Cigna Dental Benefit Summary

Northwest ISD- High Plan

09/01/2017

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

	Cigna Dental Choice			
Network	***Total Cigna DPPO***		***Out-of-Network***	
Plan Year Maximum (Class I, II & III expenses)	$1,500 Class I Applies		$1,500 Class I Applies	
Annual Deductible Individual Family	$50 $150		$50 $150	
Reimbursement Levels	Based on Reduced Contracted Fees		90th percentile of Reasonable & Customary Allowances	
Benefits	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Preventive & Diagnostic Care Oral Exams Routine Cleanings Full Mouth X-rays Bitewing X-rays Panoramic X-ray Fluoride Application Sealants	100% No Deductible	100% No Deductible	100% No Deductible	100% No Deductible
Class II: Basic Restorative Care Fillings Emergency Care to Relieve Pain Root Canal Therapy / Endodontics Osseous Surgery Periodontal Scaling and Root Planing Surgical Extractions of Impacted Teeth Brush Biopsies Oral Surgery – All Except Simple Extractions Anesthetics Oral Surgery – Simple Extractions	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Care Crowns Denture Repairs Denture Relines, Rebases and Adjustments Repairs to Bridges, Crowns and Inlays Dentures Bridges Inlays / Onlays Prosthesis Over Implant Space Maintainers	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 19 Lifetime Maximum $1000	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Missing Tooth Limitation Provision	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until insured for 24 months; thereafter, considered a Class III expense.			
Late Entrant Limit Provision	50% coverage on Class III and IV for 24 months.			
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.			
Pretreatment Review	Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.			

*For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Contracted Fee Schedule. For services provided by an out-of-network dentist, Cigna Dental will reimburse according to the Contracted Fee Schedule but the dentist may balance bill up to their usual fees.

The Cigna Dental Oral Health Integration Program (OHIP)® is designed to provide enhanced dental coverage for customers with certain eligible medical conditions. Eligible conditions for the program include cardiovascular disease, cerebrovascular disease (stroke), diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation. The program provides 100% coverage for certain dental procedures, guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. For more information and to see the complete list of eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.

Cigna Dental PPO Exclusions and Limitations

Procedure	Limitations
Oral Exams	2 per 12 consecutive months
Prophylaxis (Cleanings)	2 per 12 consecutive months
Fluoride Application	2 per 12 consecutive months for people under 18 years of age
X-Rays (routine)	Bitewings: 2 per 12 consecutive months
X-Rays (non-routine)	Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive months
Study Models or Diagnostic Casts	Payable only when in conjunction with orthodontic workup
Periodontal Treatment	Various limitations depending on the service
Bridges, Crowns and Inlays	Replacement every 60 consecutive months if unserviceable and cannot be repaired
Dentures and Partials	Replacement every 60 consecutive months if unserviceable and cannot be repaired
Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Bridge and Denture Repairs	Reviewed if more than once
Sealants	Limited to posterior tooth. 1 treatment per tooth every 36 consecutive months for children under 13 years of age
Space Maintainers	Limited to non-orthodontic treatment
Prosthesis Over Implant	1 per 60 consecutive months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non- precious metals. No porcelain or white/tooth colored material on molar crowns or bridges

Benefit Exclusions

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

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

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description. Benefits are insured and/or administered by Connecticut General Life Insurance Company. "Cigna HealthCare" refers to various operating subsidiaries of Cigna Corporation. Products and services are provided by these subsidiaries and not by Cigna Corporation. These subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

DPPO insurance coverage is set forth on the following policy form numbers: AR: HP-POL77; CA: HP-POL57; CO: HP-POL78; CT: HP-POL58; DE: HP-POL79; FL: HP-POL60; ID: HP-POL82; IL: HP-POL62; KS: HP-POL84; LA: HP-POL86: MA: HP-POL 63; MI: HP-POL88; MO: HP- POL65; MS: HP-POL90; NC: HP-POL96; NE: HP-POL92; NH: HP-POL94; NM: HP-POL95; NV: HP-POL93; NY: HP-POL67; OH: HP-POL98; OK: HP-POL99; OR: HP-POL68; PA: HP-POL100; RI: HP-POL101; SC: HP-POL102; SD: HP-POL103; TN: HP-POL69; TX: HP-POL70; UT: HP-POL104; VA: HP-POL72; VT: HP-POL71; WA: POL-07/08; WI: HP-POL107; WV: HP-POL106; and WY: HP-POL108.