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Cigna Dental Preferred Provider Insurance

The Schedule

Benefits For You and Your Dependents

The Dental Benefits Plan offered by Your Employer includes Participating and Non-Participating Providers. If You select a Participating Provider, Your cost will be less than if You select a Non-Participating Provider.

Emergency Services

The Benefit Percentage for Emergency Services incurred for charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider charges.

Participating Provider Payment

Services are paid based on the Contracted Fee that is agreed to by the provider and Us. Based on the provider's Contracted Fee, a higher level of plan payment (shown below as "The Percentage of Covered Expenses the Plan Pays") may be made to a Participating Provider resulting in a lower payment responsibility for You. To determine how Your Participating Provider compares refer to Your provider directory.
Provider information may change annually; refer to Your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.com.

Non-Participating Provider Payment

Benefit Payment

Services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 95th percentile. See definition section for further explanation of Maximum Reimbursable Charge.

BENEFIT MAXIMUMS AND DEDUCTIBLES	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Classes I, II, III Combined Calendar Year Maximum	Not Applicable	
Procedure Maximum		
Periodontal Maintenance		Not Applicable
Periodontal Scaling and Root Planing		Not Applicable

Benefits Paid for Participating and Non-Participating Provider Services will be applied toward both the Participating and Non-Participating maximum shown in the Schedule.

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Class I	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Preventive Care	100%	100%

BENEFIT HIGHLIGHTS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Class II	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Basic Restorative	80%	80%
Periodontal Maintenance	80%	80%
Class III	**The Percentage of Covered Expenses the Plan Pays**	**The Percentage of Covered Expenses the Plan Pays**
Major Restorative	67%	67%
Periodontal Scaling and Root Planing	67%	67%

Covered Dental Services

Teledentistry services are covered only when administered in conjunction with procedures and services which are covered under this plan. Covered Dental Services delivered through teledentistry are covered to the same extent We cover services rendered through in-person contact including the same cost-share, frequency limitations or any applicable benefit maximums or lack thereof.

Class I Services – Diagnostic and Preventive

Clinical oral evaluation – limited to 2 per person per Calendar Year.

Full mouth or panoramic radiographic images – Complete series or Panoramic (Panorex) – limited to 1 per person, including panoramic images, in any 60 consecutive months.

Bitewing radiographic images – limited to 1 set per person per Calendar Year.

Extraoral posterior radiographic images – limited to 1 image in any Calendar Year.

Prophylaxis (Cleaning) – limited to 2 per person per Calendar Year.

Sealant, per tooth, on an unrestored primary and permanent bicuspid or molar tooth only for a person less than 16 years old - limited to 1 treatment per tooth in any 36 consecutive months.

Caries medicament application – limited to 2 per tooth in any 1 Calendar Year.

Class II Services – Basic Restorations, Endodontics, Prosthodontic Maintenance

Amalgam restorations – unlimited. Multiple restorations on one surface will be treated as a single restoration. The replacement of any amalgam restoration involving the same surface(s) on the same tooth, by the same Dentist or a different Dentist in the same office, within a 12 consecutive month period is considered as part of the charges for the initial placement.

Resin-based composite restoration – unlimited. Multiple restorations on one surface will be treated as a single restoration. The replacement of any amalgam restoration involving the same surface(s) on the same tooth, by the same Dentist or a different Dentist in the same office, within a 12 consecutive month period is considered as part of the charges for the initial placement.

Pin Retention - Covered only in conjunction with amalgam or resin-based composite restoration. Payable one time per restoration regardless of the number of pins used.

Root canal therapy - any radiographic images, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Covered Dental Service.

Root canal therapy, retreatment - unlimited - covered only if more than 6 consecutive months have passed since the original endodontic therapy and only if necessity is confirmed by professional review.

Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation. Limited to 2 per Calendar Year.

Tissue conditioning - maxillary or mandibular.

Re-cement or re-bond crown, inlays, onlays, veneer or partial coverage restoration, indirectly fabricated or prefabricated post and core. Limited to repairs performed more than 6 consecutive months after the initial insertion.

Crown repair and fixed partial dental repair. Limited to repairs performed more than 6 consecutive months after the initial insertion.

Re-cement fixed partial denture/bridge - limited to repairs done more than 6 months after the initial insertion.

Routine extractions.

Brush biopsy.

Local anesthetic, analgesic and routine postoperative care for dental procedures are not separately reimbursed but are considered as part of the submitted fee for the global procedure.

Consultation – diagnostic service provided by dentist or physician other than the requesting dentist or physician.

Palliative treatment of dental pain, per visit - unlimited. Covered as a separate benefit and administrated at the In-Network coinsurance percentage only if no other services, other than exam and radiographic images, were performed during the visit.

Stainless steel crowns, resin crowns - covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration.

Topical application of fluoride – for a person less than 16 years old. Limited to 2 per person per Calendar Year.

Periodontal maintenance procedures (following active therapy) – limited to 2 per person per Calendar Year.

Class III Services - Major Restorations, Dentures and Bridgework, Periodontics, Oral Surgery

Crowns – Initial placement of a crown is covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration due to major decay or fracture. Replacement of a crown within 7 Calendar Years after the date it was originally installed is not covered. No coverage for replacement of crowns if damage or breakage was directly due to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.

Inlays - covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration due to major decay or fracture. Replacement of an inlay within 7 Calendar Years after the date it was originally installed is not covered.

Onlays - covered only when the tooth cannot be restored by an amalgam or resin-based composite restoration due to major decay or fracture. Replacement of an onlay within 7 Calendar Years after the date it was originally installed is not covered.

Core buildup, including any pins.

Post/post and core - covered only for endodontically treated teeth when there is insufficient tooth structure to retain the final restoration.

Prosthesis Over Implant - A prosthetic device, supported by an implant or implant abutment is a Covered Dental Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 7 Calendar Years old, is not serviceable and cannot be repaired.

Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.

Removal of impacted tooth, soft tissue, partially bony, completely bony.

Removal of residual tooth roots - 1 per tooth per lifetime.

Coronectomy - 1 per lifetime.

Biopsy of oral tissue.

Alveoloplasty.

Vestibuloplasty.

Excision of benign cysts/lesions.

Removal of exostosis (maxilla or mandible).

Removal of torus services.

Incision and drainage.

Frenectomy/Frenuloplasty.

Excision of hyperplastic tissue - per arch or pericoronal gingiva.

Gingivectomy or gingivoplasty - unlimited.

Gingival flap procedure - including root planing - unlimited.

Clinical crown lengthening - hard tissue - unlimited.

Osseous surgery - flap entry and closure is part of the allowance for osseous surgery and not a separate Covered Dental Service - Limited to 1 per 36 consecutive months.

Bone replacement graft - unlimited. If treatment involves an implant, the service is only covered if surgical implants are covered under Your plan.

Guided tissue regeneration - per site, per natural tooth – unlimited.

Pedicle soft tissue graft - unlimited.

Mesial/Distal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) - unlimited.

Free soft tissue graft (including recipient and donor surgical sites) - unlimited. If treatment involves an implant, the service is only covered if surgical implants are covered under Your plan.

Autogenous connective tissue graft procedure (including donor and recipient surgical site surgery) - unlimited. If treatment involves an implant, the service is only covered if surgical implants are covered under Your plan.

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Non-autogenous connective tissue graft (including recipient site and donor material) - unlimited. If treatment involves an implant, the service is only covered if surgical implants are covered under Your plan.

Removal of non-resorbable barrier - unlimited. Removal of a non-resorbable barrier is considered inclusive to guided tissue regenerative services, unless performed by a Dentist other than the Dentist who installed it.

Full Mouth Debridement - limited to one per lifetime.

Space Maintainers - limited to non-Orthodontic Treatment for prematurely removed or missing teeth for a person less than 19 years old.

Exparel - limited to persons 18 years and older.

Periodontal scaling and root planing - full mouth – limited to 1 time per quadrant in any 24 month period.

General Limitations and Expenses Not Covered

General Limitations

For limitations on specific Covered Dental Services, please see the Covered Dental Services.

- any treatment received outside of the United States is not covered unless the treatment is a Covered Dental Service under the plan. Any benefits for services received outside of the United States will be subject to the limitations, if any, stated under the Covered Dental Services and paid based on the Out-of-Network reimbursement shown in The Schedule;
- the initial replacement or the replacement of a partial denture, complete denture, fixed bridge, or the addition of teeth to a partial denture is not covered;
- replacement of a crown, inlay, onlay, post/post and core, or other laboratory prepared or CAD/CAM prepared restoration, within the frequency limitation stated under the Covered Dental Services is not covered unless:
  - the crown, inlay, onlay, post/post and core, other laboratory prepared or CAD/CAM prepared restoration, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits; or can be made useable according to commonly accepted dental standards.
- replacement of any amalgam or resin-based composite restoration involving the same surface(s) on the same tooth by the same Dentist or a different Dentist in the same office within the frequency limitation stated under the Covered Dental Services is not covered;
- a combination of radiographic images (such as ten or more periapical radiographic images; or a panoramic radiographic image with bite-wing radiographic images) completed on the same date of service will not be covered when the allowance meets or exceeds the allowance for an intraoral complete series of radiographic images. Plan reimbursement will be based on an intraoral complete series;
- Cone Beam CT;
- localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth. Allowable only on teeth with both periodontal pocket depths of 5 mm or greater and a prior history of periodontal therapy. Not allowable when more than eight (8) of these procedures are reported on the same date of service;
- tissue preparation such as gingivectomy/gingivoplasty or crown lengthening as a separate allowance on the same date as a restoration on the same tooth;
- when covered by Your plan, any prosthesis over an implant is subject to the same exclusions, limitations, and frequency limitations as standard traditional restorative, fixed and removable prosthetics;
- Covered Dental Services to the extent that billed charges exceed the rate of reimbursement as described in The Schedule;
- crowns, inlays, cast restorations, or other laboratory prepared or CAD/CAM prepared restorations.

The benefits provided under this plan 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 expense plan or prepaid treatment program sponsored or made available by Your Employer.

Expenses Not Covered

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

- any services not stated under Covered Dental Services and The Schedule;
- procedures that are deemed to be medical services or 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, for services and supplies received from a hospital, outpatient facility, ambulatory surgical center or similar facility;
- charges incurred due to injuries which are intentionally self-inflicted;
- charges for or in connection with an injury or illness arising out of, or in the course of any employment for wage or profit;
- charges for or in connection with an injury or illness which is covered under any workers' compensation or similar law;
- 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;
- consultations and/or evaluations associated with services that are not covered;
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) which may include but is not limited to the following: bleaching (tooth whitening), in office and/or at home, enamel microabrasion, odontoplasty, facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth will always be considered cosmetic;
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances, if orthodontics is covered) that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
- procedures, services, supplies, restorations, or appliances, whose sole or primary purpose is to change or maintain vertical dimension;
- procedures, services, supplies, restorations or appliances whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint;
- the restoration of teeth which have been damaged by erosion, attrition, abfraction or abrasion;
- bite registration or bite analysis;
- precision or semi-precision attachments;
- any procedure, service, supply or appliance used primarily for the purpose of splinting;
- porcelain, ceramic, resin, or acrylic materials on crowns or pontics on, or replacing the upper or lower first, second and/or third molars;
- services to correct congenital malformations, including the replacement of congenitally missing teeth;
- procedures, restorations, appliances or services to stabilize periodontally involved teeth;
- services associated with the diagnosis, placement, treatment, repair, removal or replacement of a dental implant, or any other services related to implants, unless covered by Your specific plan;
- myofunctional therapy;
- prescription drugs;
- treatment of jaw fractures and/or orthognathic surgery;
- Orthodontic Treatment;
- the treatment of cleft lip and cleft palate;
- charges for sterilization of equipment, infection control processes and procedures, disposal of medical waste or other requirements mandated or recommended by the Centers for Disease Control and Prevention (CDC), OSHA or other regulatory agencies; We consider these to be incidental to and part of the charges for services provided and not separately chargeable;
- charges for travel time; transportation costs;
- diagnostic casts, diagnostic models or study models;
- personal supplies, including but not limited to toothbrushes, rotary toothbrushes, floss holders, and water irrigation devices;
- oral hygiene instructions, tobacco counseling, substance use counseling, and nutritional counseling;
- charges for broken appointments; completion of claim forms; duplication of radiographic images and/or exams required by a third party;
- charges for treatment or surgery that does not meet plan guidelines;
- general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management;
- indirect pulp capping on the same date of service as a permanent restoration, We consider this to be incidental to and part of the charges for services provided and not separately chargeable;
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis;
- harmful habits treatment;
- intentional root canal treatment in the absence of injury or disease solely to facilitate a restorative procedure;
- services to the extent You or Your enrolled Dependent(s) are compensated under any group medical plan;

- house/extended care facility calls; hospital calls; office visits for observation (during regularly scheduled hours) when no other services are performed; office visits after regularly scheduled hours; and case presentations;
- procedures performed by a Dentist who is a member of the Covered Person's family except in the case of a dental emergency when no other Dentist is available. (Covered Person's family is limited to a Spouse, siblings, parents, children, grandparents, and the Spouse's siblings and parents);
- dental services that do not meet commonly accepted dental standards;
- replacement of teeth beyond the normal adult dentition of thirty-two (32) teeth;
- services not included in The Schedule, unless We agree 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;
- to the extent that You or any of Your Dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- charges in excess of the Maximum Reimbursable Charge allowances;
- procedures for which a charge would not have been made if the person had no insurance or for which the person is not legally required to pay. For example, if We determine that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of the Copayment, Deductible, and/or Coinsurance amount(s) You are required to pay for a Covered Service (as shown on The Schedule) without Our express consent, We shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that You remain responsible for any amounts that Your plan does not cover. We shall have the right to require You to provide proof sufficient to Us that You have made Your required cost share payment(s) prior to the payment of any benefits by Us. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge You or charged You at an In-Network benefits level or some other benefits level not otherwise applicable to the services received;
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law;
- Covered Dental Services to the extent that payment is unlawful where the Covered Person resides when the expenses are incurred;
- charges for or in connection with experimental procedures or treatment methods not recognized and approved by the American Dental Association or the appropriate dental specialty organization;
- charges which 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;
- services for which benefits are not payable according to the "General Limitations" section;
- charges for care, treatment or surgery that is not Medically Necessary and/or Dentally Necessary;
- athletic mouth guards.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.