooth may be charged for the upgraded post and core. Porcelain, if used on molar teeth, will be charged to the Member at an additional maximum amount of \$75.00 per tooth. Porcelain/Ceramic substrate crowns on molar teeth are not covered.</p>		
D2510	Inlay - Metallic - One Surface	\$135.00
D2520	Inlay - Metallic - Two Surfaces	\$150.00
D2530	Inlay - Metallic - Three or More Surfaces	\$170.00
D2721	Crown - Resin Based with Predominantly Base Metal	\$250.00
D2740	Crown - Porcelain/Ceramic Substrate	\$260.00
D2750	Crown - Porcelain Fused to High Noble Metal	\$250.00
D2751	Crown - Porcelain Fused to Predominantly Base Metal	\$250.00
D2752	Crown - Porcelain Fused to Noble Metal	\$250.00
D2780	Crown - 3/4 Cast High Noble Metal	\$250.00
D2781	Crown - 3/4 Cast Predominantly Base Metal	\$250.00
D2782	Crown - 3/4 Cast Noble Metal	\$250.00
D2783	Crown - 3/4 Porcelain/Ceramic	\$250.00
D2790	Crown - Full Cast High Noble Metal	\$250.00
D2791	Crown - Full Cast Predominantly Base Metal	\$250.00
D2792	Crown - Full Cast Noble Metal	\$250.00

Code	Procedure Description	MC-V7
D2799	Provisional Crown	\$38.00
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	\$20.00
D2920	Recement Crown	\$20.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	\$50.00
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	\$50.00
D2940	Protective Restoration	\$0.00
D2950	Core Buildup, Including Any Pins	\$40.00
D2951	Pin Retention - Per Tooth, In Addition to Restoration	\$40.00
D2952	Post and Core In Addition to Crown, Indirectly Fabricated	\$70.00
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	\$45.00
D2954	Prefabricated Post and Core In Addition to Crown	\$60.00
D2960	Labial veneer (Resin Laminate) - Chairside	\$175.00
D2961	Labial Veneer (Resin Laminate) - Laboratory	\$175.00
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	\$250.00
D2970	Temporary Crown (Fractured Tooth)	\$40.00
D6210	Pontic - Cast High Noble Metal	\$250.00
D6211	Pontic - Cast Predominantly Base Metal	\$250.00
D6212	Pontic - Cast Noble Metal	\$250.00
D6240	Pontic - Porcelain Fused to High Noble Metal	\$250.00
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	\$250.00
D6242	Pontic - Porcelain Fused to Noble Metal	\$250.00
D6245	Pontic - Porcelain/Ceramic	\$235.00
D6251	Pontic - Resin with Predominantly Base Metal	\$250.00

Code	Procedure Description	MC-V7
D6545	Retainer - Cast Metal for Acide Etch Fixed Prothesis	\$165.00
D6721	Crown - Resin with Predominantly Base Metal	\$250.00
D6740	Crown - Porcelain/Ceramic	\$235.00
D6750	Crown - Porcelain Fused to High Noble Metal	\$250.00
D6751	Crown - Porcelain Fused to Predominantly Base Metal	\$250.00
D6752	Crown - Porcelain Fused to Noble Metal	\$250.00
D6780	Crown - 3/4 Cast High Noble Metal	\$250.00
D6781	Crown - 3/4 Cast Predominantly Base Metal	\$250.00
D6782	Crown - 3/4 Cast Noble Metal	\$250.00
D6783	Crown - 3/4 Porcelain/Ceramic	\$250.00
D6790	Crown - Full Cast High Noble Metal	\$250.00
D6791	Crown - Full Cast Predominantly Base Metal	\$250.00
D6792	Crown - Full Cast Noble Metal	\$250.00
	Complex Rehabilitation - ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION (6 OR MORE UNITS OF CROWN AND/OR BRIDGE IN SAME TREATMENT PLAN REQUIRES COMPLEX REHABILITATION FOR EACH UNIT - ASK YOUR DENTIST FOR THE GUIDELINES)	
D6930	Recement Fixed Partial Denture	\$30.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$60.00
<u>ENDODONTICS (Root Canal Treatment, Excluding Final Restorations)</u>		
D3110	Pulp Cap - Direct (Excluding Final Restoration)	\$5.00
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	\$5.00
D3220	Pulpotomy - Removal of Pulp, Not Part of a Root Canal	\$30.00
D3221	Pulpal Debridement (<i>Not to be used when root canal is done on the same day</i>)	\$55.00
D3230	Pulpal Therapy With Resorbable Filling - Primary Anterior Teeth	\$75.00

Code	Procedure Description	MC-V7
D3240	Pulpal Therapy With Resorbable Filling - Primary Posterior Teeth	\$85.00
D3310	Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$170.00
D3320	Bicuspid Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$190.00
D3330	Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$265.00
D3346	Retreatment of Previous Root Canal Therapy - Anterior	\$320.00
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	\$350.00
D3348	Retreatment of Previous Root Canal Therapy - Molar	\$450.00
D3351	Apexification/Recalcification - Initial Visit	\$90.00
D3352	Apexification/Recalcification - Interim Visit	\$90.00
D3353	Apexification/Recalcification - Final Visit	\$90.00
D3410	Apicoectomy/Periradicular Surgery Anterior	\$170.00
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$170.00
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	\$170.00
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$125.00
D3430	Retrograde Filling - Per Root	\$90.00
D3450	Root Amputation - Per Root	\$90.00
D3920	Hemisection - Including Root Removal (Excluding Root Canal Therapy)	\$90.00
<p><u>PERIODONTICS (Treatment of Supporting Tissues [Gum and Bone] of the Teeth)</u> Periodontal Regenerative Procedures are Limited to One Regenerative Procedure Per Site (or Per Tooth, if Applicable), When Covered on the Patient Charge Schedule. The Relevant Procedure Codes are D4263, D4264, D4266 and D4267. Localized Delivery of Antimicrobial Agents is Limited to Eight Teeth (or Eight Sites, if Applicable) Per 12 Consecutive Months, When Covered on the Patient Charge Schedule</p>		
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	\$0.00
D4210	Gingivectomy or Gingivoplasty - 4 or More Teeth, Per Quadrant	\$225.00
D4211	Gingivectomy or Gingivoplasty - 1 to 3 Teeth, Per Quadrant	\$150.00

Code	Procedure Description	MC-V7
D4240	Gingival Flap, Including Root Planing - 4 or More Teeth, Per Quadrant	\$250.00
D4241	Gingival Flap, Including Root Planing - 1 to 3 Teeth, Per Quadrant	\$200.00
D4249	Clinical Crown Lengthening - Hard Tissue	\$250.00
D4260	Osseous Surgery - 4 or More Teeth, Per Quadrant	\$365.00
D4261	Osseous Surgery - 1 to 3 Teeth, Per Quadrant	\$300.00
D4320	Provisional Splinting - Intracoronal	\$75.00
D4321	Provisional Splinting - Extracoronal	\$80.00
D4341	Periodontal Scaling and Root Planing - 4 or More Teeth Per Quadrant <i>(Limit 4 Quadrants per Consecutive 12 Months)</i>	\$90.00
D4342	Periodontal Scaling and Root Planing - 1 to 3 Teeth, Per Quadrant <i>(Limit 4 Quadrants per Consecutive 12 Months)</i>	\$75.00
D4355	Full Mouth Debridement to Allow Evaluation and Diagnosis <i>(1 Per Lifetime)</i>	\$80.00
D4381	Localized Delivery of Antimicrobial Agents, Per Tooth, By Report	\$25.00
D4910	Periodontal Maintenance <i>(Limited to 2 Per Calendar Year) Only Covered After Active Therapy.</i>	\$60.00
D9940	Occlusal Guard - By Report <i>(Limit 1 Per 24 Months)</i>	\$90.00
D9951	Occlusal Adjustment Limited	\$45.00
D9952	Occlusal Adjustment Complete	\$120.00
<p><u>PROSTHETICS (Removable Tooth Replacement - Dentures) (Includes Up to 4 Adjustments Within First 6 Months After Insertion - Replacement Limit 1 Every 5 Years). Characterization is considered an upgrade with maximum additional charge to the Member of \$200 per denture.</u></p>		
D5110	Full Upper Denture	\$325.00
D5120	Full Lower Denture	\$325.00
D5130	Immediate Full Upper Denture	\$350.00
D5140	Immediate Full Lower Denture	\$350.00
D5211	Upper Partial Denture - Resin Base (Including Clasps, Rests and Teeth)	\$375.00
D5212	Lower Partial Denture - Resin Base (Including Clasps, Rests and Teeth)	\$375.00

Code	Procedure Description	MC-V7
D5213	Upper Partial Denture - Cast Metal Framework (Including Clasps, Rests and Teeth)	\$400.00
D5214	Lower Partial Denture - Cast Metal Framework (Including Clasps, Rests and Teeth)	\$400.00
D5281	Removable Unilateral Partial Denture One Piece Cast Metal (Including Clasps and Teeth)	\$160.00
D5410	Adjust Complete Denture Upper	\$25.00
D5411	Adjust Complete Denture Lower	\$25.00
D5421	Adjust Partial Denture Upper	\$25.00
D5422	Adjust Partial Denture Lower	\$25.00
<u>REPAIRS TO PROSTHETICS</u>		
D5510	Repair Broken Complete Denture Base	\$10.00
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	\$10.00
D5610	Repair Resin Denture Base	\$10.00
D5620	Repair cast framework	\$10.00
D5630	Repair or Replace Broken Clasp	\$10.00
D5640	Replace Broken Teeth - Per Tooth	\$10.00
D5650	Add Tooth to Existing Partial Denture	\$10.00
D5660	Add Clasp to Existing Partial Denture	\$10.00
<u>DENTURE RELINING (Limit 1 Every 36 Months)</u>		
D5710	Rebase Complete Upper Denture	\$20.00
D5711	Rebase Complete Lower Denture	\$20.00
D5720	Rebase Upper Partial Denture	\$20.00
D5721	Rebase Lower Partial Denture	\$20.00
D5730	Reline Complete Upper Denture (Chairside)	\$69.00
D5731	Reline Complete Lower Denture (Chairside)	\$69.00

Code	Procedure Description	MC-V7
D5740	Reline Upper Partial Denture (Chairside)	\$69.00
D5741	Reline Lower Partial Denture (Chairside)	\$69.00
D5750	Reline Complete Upper Denture (Laboratory)	\$10.00
D5751	Reline Complete Lower Denture (Laboratory)	\$10.00
D5760	Reline Upper Partial Denture (Laboratory)	\$10.00
D5761	Reline Lower Partial Denture (Laboratory)	\$10.00
<u>INTERIM DENTURES (Limit 1 Every 5 years)</u>		
D5820	Interim Partial Denture (Upper)	\$150.00
D5821	Interim Partial Denture (Lower)	\$150.00
D5850	Tissue Conditioning - Upper	\$20.00
D5851	Tissue Conditioning - Lower	\$20.00
<u>ORAL SURGERY (Includes Routine Post-Operative Treatment)</u>		
Surgical Removal of Impacted Tooth - Not Covered for Ages Below 15 Unless Pathology (disease) Exists.		
D7111	Extraction of Coronal Remnants - Deciduous Tooth	\$35.00
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	\$55.00
D7210	Surgical Removal of Erupted Tooth - Removal of Bone and/or Section of Tooth	\$60.00
D7220	Removal of Impacted Tooth - Soft Tissue	\$85.00
D7230	Removal of Impacted Tooth - Partially Bony	\$100.00
D7240	Removal of Impacted Tooth - Completely Bony	\$120.00
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	\$70.00
D7270	Tooth Stabilization of Accidentally Evulsed or Displaced Tooth	\$150.00
D7310	Alveoloplasty in Conjunction with Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	\$110.00
D7320	Alveoloplasty Not in Conjunction with Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	\$110.00

Code	Procedure Description	MC-V7
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	\$80.00
D7960	Frenulectomy - Also Known as Frenectomy or Frenotomy - Separate Procedure Not Incidental to Another	\$90.00
D7971	Excision of Pericoronaral Gingiva	\$90.00
<u>ORTHODONTICS (Tooth Movement)</u>		
Orthodontic Treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8050	Interceptive Orthodontic Treatment of the Primary Dentition (Banding)	\$448.00
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition (Banding)	\$448.00
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition (Banding)	\$798.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (Banding)	\$1,025.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition (Banding)	\$1,125.00
D8660	Pre-Orthodontic Treatment Visit	\$120.00
D8670	Periodic Orthodontic Treatment Visit (As Part of Contract)	
	Children (Up to 19th Birthday):	
	24 Month Treatment Fee	\$136.00
	Charge Per Month for 24 Months	\$3,264.00
	Adults:	
	24 Month Treatment Fee	\$164.00
	Charge Per Month for 24 Months	\$3,936.00
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	\$230.00
D8999	Unspecified Orthodontic Procedure, By Report (Orthodontic Treatment Plan and Records)	\$228.00
<u>General Anesthesia/IV Sedation</u>		
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$25.00

Code	Procedure Description	MC-V7
D9430	Office visit for observation (during regularly scheduled hours)	\$0.00
D9920	Behavior management, by report	\$35.00
<u>EMERGENCY SERVICES</u>		
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	\$5.00
D9440	Office Visit - After Regularly Scheduled Hours	\$45.00
<u>MISCELLANEOUS SERVICES</u> External Bleaching (D9972) is limited to the use of take-home bleaching trays. All other bleaching methods are not covered.		
D9972	External Bleaching - Per Arch	\$125.00
D9973	External bleaching - per tooth	\$60.00
D9974	Internal bleaching - per tooth	\$60.00
	Missed Appointment	\$25.00
This may contain CDT codes and/or portions of, or excerpts from the Nomenclature contained within the Current Dental Terminology, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any		

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling CIGNA Dental at the toll free number listed on your ID card or plan materials.

Multiple ways to locate a *DHMO Network General Dentist:

- On-line provider directory at www.cigna.com
- On-line provider directory on myCIGNA.com
- Call the number located on your ID card to:
 - Use the Dental Office Locator via Speech Recognition
 - Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

*The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

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