Welcome to Cigna Healthcare Dental DPPO.

Here's everything you need to know about your plan.

So you've got a Dental DPPO 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-Insurance:** Your Dental DPPO plan is a coinsurance plan. When you get a dental service, Cigna Healthcare℠ allows your network dentist to charge a certain amount. Then, you pay a percentage of that cost. Your plans pays the rest.
- **Your Dentist:** You can choose any dentist or specialist you want, and you don't need a referral to visit a specialist. You will typically spend less when you visit a Cigna Healthcare network dentist because we've negotiated discounted rates with those dentists.
- **Deductible:** You need to meet a deductible before eligible expenses begin to be covered by your plan.
- **Maximum Amount:** There's a calendar year maximum, which is a set maximum amount that your plan will pay for your dental claims during the plan year. Once you reach that amount, your plan will no longer pay a percentage of your costs for the rest of that plan year.

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

Plan Details*	DPPO
	$1,750
Deductible	$25 Individual $75 Family
Class I: Diagnostic & Preventive	85% covered by the plan
Class II: Basic Restorative	85% covered by the plan
Class III: Major Restorative	50% covered by the plan
Class IV: Orthodontia	Not covered
Class IX: Implants	50% covered by the plan
Calendar year maximum	$1,750
Out of network	$1,000
Ortho lifetime maximum	Not covered
Implants lifetime maximum	No maximum

*See the summary of exclusions and limitations.

DPPO 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

DPPO Exclusions (*continued*)

- 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

DPPO Limitations

Procedure	Limit
Exams	Two per calendar year
Prophylaxis (cleanings)	Three per calendar year
Fluoride	2 per calendar year for people under 19
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years.
Model	Payable only when in conjunction with ortho workup
Minor perio (non-surgical)	Various limitations depending on the service
Perio surgery	Various limitations depending on the service
Crowns	Replacement every 5 years
Prosthesis over implants	1 per every 5 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.
Bridges	Replacement every 5 years
Dentures and partials	Dentures and partials
Relines, rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 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 up to age 14.
Space maintainers	Limited to non-orthodontic treatment. No frequency limit for participants under age 19.
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
Missing tooth provision	No limitation (teeth missing prior to the effective date of coverage are covered)
Late entrant limit	50% coverage on Class III, IV (if applicable) and IX for 12 months
Pre-treatment review	Available on a voluntary basis when extensive work in excess of $200 is proposed

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.

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.

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