ORTHO IN PROGRESS

Cigna Dental PPO (DPPO)

Even though you or a family member is in the middle of "active orthodontic treatment," when you join the Cigna DPPO, your plan may help pay some of your orthodontic costs

Q: What is "Orthodontics in Progress"?
A: "Orthodontics in Progress" refers to orthodontic treatment that began under a different carrier and continues into the new Cigna coverage period. Contributions may be available for patients whose teeth are being actively moved by bands or appliances (such as braces) at the time their Cigna dental coverage becomes effective. The Cigna DPPO plan covers orthodontics in progress, subject to your specific plan's limitations. Keep in mind, new benefits do not change the terms of the contract you signed with your orthodontist prior to enrolling with Cigna. You are still responsible for the orthodontist's total case fee.

Q: How much is my benefit amount?
A: Your benefit amount is determined by your plan's coinsurance level for orthodontia and the number of months of active treatment remaining when your Cigna DPPO plan takes effect. After you enroll, you must have your orthodontist submit the following information to your claim office:

- The original treatment plan showing the total months of active treatment
- The orthodontist's total case fee
- The banding date

Once your Cigna plan takes effect, the coinsurance percentage for orthodontia is applied to the contracted monthly payment you owe to your orthodontist. You are responsible for the balance. Your Cigna plan will contribute to your costs until the lifetime orthodontia maximum in your plan has been met, or until active treatment is completed (whichever comes first).

Q: How will Cigna pay the orthodontist?
A: Cigna will pay your orthodontist quarterly. If you have prepaid your bill, you can request that we pay you directly.

Q: What about non-orthodontic treatment in progress?
A: Generally, root canal treatment, crown and bridge work, and dentures in progress are not covered under the Cigna DPPO plan. You should complete these procedures under the guidelines of your prior insurance plan. See the exclusions and limitations in your plan documents for more details.

1.800.Cigna24 (1.800.244.6224) ▪ www.cigna.com

GO YOU

Offered by: Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company

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Cigna Dental PPO (DPPO)

LIMITATIONS & EXCLUSIONS

All plans have limitations and exclusions. Please refer to your employer's insurance certificate, summary plan description or evidence of coverage for a complete list of plan limitations and both covered and not covered services.

Listed below are the standard limitations and exclusions on services covered by your dental plan:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (Cleanings)	Two per calendar year
Fluoride	One per calendar year for people under 19
Histopathologic Exams	Various limits per calendar year depending on specific test
X-Rays (routine) Bitewings	Two per calendar year
X-Rays (non-routine) Full Mouth	One every 36 consecutive months. Panorex: one every 36 consecutive months.
Model	Payable only when in conjunction with ortho workup and extensive perio treatment
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every five years
Bridges	Replacement every five years
Dentures and Partials	Replacement every five years
Relines, Rebases	Covered if more than six months after installation
Adjustments	Covered if more than six months after installation
Repairs – Bridges	Reviewed if more than once
Repairs – Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years.
Space Maintainers	Limited to non-orthodontic treatment
Prosthesis Over Implant	One per 60 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.
Alternate Benefit	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.

Continue for more details

Benefit Exclusions

- Services performed primarily for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge or denture within five years following the date of its original installation
- Replacement of a bridge or denture which can be made useable according to accepted 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
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations; precision or semi-precision attachments; splinting
- 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
- Charges 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
- 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
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- 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);
- 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. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your dependents.
- 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.