

# AAQHC - Platinum Plan

CIGNA Dental PPO Benefit Summary Effective 10/01/2007



CIGNA Dental

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

Benefits	CIGNA Dental PPO	
	In-Network	Out-of-Network
<b>Calendar Year Maximum</b>		
(Class I, II, and III Expenses)	\$2,500	\$2,500
<b>Calendar Year Deductible</b>		
Per Individual	\$50	\$50
Per Family	No Limit	No Limit
<b>Class I Expenses - Preventive &amp; Diagnostic Care</b>		
Oral Exams Cleanings Bitewing X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Full Mouth X-rays Panoramic X-Rays Emergency Care to Relieve Pain Histopathologic Exams	100%, No Deductible	100%, No Deductible
<b>Class II Expenses - Basic Restorative Care</b>		
Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Major Periodontics Minor Periodontics Root Canal / Therapy Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures	80%, After Deductible	80%, After Deductible
<b>Class III Expenses - Major Restorative Care</b>		
Crowns Dentures Bridges	60%, After Deductible	60%, After Deductible
<b>Class IV Expenses - Orthodontia</b>		
Coverage for Eligible Children and Adults Lifetime Maximum	50%, No Separate Deductible \$2,000	50%, No Separate Deductible \$2,000
<b>Missing Tooth Provision</b>	The amount payable is 50% of the amount otherwise payable until insured for 24 months; thereafter, considered a Class III expense.	
<b>Pretreatment Review</b>	Available on a voluntary basis when extensive work in excess of \$200 is proposed.	
<b>Out-of-Network Reimbursement</b>	80th Percentile	
<b>Student Age</b>	23	

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## **CIGNA Dental PPO / Indemnity Exclusions and Limitations:**

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<b>Procedure</b>	<b>Exclusions &amp; Limitations</b>
Late Entrants Limit	50% coverage on Class III and IV for 12 or 24 months
Exams	Two per Calendar year
Prophylaxis (cleanings)	Two per Calendar year
Fluoride	1 per calendar year for people under 19
Histopathologic Exams	Various limits per calendar year depending on specific test
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup and extensive Perio treatment
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs – Bridges	Reviewed if more than once
Repairs – Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years
Space Maintainers	Limited to non-Orthodontic treatment
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, CG will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.

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### ***Benefit Exclusions:***

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

*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.*