

**Cigna Dental Benefit Summary**  
**Clinton Public School - Enhanced Plan with HEP**  
**Plan Effective Date: 07/01/2019**



**Insured by:** Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

<b>Cigna Dental PPO</b>				
<b>Network Options</b>	<b>In-Network: State of Connecticut Network</b>		<b>Non-Network: See Non-Network Reimbursement</b>	
<b>Reimbursement Levels</b>	Based on Contracted Fees		Maximum Allowable Charge	
<b>Calendar Year Benefits Maximum</b> Class I, II, III, VII Dental Implants	\$3,000 No Calendar year maximum for Periodontal Maintenance and Periodontal Scaling & Root Planing Dental Implants \$500			
<b>Annual Deductible</b> Individual Family	\$25 \$75		\$25 \$75	
<b>Benefit Highlights</b>	<b>Plan Pays</b>	<b>You Pay</b>	<b>Plan Pays</b>	<b>You Pay</b>
<b>Class I: Diagnostic &amp; Preventive</b> Oral Exams Routine Cleanings Fluoride Application Sealants Bitewing X-rays Full Mouth X-rays Panoramic X-ray	100% No Deductible	0% No Deductible	100% No Deductible Maximum Allowable Charge	0% No Deductible Maximum Allowable Charge
<b>Class II: Basic Restorative</b> Fillings (amalgam & composite) Space Maintainers Emergency Care to Relieve Pain Oral Surgery – Simple Extractions Oral Surgery – All Except Simple Extractions Surgical Extractions of Impacted Teeth Anesthesia Major/Minor Periodontics Root Canal Therapy / Endodontics Denture Adjustments and Repairs Repairs to Bridges, Crowns and Inlays	80% After Deductible	20% After Deductible	80% After Deductible Maximum Allowable Charge	20% After Deductible Maximum Allowable Charge
<b>Class III: Major Restorative</b> Crowns / Inlays / Onlays Prosthesis Over Implant Stainless Steel/Resin Crowns	67% After Deductible	33% After Deductible	67% After Deductible Maximum Allowable Charge	33% After Deductible Maximum Allowable Charge
<b>Class IV: Orthodontia</b> Coverage for adults and dependent children \$1,500 Lifetime Maximum	50% No Deductible	50% No Deductible	50% No Deductible Maximum Allowable Charge	50% No Deductible Maximum Allowable Charge
<b>Class VI: Periodontal Maintenance</b> Periodontal Maintenance No Maximum	100% No Deductible	0% No Deductible	100% No Deductible Maximum Allowable Charge	0% No Deductible Maximum Allowable Charge
<b>Class VII: Prosthetics</b> Bridges Dentures	50% After Deductible	50% After Deductible	50% After Deductible Maximum Allowable Charge	50% After Deductible Maximum Allowable Charge
<b>Class VIII: Periodontal Scaling and Root Planing</b> Periodontal Scaling and Root Planing No Maximum	80% After Deductible	20% After Deductible	80% After Deductible Maximum Allowable Charge	20% After Deductible Maximum Allowable Charge
<b>Class IX: Implants</b> \$500 Calendar Year Maximum	50% After Deductible	50% After Deductible	50% After Deductible Maximum Allowable Charge	50% After Deductible Maximum Allowable Charge
<b>Benefit Plan Provisions:</b>				
<b>In-Network Reimbursement</b>	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			

<b>Non-Network Reimbursement</b>	Maximum Allowable Charge
<b>Cross Accumulation</b>	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
<b>Annual Deductible</b>	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
<b>Late Entrant Limitation Provision</b>	No coverage until next open enrollment.
<b>Pretreatment Review</b>	Pretreatment review is available on a voluntary basis when dental work in excess of \$200 is proposed.
<b>Alternate Benefit Provision</b>	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. This provision does not apply to fillings.
<b>Oral Health Integration Program</b>	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to <a href="http://www.mycigna.com">www.mycigna.com</a> or call customer service 24/7 at 1.800.CIGNA24.

**Benefit Limitations:**

Missing Tooth Limitation	Not applicable.
Oral Exams	2 per calendar year
X-rays (routine)	Bitewings: 1 per calendar year
X-rays (non-routine)	Full mouth: 1 every 5 calendar years; Panorex: 1 every 5 calendar years
Cleanings	2 routine and 2 periodontal cleanings per calendar year
Fluoride Application	2 per calendar year for children under 16 years of age
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 3 calendar years on children under 16
Space Maintainers	Limited to non-orthodontic treatment for children under age 16
Study Models or Diagnostic Casts	Payable only when in conjunction with ortho work up
Periodontal Treatment	Various limitations depending on the service, Frequency limit of once per 24 months
Periodontal Surgery	Various limitations depending on the service, Frequency limit of once per 36 months
Inlays and Crowns	Replacement every 7 years if unserviceable and cannot be repaired
Dentures, Bridges and Partial	Replacement every 7 years if unserviceable and cannot be repaired
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	1 per 7 years 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:**

Covered Expenses will not include, and no payment will be made for the following:

Procedures and services not listed under Benefit Highlights;

Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;

Restorative: Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;

Periodontic: bite registrations; splinting; Prosthodontic: precision or semi-precision attachments;

Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;

Athletic mouth guards; Replacement of a lost or stolen appliance; Services performed primarily for cosmetic reasons; Personalization;

Services that are deemed to be medical in nature; Services and supplies received from a hospital; Drugs: prescription drugs

Charges in excess of the Maximum Allowable Charge.

Contracted providers are not obligated to provide discounts on non-covered services and may charge their usual fees.

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