Cigna Dental Benefit Summary
John Carroll University
Plan Renewal Date: 01/01/2019

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Benefit Plan Features	***Total Cigna***		***Non-Network***
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.		
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.		
Calendar Year Benefits Maximum Applies to: Class I, II and III expenses	Year 1: $1,200 Year 2: $1,450 Year 3: $1,700 Year 4: $1,950	Year 1: $1,200 Year 2: $1,450 Year 3: $1,700 Year 4: $1,950	Year 1: $1,200 Year 2: $1,450 Year 3: $1,700 Year 4: $1,950
Progressive Maximum Benefit: Progressive Benefit Year 2: Increase contingent upon receiving Preventive Services in Plan Year 1. Progressive Benefit Year 3: Increase contingent upon receiving Preventive Services in Plan Years 1 and 2. Progressive Benefit Year 4: Increase contingent upon receiving Preventive Services in Plan Years 1, 2 and 3.			
Calendar Year Deductible Individual Family	 $50 $150	 $50 $150	 $50 $150
Benefit Highlights	***Plan Pays***	***Plan Pays***	***Plan Pays***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: bitewing X-rays: full mouth X-rays: panoramic X-rays: periapical Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	90% No Deductible	90% No Deductible
Class II: Basic Restorative Restoration: fillings Oral Surgery: simple extractions Oral Surgery: oral surgical procedures Oral Surgery: extractions of impacted teeth Periodontal Maintenance Anesthesia: general and IV sedation Periodontics: perio scaling and root planing Periodontics: osseous surgery Endodontics: root canal therapy Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines Rebases and Adjustments	80% After Deductible	70% After Deductible	70% After Deductible
Class III: Major Restorative Inlays and Onlays Stainless Steel and Resin Crowns Crowns, Bridges and Dentures Prosthesis Over Implant	50% After Deductible	40% After Deductible	40% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 23 Lifetime Benefits Maximum: $1,000	50% After Deductible	40% After Deductible	40% After Deductible

Benefit Plan Provisions:	
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $500 is proposed.
Alternate Benefit Provision	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.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the plan deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations: *Benefit frequency limitations are based on date of service.*	
Missing Tooth Limitation Provision	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 24 months; thereafter, considered a Class III expense.
Oral Exams	1 per 6 consecutive months
X-rays: bitewing	1 set per 12 consecutive months, limited to 4 films per set
X-rays: full mouth or panoramic	1 per 60 consecutive months
X-rays: periapical	4 per 12 consecutive months if not in conjunction with an operative procedure
X-rays: Intraoral occlusal	2 per 12 consecutive months
Cleaning: routine	1 prophylaxis (Class I) or periodontal maintenance (Class II) per 6 consecutive months
Fluoride Application	1 per 12 consecutive months for children under age 14
Sealants (per tooth)	1 treatment per lifetime; payable on unrestored permanent bicuspid or molar teeth only
Space Maintainers	Limited to non-orthodontic treatment for children under age 14
Restoration: fillings	1 per 12 consecutive months; applies to replacement of identical surface fillings only, no composite, white/tooth colored fillings on bicuspid or molar teeth
Inlays and Crowns	Replacement limited to 1 per 84 consecutive months. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges. Replacement must be indicated by major decay. For children under age 16, benefits for crowns and inlays are limited to resin or stainless steel.
Stainless Steel and Resin Crowns	1 per 36 consecutive months for children under age 16
Endodontic Treatment	Root canal retreatment 1 per 24 consecutive months, based on necessity
Periodontal Scaling and Root Planning	1 per quadrant per 36 consecutive months
Dentures and Partials	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired
Denture Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months
Denture Repairs	Covered if more than 12 months after installation
Denture Rebases and Relines	Covered if more than 12 months after installation; 1 per 36 consecutive months
Prosthesis Over Implant	1 per 84 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
Bridges	Replacement limited to 1 per 84 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
Diagnostic Casts	Payable only in conjunction with orthodontic workup
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: core buildup; veneers; precious or semi-precious metals for crowns, bridges, pontics and abutments; restoration of teeth which have been damaged by erosion, attrition or abrasion; Periodontics: bite registrations; splinting;	

Prosthodontics: overdentures; precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;
Implants: implants or implant related services;
Anesthesia: general anesthesia or intravenous sedation, when used for the purposes of anxiety control or patient management is not covered; may be considered only when medically or dentally necessary and when in conjunction with covered complex oral surgery;
Procedures, appliances or restorations, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion;
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;
Services that are deemed to be medical in nature; services and supplies received from a hospital;
Charges in excess of the Maximum Reimbursable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

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