

# CIGNA Dental Benefit Summary

## Arlington ISD Low Plan

### PPO Core Network



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)	\$750		\$750	
<b>Annual Deductible</b>				
Individual	\$50 per person		\$50 per person	
Family	\$150 per family		\$150 per family	
<b>Reimbursement Levels**</b>	Based on Reduced Contracted Fees		80th percentile of Reasonable and Customary Allowances	
	<b>Plan Pays</b>	<b>You Pay</b>	<b>Plan Pays</b>	<b>You Pay</b>
<b>Class I - Preventive &amp; Diagnostic Care</b>	80%	20%	80%	20%
Oral Exams Routine Cleanings Bitewing X-rays Full Mouth X-rays Panoramic X-ray Emergency Care to Relieve Pain Fluoride Application Sealants Space Maintainers				
<b>Class II - Basic Restorative Care</b>	50%*	50%*	50%*	50%*
Fillings Root Canal Therapy/Endodontics Osseous Surgery Periodontal Scaling and Root Planing Brush Biopsies Oral Surgery - all except simple extractions Oral Surgery – Simple Extractions				
<b>Class III - Major Restorative Care</b>	50%*	50%*	50%*	50%*
Crowns Surgical Extractions of Impacted Teeth Anesthetics Histopathologic Exams Denture Repairs Denture Relines, Rebases and Adjustments Repairs to Bridges, Crowns and Inlays Dentures Bridges Inlays/Onlays Prosthesis Over Implant				
<b>Class IV - Orthodontia</b>	Not covered	100% of your dentist's usual fees	Not covered	100% of your dentist's usual fees

Missing Tooth Limitation – Teeth missing prior to coverage under the CIGNA Dental plan are not covered.

Pretreatment review is available on a voluntary basis when extensive dental work in excess of \$500 is proposed.

\* Subject to annual deductible

\*\*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 Reasonable and Customary Allowances but the dentist may balance bill up to their usual fees.

## ***CIGNA Dental PPO Exclusions and Limitations***

<b>Procedure</b>	<b>Exclusions and Limitations</b>
Late Entrants Limit	No coverage except for Class I (as defined in these plans) for 12 months
Exams	1 per 6-month consecutive period.
Prophylaxis (Cleanings)	1 routine prophy or perio maintenance procedure per 6-month consecutive period (routine prophy is Class I; perio prophy is Class II).
Fluoride Treatments	1 per consecutive 12 months for participants younger than age 14.
Histopathologic Exams	Payable if the biopsy is covered. No coverage for other diagnostic tests.
X-rays (routine)	Bitewings: 1 set in any consecutive 12 month period. Limited to a maximum of 4 films per set.
X-rays (non-routine)	Full mouth or Panorex: 1 per 60 consecutive months.
Periapical x-rays:	4 in 12 consecutive months if not performed in conjunction with an operative procedure.
Intraoral occlusal x-rays:	2 in 12 consecutive months.
Models	Not covered.
Fillings	1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only). No composite, white/tooth colored fillings on bicuspid or molar teeth.
Sealants	1 treatment per tooth per lifetime. Payable on unrestored permanent bicuspid or molar teeth only.
Minor Perio (non-surgical)	Root planing-1 per quadrant per 36 consecutive months.
Perio Surgery	1 per 36 consecutive months per area of the mouth (same service).
Crowns and Inlays	Replacement limited to 1 per 84 consecutive months. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. Replacement must be indicated by major decay. For participants less than age 16, benefits for crowns and inlays are limited to resin or stainless steel.
Stainless Steel & Resin	1 per 36 consecutive months for participants younger than age 16.
Crowns	
Bridges	Replacement limited to 1 per 84 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.
Dentures and Partial	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired.
Relines, Rebases	Covered if more than 12 months after installation; 1 per 36 consecutive months.
Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months.
Repairs - Bridges	Covered if more than 12 months after installation.
Repairs - Dentures	Covered if more than 12 months after installation.
Endodontics	Root canal re-treatment 1 per 24 consecutive months, if necessity demonstrated.
Prosthesis Over Implant	1 per 84 consecutive months is 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.
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.

### **Benefit Exclusions:**

- Services performed primarily for cosmetic reasons; Replacement of a lost or stolen appliance;
- Initial placement of a full or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan; removal of only a permanent third molar will not qualify for an initial or replacement denture or bridge;
- Overdentures, personalization, precision or semi-precision attachments;
- Replacement of a bridge, denture or crown within 84 months following its initial date of insertion;
- Replacement of a bridge, denture or crown which can be made useable according to 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, the restoration of teeth which have been damaged by erosion, attrition or abrasion; bite registration; or bite analysis;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- Core buildup, labial veneers; 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;
- 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;
- Procedures for which a charge would not have been made in the absence of coverage, for 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; Procedures which are not necessary and which do not have uniform professional endorsement;
- 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;
- IV sedation or general anesthesia, except when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- Fees charged for broken appointments, claim form submission or sterilization;
- Services not included in the list of covered dental expenses, unless Connecticut General agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- 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; Replacement of teeth beyond the normal complement of 32;
- Prescription drugs; Athletic mouth guards; Myofunctional therapy;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- 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);
- Any procedure, service, or supply which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least three years, as determined by CG; Temporary, transitional or interim dental services; Diagnostic casts, diagnostic models, or study models;
- 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 (\$100.00-\$200.00) per 12 consecutive month period);
- Procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- Any charges, including ancillary charges, made by hospital, ambulatory surgical center or similar facility;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- 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.

- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.

*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.*

*The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc. The CIGNA Dental EPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc. "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 Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries. For Arizona/Louisiana residents the dental PPO product is known as the CG Dental PPO. For Texas residents the dental PPO product is known as CIGNA Dental Choice Plan.*

© 2009 CIGNA

BSD18280