

CHOOSE WELL. SMILE BRIGHT.

Get to know your dental plan options,
so you can feel good about your decision.



Welcome to another plan year with Cigna Dental.

We're grateful for the opportunity to serve you again this year. And as your dental benefits provider, we're committed to giving you the information you need in a clear, easy-to-understand way to help you choose the plan that's right for you. As always, no matter which plan you choose, you'll have access to valuable tools and resources to help you better manage your oral health - and your overall well-being - all year long.

HERE ARE YOUR OPTIONS AT A GLANCE.

Cigna Dental Care® (DHMO ¹)	Dental PPO (DPPO)
<ul style="list-style-type: none"> ▶ Your Cigna Dental Care (DHMO) plan is a copayment plan. When you get a dental service, Cigna 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. ▶ 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 7th birthday. ▶ 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. ▶ There's no annual deductible or calendar year maximum. 	<ul style="list-style-type: none"> ▶ Your DPPO plan is a coinsurance plan. When you get a dental service, Cigna allows your network dentist to charge a certain amount. Then, you pay a percentage of that cost. Your plan pays the rest. ▶ You can choose any dentist or specialist you want, and you do not need a referral to visit a specialist. You will typically spend less when you visit a Cigna network dentist because Cigna has negotiated discounted rates with these dentists. ▶ You need to meet a deductible before eligible expenses begin to be covered by your plan. ▶ There is 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.
<p>THE UPSIDE: Greater potential savings</p>	<p>THE UPSIDE: More flexibility</p>

MARK YOUR CALENDAR FOR OPEN ENROLLMENT.

You have from **10/25** through **11/17/2021** to choose the dental plan that's right for you.

Together, all the way.®



Offered by Cigna Health and Life Insurance Company or its affiliates

Here's a more detailed view to help you compare the costs and benefits.

ANNUAL PLAN COSTS

COVERAGE LEVEL	DENTAL PPO (DPPO) COSTS PER YEAR	CIGNA DENTAL CARE (DHMO) COSTS PER YEAR	SAVINGS OPPORTUNITY PER YEAR WITH CIGNA DENTAL CARE (DHMO)
Team member only	\$335.66	\$117.84	\$217.82
Team member + spouse	\$704.86	\$322.14	\$382.72
Team member + children	\$603.46	\$488.02	\$115.44
Team member + spouse + children	\$973.70	\$675.48	\$298.22

Costs are subject to change.

PLAN COVERAGE*

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

PLAN DETAILS*	DENTAL PPO (DPPO)		CIGNA DENTAL CARE (DHMO)
	In-network	Out-of-network	
Deductible	\$50/\$150 covered by the plan	\$100/\$300 covered by the plan	No deductible
Class I	100% covered by the plan	80% covered by the plan	You incur no charge for the following services: routine cleaning, x-rays, oral exams, topical fluoride.
Class II	80% covered by the plan after the deductible	50% covered by the plan after the deductible	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 K1109 for the costs.
Class III	50% covered by the plan after the deductible	40% covered by the plan after the deductible	
Calendar year maximum combined in-network and out of network	\$1,500 covered by the plan the plan after the deductible	\$1,500 covered by the plan the plan after the deductible	No maximum
Ortho lifetime maximum \$1,000	50% covered by the plan the plan	50% covered by the plan the plan	No maximum

*See a summary of exclusions and limitations beginning on page 3 of this document.

Need help deciding? Answer these simple questions to get a better understanding of which plan is right for you and your family.

FOR EACH QUESTION BELOW, CHECK EITHER "YES" OR "NO".		
Do you prefer a plan that tells you the exact dollar amount you will pay for each procedure, so you don't have to calculate percentages?	<input type="checkbox"/> YES >	<input type="checkbox"/> NO >
Do you prefer a dental plan that has no calendar year maximums, so you don't have to worry about your benefits running out if you reach a certain amount?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you prefer a dental plan with no deductibles, so your benefits kick in right away, rather than waiting to reach a certain level of out-of-pocket expenses first?	<input type="checkbox"/> YES >	<input type="checkbox"/> NO >
Would you change dentists if it meant spending less out-of-pocket for your dental care costs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

DID YOU ANSWER YES TO TWO OR MORE QUESTIONS?

If so, we strongly encourage you to take a closer look at the <Cigna Dental Care (DHMO)> plan. You may be surprised at the benefits – in cost, coverage and convenience. Plus, your dentist may already participate in the Cigna Dental Care Access Plus network.

To see if your dentist is in-network or to find a new one:

- › Go to **Cigna.com**
- › Click on “Find a Doctor, Dentist or Facility” at the top of the page
- › Choose “Plans through your employer or school”
- › Choose Cigna Dental Care Access Plus
- › Enter your search criteria

Note: The network changes frequently. Once you find a doctor in the directory, call the dental office to confirm they are accepting patients in the Cigna Dental Care Access [Plus] network before making an appointment.

DID YOU ANSWER NO TO TWO OR MORE QUESTIONS?

If so, check out the DPPO plan to see if it fits your needs and budget. To find a Dental PPO dentist on **Cigna.com**, follow the same steps as above but choose the Cigna Dental PPO network.

**For questions about your plan options during enrollment, give us a call to speak with a live customer service representative:
24 hours a day, 365 days a year | 800.Cigna24
Or, visit Cigna.com**

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
- › 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
- › 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

DPPO Exclusions: (continued)

- › 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
- › The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage
- › 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
- › 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
- › Services performed by a prosthodontist
- › Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- › Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service
- › Infection control and/or sterilization
- › The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement
- › The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- › Services to correct congenital malformations, including the replacement of congenitally missing teeth
- › The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- › Crowns, bridges and/or implant supported prosthesis used solely for splinting
- › Resin bonded retainers and associated pontics
- › As to orthodontic treatment: incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment>

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 (routine)	Bitewings: 2 per calendar year
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 and inlays	Replacement 1 every 5 years
Bridges	Replacement 1 every 5 years
Dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient
Relines, rebases	One every 36 months
Denture adjustments	Four within the first 6 months after installation

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;
- 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.

DPPO Limitations

PROCEDURE	LIMIT
Late Entrants Limit	50% coverage on Class III and IV for 12 months
Exams	Two per Calendar year
Prophylaxis(Cleanings)	Two per Calendar year
Fluoride	1 per Calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per Calendar year
X-Rays (non-routine)	Full mouth: 1 every 36 consecutive months, Panorex: 1 every 36 consecutive months
Model	Payable only when in conjunction with Ortho workup
MinorPerio(non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
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
SpaceMaintainers	Limited to non-Orthodontic treatment
ProsthesisOverImplant	1 per 60 consecutivemonths 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



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.

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

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 representative.

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