Welcome to Cigna Healthcare Dental DHMO.

We're glad you're here.

So you've got a Cigna Dental Care® (DHMO[1]) plan. What a great choice. Whether you need routine oral care or have a dental problem, this plan will provide you with access to the care you need when you need it.

How your plan works.

- **Co-Pays:** Your Cigna Dental Care (DHMO) plan is a co-payment plan. When you get a dental service, Cigna Healthcare allows your network dentist to charge a certain amount. Then, you pay a fixed portion of that cost, as listed in your Patient Charge Schedule. Your plan pays the rest.
- **Your Dentist:** You'll need to choose a general dentist from the Cigna Dental Care Access Plus network, who can refer you to a specialist, if needed.[2] Children can remain with a pediatric network dentist up to their 13th birthday.
- **Updates:** Change your Cigna Dental Care Access Plus Network General Dentist (NGD) anytime. Simply go online to select your NGD or call customer service. Changes made by the 15th of the month will go into effect the first day of the following month. If you need an immediate change, customer service can help 24/7.
- **Deductible:** There's no annual deductible or calendar year maximum with this plan.

Questions?

Visit **Cigna.com**® or call **800.997.1654** to speak to a live customer service agent 24/7.

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What your plan covers.

The DHMO amounts apply only when you get care from in-network dentists.

Plan Details*	Cigna Dental Care (DHMO)
Deductible	No deductible
Class I: Diagnostic & Preventive	You incur no charge for the following services: routine cleaning, x-rays, oral exams, topical fluoride
Class II: Basic Restorative	The DHMO sets the cost for services based on a Patient Charge Schedule (PCS). The PCS is a list of fees for each covered service within the plan. Refer to your PCS P2X00 for the costs.
Class III: Major Restorative	
Class IV: Orthodontia	
Class IX: Implants	
Calendar year maximum	Adult and Children coverage. Refer to your PCS P2X00 for the costs.
Out of network	
Ortho lifetime maximum	
Implants lifetime maximum	

*See the summary of exclusions and limitations.

DHMO Exclusions

- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- 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 received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- Services for the charges which the person is not legally required to pay
- Charges which would not have been made if the person had no insurance
- Services received due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)[2]
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- 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[3]
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- General anesthesia or IV sedation when used for the purpose of anxiety control or patient management

DHMO Exclusions (*continued*)

- Prescription medications
- 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. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- Surgical implant of any type unless specifically listed on your PCS
- Services considered unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- Services to the extent you or your enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy[4]
- The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[5]
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[5]
- Consultations and/or evaluations associated with services that are not covered
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure

DHMO Limitations

Procedure	Limit
Oral evaluations	Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145)
X-rays (non-routine)	Full mouth: 1 every 3 calendar years Panorex: 1 every 3 calendar years
Periodontal root planning and scaling	Limit 4 quadrants per consecutive 12 months
Periodontal maintenance	Limited to 4 per year and (only covered after active periodontal therapy)
Crowns, dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	If covered, maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months may require an additional payment by the patient.
Relines, rebases	One every 24 months
Denture adjustments	Four within the first 6 months after installation
Prosthesis over implants	If covered, replacement limited to once every 5 years if unserviceable and cannot be repaired

DHMO Limitations *(continued)*

Surgical placement of implant	If covered, surgical placement of implants (D6010, D6012, D6040, and D6050) have a limit of 1 implant per calendar year with a replacement of 1 per 10 years
Temporomandibular Joint (TMJ) treatment	One occlusal orthotic device per 24 months
Athletic mouth guard	One athletic mouth guard per 12 months
General anesthesia/ IV sedation	General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule (PCS). IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the PCS. Plan limitation for this benefit is 1 hour per appointment.

Specialty treatment plans may require payment authorization for services to be covered. Before treatment starts, you should verify with your network specialty dentist that your treatment plan has been authorized for payment by Cigna. Depending on your plan, if more than one professionally accepted and appropriate method of treatment can be used to treat a dental condition, coverage may be limited to the less costly covered service. If you choose the more costly service, the fee listed on the Patient Charge Schedule may not apply. Review your plan documents for the details of your employer's specific dental plan.

1. The term DHMO is a brand name 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 (including Dental HMO plans), and plans with open access features. The Cigna Dental Care plan may not be available in all states.
2. A benefit is paid for covered out-of-network emergency dental care. Certain states mandate coverage for dental care received out-of-network. For example, in Minnesota, the plan will pay 50% of the value of your network benefit for covered out-of-network services. In Oklahoma, the plan will pay the same amount it pays network dentists for covered out-of-network services. You are responsible for any charges not covered by the plan. Other states may have similar mandates. Refer to your plan documents for cost and coverage details.
3. Oklahoma residents: This exclusion is replaced by the following: War or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
4. Arizona and Pennsylvania residents: This exclusion does not apply. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.
5. California and Texas residents: Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under your PCS.

Dentists who participate in the Cigna Healthcare network are independent contractors solely responsible for the treatment provided to their patients. Dentists are not agents of Cigna Healthcare.

This document provides highlights of coverage only. It is not a contract. If there are any differences between the information provided in this document and the official plan documents, the terms of the official plan documents will apply.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group. Cigna Healthcare Dental PPO plans are insured or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company, with network management services provided by Cigna Dental Health, Inc. (CDHI) and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network. Cigna Dental Care (DHMO) plans are insured by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., **a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes**, Cigna Dental Health of Kansas, Inc. (KS & NE), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, Cigna Dental Care plans are insured by CHLIC or Cigna HealthCare of Connecticut, Inc., and administered by CDHI. CHLIC policy forms: OK – DPPO: HP-POL99/HP-POL388, DHMO: POL115; OR - DPPO: HP-POL68/HP-POL352, DHMO: HP-POL121 04-10; TN – DPPO: HP-POL69/HC-CER2V1/HP-POL389 et al., DHMO: HP-POL134/HC-CER17V1 et al. The Cigna Healthcare name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

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