Cigna Dental Care® (DHMO)

DOES YOUR PLAN COVER ORTHODONTICS IN PROGRESS?

Even though you or a family member is in the middle of "active orthodontic treatment," when you join the Cigna DHMO*, your plan may help pay some of your orthodontic costs.

Q: What is "Orthodontics in Progress"?

A: Are you getting "active orthodontic treatment" that will not be finished until after your Cigna plan takes effect? "Active treatment" means the orthodontist has started to make your teeth move by putting bands between your teeth, or by putting an orthodontic appliance (such as braces) in your mouth. If so, this is called "Orthodontics in Progress."

Q: Do I have coverage for Orthodontics in Progress under my new Cigna plan?

A: Your Cigna DHMO Patient Charge Schedule ("PCS") tells you if you have orthodontic coverage under your plan. Your coverage with Cigna may be different from the coverage you had under your old plan. Keep in mind, enrolling in the Cigna plan does not change the terms of the contract you signed with your orthodontist when your treatment began. You are still responsible for the orthodontist's total case fee.

Q: What happens if I enroll again after my plan year ends and get a new PCS at the beginning of a new coverage period?

A: Even though you would continue to be covered by a Cigna DHMO plan when a new coverage period begins, sometimes your PCS will change. When this happens, your orthodontic copay may change too.

- If you started orthodontic treatment before the new coverage period began, you will owe the copay listed on the *old* PCS for your orthodontic treatment plan.
- If you will wait until after the new coverage period begins to start a new orthodontic treatment plan, then you will owe the copay listed on the *new* PCS.

Orthodontics in Progress Example**

(Based on Patient Charge Schedule K1-08)

- 24 months of active treatment began on 08/09/12.
- On 1/1/13, the patient's Cigna DHMO plan takes effect.
- 20 months of active treatment remaining.
- Cigna DHMO contribution for active treatment per month is $26.25.
- The Cigna DHMO plan pays $525 ($26.25 per month x 20 months of remaining active treatment).

In this example, the patient's Cigna DHMO plan would contribute $26.25 per month of the monthly orthodontic payments for the 20 months of active treatment remaining. After the 20 months, plan contributions stop because active treatment has been completed. The patient is responsible for any remaining balance owed to the orthodontist.

***For illustrative purposes only.*

Q: How do I find out how much coverage I have and get payment?

A: After you enroll, you or your orthodontist can complete a standard ADA claim form. You can get one by calling Cigna Customer Service **at 1.800.Cigna24**. To complete the form, you must know:

- The phase of treatment ("active treatment" or "retention" – ask your orthodontist to explain).
- The number of months of orthodontic treatment you still have to go after your new Cigna plan becomes effective.

Once you or your dentist return a completed form to Cigna, we can let you know if your plan will pay for orthodontics in progress and how much will be covered. If we determine that your services will be covered, your plan can pay your orthodontist quarterly. Or, if you paid for your entire orthodontic treatment plan before you enrolled, we can pay you directly.

Please see the reverse side for more details.

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Q: What about non-orthodontic treatment in progress?

A: "Non-orthodontic treatment in progress" may include root canal treatment, crown and bridge work, dentures, and implant supported prosthesis (including crowns, bridges and dentures). Generally, your Cigna DHMO plan does not cover dental treatment that isn't finished before your Cigna plan takes effect. This means you should pay your dentist or specialist for that treatment based on what your old plan covered; not based on what your Cigna plan covers. For more information about covered and non-covered services, review your plan materials.

Q: Will the patient charge for retention on the Patient Charge Schedule apply?

A: No. Cigna's contribution level takes the cost of retention into consideration.

More questions?
Call us 24/7/365 at 1.800.Cigna24 or visit us online at www.Cigna.com.

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*The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The Cigna DHMO is not available in the following states: AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.

**Minnesota Residents: When enrolling in a DHMO plan, you must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. You'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Service for more information.

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

All group dental plans and insurance policies have exclusions and limitations. For costs and details about the services covered under your plan, review your enrollment materials. Dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided and are not agents of Cigna.

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LIMITATIONS & EXCLUSIONS

All plans have limitations and exclusions. Please refer to your employer's insurance certificate, summary plan description or evidence of coverage for a complete list of plan limitations and both covered and not covered services.

Listed below are the standard limitations and exclusions on services covered by your dental plan:

LIMITATIONS ON COVERED SERVICES

1. Frequency – The frequency of certain covered services, like cleanings, is limited. Your Patient Charge Schedule (PCS) lists any limitations on frequency.
2. Pediatric dentistry – Coverage for treatment by a pediatric dentist ends on your child's seventh birthday. Effective on your child's seventh birthday, dental services must be obtained from a network general dentist; however, exceptions for medical reasons may be considered on an individual basis.
3. 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 PCS lists any limitations on oral surgery.
4. Periodontal services (gum tissue and supporting bone) – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the PCS. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the PCS.
5. Clinical oral evaluations – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations and oral evaluations for patients under three years of age are limited to a total of four evaluations during a 12-consecutive-month period.

GENERAL LIMITATIONS

No payment will be made for expense incurred or services received:

- For, or in connection with, an injury arising out of, or in the course of, any employment for wage or profit;
- For charges that 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 charges that the person is not legally required to pay;
- For charges that would not have been made if the person had no insurance; or
- Due to injuries that are intentionally self-inflicted.

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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:

1. services not listed on the Patient Charge Schedule.

2. services provided by a non-Network Dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).

3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.

4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.

5. 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.

6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.

7. 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.

8. prescription drugs.

9. procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. diagnose or treat conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or, if your Patient Charge Schedule ends in "-04" or higher, c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

10. 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.

11. 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.

12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.

13. procedures or appliances for minor tooth guidance or to control harmful habits.

14. hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)

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

16. the completion of crowns, bridges, dentures, root canal treatment, or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage. (California and Texas residents: Pre-existing conditions, including the completion of crowns, bridges, dentures, root canal treatment or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule.)

17. consultations and/or evaluations associated with services that are not covered.

18. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.

19. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.

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

21. services performed by a prosthodontist.

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

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

24. 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.

25. the recementation of any inlay, onlay, crown, post and core, fixed bridge or 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.

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

27. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.

28. crowns, bridges and/or implant supported prosthesis used solely for splinting.

29. 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.