Summary of Benefits
Insurance Plan Information

Cigna Healthcare Dental Insurance

Cigna Healthcare® bundled plans help keep your eyes and smile healthier today, so you can enjoy life at its fullest every day. We make it easy with one bundled plan, one simple premium and one place for dedicated support.

Dental Benefit	CIGNA HEALTHCARE DENTAL	
	Advantage Network	**Out-of-network*** Out-of-pocket expenses may be higher; these providers do not offer Cigna Healthcare® customers our contracted or discounted fees.
Individual plan deductible	$100 per person	
Family plan deductible	Not Applicable	
Plan maximum	$1,500 per person	
Payment levels	Based on provider's contracted fees for covered services	Based on provider's actual billed charges and the contracted fee
Class I: Preventative/Diagnostic services		
Preventive/diagnostic services Routine cleanings, oral Exams, routine X-Rays, nonroutine X-Rays, sealants, fluoride treatment, space maintainers (non-orthodontic), emergency treatment	You pay $0	You pay $0
Class II: Basic Restorative Services		
Basic restorative services Fillings, Routine Tooth Extraction, Wisdom Tooth Extraction, Relines, Rebases, and Adjustments, Repairs - Bridges, Crowns, and Dentures	You pay 30% (after deductible).	You pay 30% (after deductible).
Class III: Major Restorative Services		
Major restorative services Root Canal Therapy, Crowns, Prosthesis Over Implant, Minor and Major Periodontics, Dentures, Bridges, Anesthetics	You pay 50% (after deductible).	You pay 50% (after deductible).
Class IV: Orthodontia		
Orthodontia (medically/dentally necessary)	Not Covered	Not Covered
Class V: Implants		
Implants	Not Covered	Not Covered

This summary contains highlights only.

* If you choose to visit a dentist out-of-network, you will pay the out-of-network benefit and the difference in the amount that Cigna Healthcare reimburses for such services (contracted fee) and the amount charged by the dentist (actual billed charged), except for emergency services.[1] This is known as balance billing. See Cigna Healthcare Dental terms on the last page for actual billed charges, balance billing and contracted fee.

1. Emergency services as defined by your plan.

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Cigna Healthcare Dental plans

Procedure	CIGNA HEALTHCARE DENTAL Frequency/Limitation
	Class I: Preventive/Diagnostic services
Routine cleanings	I per consecutive 6-month period (MD I per consecutive 12-month period)
Oral exams	I per consecutive 6-month period (MD I per consecutive 12-month period)
Routine X-Rays	Bitewings: I set in any consecutive 12-month period
Nonroutine X-Rays	Full mouth or Panorex: I per consecutive 60-month period
Sealants	I treatment per tooth per lifetime for children under 14; payable on unrestored permanent bicuspid or molar teeth only
Fluoride treatment	I per consecutive 12-month period for children under 14
Space maintainers (non-orthodontic)	Limited to non-orthodontic treatment for prematurely removed or missing teeth
Emergency treatment	Paid as a separate benefit only if no other service, except X-rays, is rendered during the visit
	Class II: Basic Restorative Services
Fillings	I per consecutive 12-month period, applies to identical surface filling only
Routine tooth extraction	Includes an allowance for local anesthesia and routine postoperative care
Wisdom tooth extraction	Includes an allowance for local anesthesia and routine postoperative care
	Class III: Major Restorative Services
Periodontal deep cleaning	I per consecutive 36-month period
Periodontal maintenance	I per consecutive 6-month period (MD I per consecutive 12-month period);
Root canal therapy	I per tooth per lifetime; Retreatment I per consecutive 24-month period
Crowns	I per tooth per consecutive 84-month period; replacement must be indicated by major decay
Bridge	I per tooth per consecutive 84-month period; must be unserviceable and cannot be repaired
Denture	I per tooth per consecutive 84-month period; must be unserviceable and cannot be repaired
Prosthesis Over Implant	I per tooth per consecutive 84-month period; must be unserviceable and cannot be repaired
	Class IV: Orthodontia
Orthodontia (medically/dentally necessary)	Not Covered

Cigna Healthcare Vision and Hearing benefits

	CIGNA HEALTHCARE DENTAL
Benefit	**Annual maximum**
	Vision
Eye Examinations, including refraction	The plan pays 50% of expenses, not to exceed a $75 calendar year maximum per person
Materials (corrective eyeglasses or contact lenses, including fittings and follow-up visits)	$200 calendar year maximum per person
	Hearing
Hearing Examinations	$50 calendar year maximum per person
Materials (Hearing Aids, including fittings and repairs)	$500 calendar year maximum per person

This summary contains highlights only.

Cigna Healthcare Dental plans

Plan Exclusions

What is not covered by this plan excluded services

Covered expenses do not include expenses incurred for:

- Procedures which are not included in the policy.
- Procedures which are not necessary and which do not have uniform professional endorsement.
- Procedures which are not necessary and which do not have uniform professional endorsement.
- Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- Procedures, appliances or restorations whose main purpose is to diagnose or treat dysfunction of the temporomandibular joint (Services are covered in MN and NV).
- The alteration or restoration of occlusion.
- The restoration of teeth which have been damaged by erosion, attrition or abrasion.
- Bite registration or bite analysis.
- Any procedure, service or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- The surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.
- Core build-ups
- Cone beam imaging
- Replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or
  - Replacement of a bridge, crown or denture within 84 consecutive months years after the date it was originally installed unless: the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while the person is covered under this plan.
  - The partial denture is less than 84 consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional necessary extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- The replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying natural tooth.
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- The initial placement of a full denture, partial denture, or bridge unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan (the removal of only a permanent third molar will not qualify a full or partial denture for benefit under this provision).
- Replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- Replacement of lost or stolen appliances.
- Replacement of teeth beyond the normal complement of 32.

Cigna Healthcare Dental plans

Plan Exclusions and Limitations

- Prescription drugs.
- Athletic mouth guards.
- Myofunctional therapy.
- Precision or semi-precision attachments.
- Denture duplication.
- Separate charges for acid etch.
- Labial veneers (laminate).
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old.
- Treatment of jaw fractures and orthognathic surgery.
- Orthodontic treatment. Exclusion does not apply if the plan otherwise covers services for orthodontic treatment.
- Charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- Charges for travel time; transportation costs.
- Temporary, transitional or interim dental services.
- Any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least three years, as determined by Cigna Healthcare.
- Diagnostic casts, diagnostic models or study models.
- General anesthesia or intravenous sedation, when used for the purposes of anxiety control or patient management is not covered; may be considered only when medically or dentally necessary and when in conjunction with covered complex oral surgery.
- VDT (video display terminal)/computer eyeglass benefit.
- Medical or surgical treatment of the eyes.
- Any type of corrective vision surgery, including LASIK surgery, radial ketatonomy (RK), automated lamellar keratoplasty (ALK), or conductive keratoplasty (CK).
- Orthoptic or vision training and any associated supplemental testing.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Safety eyewear.
- Sub-normal vision aids or non-prescription lenses.
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage.
- Assistive Listening Devices (ALDs).
- Medical and/or surgical treatment of the internal or external structures of the ear, including but not limited to Cochlear implants.
- Hearing Aids not prescribed by a Licensed Hearing Care Professional.
- Ear protective devices or plugs.
- Hearing Aids maintenance/service contracts, ear molds and other miscellaneous repairs.
- Hearing Aids purchased online or over the counter (OTC).
- Disposable Hearing Aids
- Any charge for any treatment performed outside of the United States other than for emergency treatment (any benefits for emergency treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period).
- Oral hygiene, plaque control and diet instruction; broken appointments; completion of claim forms; personal supplies (water pick, toothbrush, floss holder); duplication of x-rays and exams required by a third party.
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- Services that are deemed to be medical services.
- Services for which benefits are not payable according to the "General Limitations" section.

General limitations

No payment will be made for expenses incurred for you or any one of your dependents:

- For services not specifically listed as covered services in the policy.
- For services or supplies that are not dentally necessary.
- For services received before the effective date of coverage.
- For services received after coverage under this policy ends.
- For services for which you have no legal obligation to pay or for which no charge would be made if you did not have dental insurance coverage.

Cigna Healthcare Dental plans

Plan Limitations

- For professional services or supplies received or purchased directly or on your behalf by anyone, including a dentist, from any of the following:
  - Yourself or your employer.
  - A person who lives in the insured person's home, or that person's employer.
  - A person who is related to the insured person by blood, marriage or adoption or that person's employer.
- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- For or in connection with a sickness which is covered under any workers' compensation or similar law.
- For charges made by a hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected condition.
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- To the extent that billed charges exceed the rate of reimbursement as described in the schedule.
- 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.
- Charges for or in connection with experimental procedures or treatment methods. In determining whether services are experimental, Cigna Healthcare in consultation with a dental consultant, will consider if such services: (a) are approved by the American Dental Association or the appropriate dental specialty society; (b) are in general use in the medical/dental field in the state of Washington (WA residents only); (c) are under continued scientific testing and research; (d) have shown a demonstrable benefit for a particular dental condition or disease; and (e) are proven to be safe and effective.
- 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 .

Cigna Healthcare Dental plans

Cigna Healthcare Dental terms

Below you will find easy-to-understand definitions for commonly used words and phrases.

Actual billed charges: The fee that a provider charges a patient who does not have dental insurance for a service. If a patient has dental insurance and visits an Advantage provider, the provider charges the negotiated rate/contracted fee for covered services.

Balance billing: When an out-of-network provider bills you for the difference between the charges for a service and what Cigna Healthcare will pay for that service after coinsurance and the contracted fee have been applied. For example, an out-of-network provider may charge $100 to fill a cavity. If the contracted fee is $50 for that service and the coinsurance is 50%, assuming the calendar-year deductible has already been met, Cigna Healthcare will pay $25 and you will pay $25. Because you are visiting an out-of-network provider, the provider may bill you the remaining $50; thus, your total out-of-pocket cost could be $75. Balance billing charges are separate from any applicable deductible and coinsurance.

Plan deductible: The dollar amount you must pay each year for eligible dental expenses before the insurance begins paying for basic and major and restorative care services and orthodontia, if covered by your plan.

Plan maximum: The most you will pay for covered services during a calendar year (12-month period beginning each January 1). You will no longer have to pay any coinsurance for covered dental services for the remainder of that year once you reach your calendar-year out-of-pocket maximum.

Advantage or Total network: A network made up of dentists who have contracted with Cigna Healthcare and agreed to accept a predetermined contracted fee for the services provided to Cigna Healthcare customers. Visiting a provider in this network means you'll save the most money because the fee is discounted.

Coinsurance: Your share of the cost of a covered dental service (a percentage amount). You pay coinsurance plus any deductible amount not met yet for that calendar year. For example, if you go to the dentist and your visit costs $200, the dentist sends a claim to Cigna Healthcare. If you have already met your annual deductible amount, Cigna Healthcare may pay 80% ($160) and you will pay a coinsurance of 20% ($40).

Contracted fee: The fee to be charged for a service that Cigna Healthcare has negotiated with a contracted provider on your behalf. The most Cigna Healthcare will pay a dentist for a covered service or procedure for out-of-network dental care is based on a basic Advantage fee schedule within a specified area. See example provided under balance billing.

Out-of-network providers: Providers who have not contracted with Cigna Healthcare to offer you savings. They charge their own standard fees, also referred to as actual billed charges.

Hearing Aid: Means a non-experimental, wearable electronic instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries, cords, and other Assistive Listening Devices, including, but not limited to, frequency modulation systems.

Cigna Healthcare Dental plans

Important Plan Disclosures

Dental plans are insured by Cigna Health and Life Insurance Company, with network management services provided by Cigna Dental Health, Inc. Rates may vary based on age, number of enrolled dependents, geographic location (residential zip code) and plan design.

Rates are subject to change upon 30 days' prior notice in Arizona and Tennessee, and 45 days' prior notice in Florida.

Waiting periods may apply.

Dental preferred provider insurance policies have exclusions, limitations, reduction of benefits and terms under which policies may be continued in force or discontinued. The policy may be cancelled by Cigna Healthcare due to failure to pay premium, fraud, or ineligibility; when the insured no longer lives in the service area; or if we cease to offer policies of this type or any individual dental plans in the state, in accordance with applicable law. You may cancel the policy, on the first of the month following our receipt of your written notice. We reserve the right to modify the policy, and the cancellation will take effect including policy provisions, benefits and coverages, consistent with state or federal law. The policy renews on a calendar-year basis.

Notice to buyer: This policy provides dental coverage only. Review your policy carefully.

For costs and additional details about coverage, contact Cigna Health and Life Insurance Company at 900 Cottage Grove Rd., Bloomfield, CT 06152 or 866.GET.Cigna (866.438.2446).

(Except NY and NM)

Product availability may vary by location and plan type and is subject to change. All dental insurance policies contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company and Cigna Dental Health, Inc. In Texas, the Dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO Advantage network. In Utah, all products and services are provided by Cigna Health and Life Insurance Company (Bloomfield, CT).

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