CIGNA
A Business of Caring.

CIGNA Dental Benefit Summary

2008 Benefits	***CIGNA Dental Care® (DHMO)*** ***K1-06***
Calendar Year Maximum (Class I, II and III expenses)	N/A - Maximum does not apply
Calendar Year Deductible Employee Employee & 1 Employee & 2 or more	N/A - No deductibles need to be met
Reimbursement Levels	- ***Fixed co-payments*** - ***No deductibles*** - ***No dollar maximums*** - ***No claim forms***
	You Pay
Class I – Preventive & Diagnostic Care Oral Exams (Two per year) Routine Cleanings (Two per year) Full Mouth X-rays (One complete set every three years) Bitewing X-rays (Two per year) Panoramic X-ray (One every three yrs) Fluoride Application (one/yr under 19) Sealants (Limited to posterior teeth for a person less than 14; one treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	Exams, X-rays, cleaning $0 co-payment **Fixed** co-payments may apply per procedure.
Class II – Basic Restorative Care Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling & Root Planing Denture Adjustments & Repairs Extractions Oral Surgery	**Fixed** copayments per procedure.
Class III – Major Restorative Care Crowns Dentures Bridges	**Fixed** copayments per procedure.
Class IV – Orthodontia Available for children and adults Orthodontia Lifetime Maximum	**Fixed** copayments per procedure. **Member** co-payment applies for a 24-month treatment plan Refer to patient copay charge schedule.

Pretreatment review is suggested when dental work in excess of $200 is proposed.

CIGNA Dental Care® (DHMO) Patient Copay Charge Schedule (K1-06)

A complete list of covered services and patient charges is included on the Patient Charge Schedule you will receive after enrollment.

	CIGNA DHMO Patient Copays
Diagnotic/Preventive	
Periodic Oral Evaluation	$ 0
Limited Oral Evaluation - Problem Focused	0
Comprehensive Oral Evaluation	0
Re-evaluation – Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	0
X-Rays Intraoral – Complete Series (including bitewings)*	0
X-Rays Intraoral – Periapical First Film	0
X-Rays Intraoral – Periapical Each Additional Film	0
X-Rays (Bitewing) - Single Film	0
X-Rays (Bitewing) - Two Films	0
X-Rays (Bitewing) - Four Films	0
X-Rays (Panoramic)*	0
Prophylaxis – Adult**	0
Prophylaxis – Child**	0
Topical Application of Fluoride - (prophylaxis not included) – Child (up to 19th birthday)**	0
Oral Hygiene Instructions	0
Sealant - Per Tooth***	10
Restorative (Fillings)	
Amalgam - One Surface, Primary	$ 0
Amalgam - Two Surfaces, Primary	0
Amalgam - One Surface, Permanent	0
Amalgam - Two Surfaces, Permanent	0
Amalgam - Three Surfaces, Permanent	0
Amalgam - Four or More Surfaces, Permanent	0
Resin-Based Composite - One Surface, Anterior	0
Resin-Based Composite - Two Surfaces, Anterior	0
Resin-Based Composite - Three Surfaces, Anterior	0
Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	75
Resin-Based Composite - One Surface, Posterior – Primary	40
Resin-Based Composite - Two Surfaces, Posterior – Permanent	50
Resin-Based Composite - Three Surfaces, Posterior – Permanent	70
Crown & Bridge (Including Temporaries) *All charges for crown and bridge are per unit (each replacement or supporting tooth equals one unit – Replacement limit 1 every 5 years.*	
Crown – Porcelain/Ceramic Substrate	$ 465
Crown - Porcelain Fused to High Noble Metal	425
Crown - Porcelain Fused to Predominantly Base Metal	380
Crown - Porcelain Fused to Noble Metal	405
Crown - Full Cast Noble Metal	405
Recement Crown	40
Sedative Filling	10
Core Buildup, Including Any Pins	120
Prefabricated Post and Core In Addition to Crown	120
Endodontics (Root Canal Treatment, Excluding Final Restorations)	
Pulp Cap - Direct (Excluding Final Restoration)	$ 10
Pulp Cap - Indirect (Excluding Final Restoration)	10
Therapeutic Pulpotomy (Excluding Final Restoration)	55
Anterior Root Canal (Excluding Final Restoration)•	175
Bicuspid Root Canal (Excluding Final Restoration)•	205
Molar Root Canal (Excluding Final Restoration) •	280
Periodontal (Treatment of Supporting Tissues [Gum & Bone] of the Teeth)	
Periodontal Evaluation and Treatment Plan	$ 30
Periodontal Scaling and Root Planing, (Per Quadrant - 4 or more contiguous teeth or bound teeth spaces)•••	70
Periodontal Scaling and Root Planing (Per Quadrant) (1-3 teeth) •••	35
Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis ••	50
Periodontal Maintenance Procedure ••••	40

CIGNA DHMO

		Patient Copays
Prosthetics (Removable Tooth Replacement – Dentures) *Includes up to 4 adjustments within first 6 months after insertion.* *Replacement limit 1 every 5 years.*		
Complete Denture – Maxillary	$	535
Complete Denture – Mandibular		535
Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)		615
Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)		615
Repairs to Prosthodontics		
Add Tooth to Existing Partial Denture	$	70
Oral Surgery (Includes Routing Post-Operative Treatment)		
Extraction - Erupted tooth or exposed root)	$	10
Removal of impacted tooth – Partially bony		70

Surgical removal of impacted tooth-(Not covered unless pathology [disease] exists). Surgical removal of wisdom tooth/3rd molar for orthodontic reasons only is not covered.

Orthodontics (Tooth Movement) *Orthodontic Treatment (Maximum lifetime benefit of 24 months of interceptive and/or comprehensive treatment; atypical casesor cases beyond 24 months require an additional payment by the patient)*		
Children (Up to 19th Birthday) – Periodic Orthodontic Treatment Visit, 24 month treatment fee	$	1,700
Adults– Periodic Orthodontic Treatment Visit , 24 month treatment fee		2,100
General Anesthesia/IV Sedation *Covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule.*		
General Anesthesia – First 30 Minutes•	$	145
General Anesthesia – Each Additional 15 Minutes		65
Intravenous Sedation/Analgesia – First 30 Minutes		145
Intravenous Sedation/Analgesia – Each Additional 15 Minutes		65
Emergency Services		
Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	$	0
Office Visit – After Regularly Scheduled Hours		50

*** Limit 1 every 3 years.**
**** Limit 1 every 6 months .**
*****Up to 14th birthday.**

• Permanent Tooth.
•• Limit 1 per lifetime.
••• Limit 4 quadrants per consecutive 12 months.
•••• Limit 2 within 12 months.

Exclusions and limitations may apply. Consult your group agreement for details. This Fee Overview reflects the patient charges on your Patient Charge Schedule. In case of any discrepancy between this Dental Fee Overview and your Patient Charge Schedule sent to you after your enrollment, the Patient Charge Schedule will prevail

CIGNA Dental HMO Exclusions and Limitations

LIMITATIONS

Listed below are limitations on services covered by your Dental Plan:

1. **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

2. **Specialty Care** - Payment authorization is required for coverage of services by a Network Specialty Dentist.

3. **Pediatric Dentistry** - Coverage for referral to a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 7th birthday.

4. **Oral Surgery** - The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

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:

a) Services not listed on the Patient Charge Schedule.

b) Services provided by a non-Network Dentist without CIGNA Dental's prior approval (except emergencies).

c) Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.

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

e) 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.

f) Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).

g) 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.

h) Prescription drugs.

i) 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 abnormal 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.

j) Replacement of fixed and/or removable appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

k) Services associated with the placement or prosthodontic restoration of a dental implant.

l) Services considered to be unnecessary or experimental in nature. (California and Maryland residents: This exclusion should read “Services considered to be unnecessary.” Pennsylvania residents: This exclusion should read “Services considered experimental in nature.”)

m) Procedures or appliances for minor tooth guidance or to control harmful habits.

n) 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.)

o) Services to the extent you, or your Dependent, are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy. (Arizona and Pennsylvania residents: Services compensated under group medical plan, no-fault auto insurance policies or insured motorist polices are not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or insured motorists policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded

p) The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage. (not applicable in Texas or California)

q) Crowns and bridges used solely for splinting.

r) Resin-bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.
In case of any discrepancy between this brochure and your plan documents, the plan documents prevail.

Covered expenses will not include, and no payment will be made for, expenses incurred for:

- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second or third molars;
- Bite registrations; precision or semi-precision attachments; or splinting;
- A 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;
- Services for which benefits are not payable according to the “General Limitations” section.

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.

General Limitations

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

- 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;
- 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;
- To the extent that they are more than either the applicable Contracted Fee, applicable Reasonable or Customary Charges or applicable Scheduled Amount;
- 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; or
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

No payment will be made for expenses incurred by you or any one of your Dependents 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.

If you are a new hire, and you and your covered dependents having missing teeth when coverage becomes effective, the plan pays only 50% of the amount normally covered for major and orthodontic services for the first 24 months of coverage.