Cigna Dental Benefit Summary
City of Tucson - AZ

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Benefits	***Cigna Dental PPO***			
	In-Network		***Out-of-Network***	
Network	***Cigna DPPO Advantage***			
Plan Year Maximum (Class I, II and III expenses)	$2,000		$1,500	
Annual Deductible Individual Family	$25 per person $75 per family		$50 per person $150 per family	
Reimbursement Levels**	Based on Reduced Contracted Fees		80th percentile of Reasonable and Customary Allowances	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I - Preventive & Diagnostic Care Oral Exams Routine Cleanings Full Mouth X-rays Bitewing X-rays Panoramic X-ray Periapical X-rays Fluoride Application Sealants Space Maintainers Emergency Care to Relieve Pain	100%	No Charge	80%	20%
Class II - Basic Restorative Care Fillings Root Canal Therapy/Endodontics Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Oral Surgery – Simple Extractions Oral Surgery – all except simple extractions Anesthetics Surgical Extractions of Impacted Teeth Repairs to Bridges, Crowns and Inlays	90%*	10%*	80%*	20%*
Class III - Major Restorative Care Crowns Dentures Bridges Inlays/Onlays Prosthesis Over Implant	60%*	40%*	50%*	50%*
Class IV - Orthodontia Lifetime Maximum	60% $2,000 Covered for Children & Adults	40%	60% $2,000 Covered for Children & Adults	40%
Class IX - Implants Deductible Annual Maximum	60% Subject to plan deductible Subject to plan annual maximum	40%	50% Subject to plan deductible Subject to plan annual maximum	50%

Missing Tooth Limitation – The amount payable is 50% of the amount otherwise payable until insured for 24 months; thereafter, considered a Class III expense.
Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.
* Subject to annual deductible
Dental Oral Health Integration Program (OHIP) - All dental customers = Clinical research shows an association between oral health and overall health. The Cigna Dental Oral Health Integration Program (OHIP)® is designed to provide enhanced dental coverage for customers with certain eligible medical conditions. Eligible conditions for the program include cardiovascular disease, cerebrovascular disease (stroke), diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation. The program provides:

- 100% coverage for certain dental procedures
- guidance on behavioral issues related to oral health
- discounts on prescription and non-prescription dental products

For more information and to see the complete list of eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
**For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Contracted Fee Schedule. For services provided

by an out-of-network dentist, Cigna Dental will reimburse according to Reasonable and Customary Allowances but the dentist may balance bill up to their usual fees.

Cigna Dental PPO Exclusions and Limitations

Procedure	Exclusions and Limitations
Late Entrants Limit	50% coverage on Class III and IV for 24 months
Exams	Two per Plan year
Prophylaxis (Cleanings)	Two per Plan year
Fluoride	1 per Plan year for people under 19
X-Rays (routine)	Bitewings: 2 per Plan 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
Minor Perio (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
Space Maintainers	Limited to non-Orthodontic treatment, no age limit
Prosthesis Over Implant	1 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

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.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions andlimitations, including legislated benefits, will be provided in your insurance certificate or plan description. Benefits are insured and/or administered by Connecticut General Life Insurance Company.
"Cigna HealthCare" refers to various operating subsidiaries of Cigna Corporation. Products and services are provided by these subsidiaries and not by Cigna Corporation. These subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

DPPO insurance coverage is set forth on the following policy form numbers: AR: HP-POL77; CA: HP-POL57; CO: HP-POL78; CT: HP-POL58; DE: HP-POL79; FL: HP-POL60; ID: HP-POL82; IL: HP-POL62; KS: HP-POL84; LA: HP-POL86: MA: HP-POL 63; MI: HP-POL88; MO: HP-POL65; MS: HP-POL90; NC: HP-POL96; NE: HP-POL92; NH: HP-POL94; NM: HP-POL95; NV: HP-POL93; NY: HP-POL67; OH: HP-POL98; OK: HP-POL99; OR: HP-POL68; PA: HP-POL100; RI: HP-POL101; SC: HP-POL102; SD: HP-POL103; TN: HP-POL69; TX: HP-POL70; UT: HP-POL104; VA: HP-POL72; VT: HP-POL71; WA: POL-07/08; WI: HP-POL107; WV: HP-POL106; and WY: HP-POL108.

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administered by CGLIC or CHLIC, with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Arizona and Louisiana, the insured Dental PPO plan offered by CGLIC is known as the "CG Dental PPO". In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network. Cigna Dental Care (DHMO) plans are underwritten or administered 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. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc. (Kentucky and Illinois), 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 underwritten by CGLIC, CHLIC, or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc.

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