Alief Independent School District

# 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) |
|---|---|
| › 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.<br>› 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.<br>› 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.<br>› There's no annual deductible or policy year maximum. | › Your DPPO plan offerings are coinsurance plans. 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.<br>› 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.<br>› You need to meet a deductible before eligible expenses begin to be covered by your plan.<br>› There is a policy 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. |
| THE UPSIDE: Greater potential savings | THE UPSIDE: More flexibility |

**Together, all the way.®**

Cigna®

**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 | CIGNA DENTAL CARE (DHMO) ANNUAL PLAN PREMIUM COSTS | DENTAL PPO (DPPO) LOW PLAN OPTION ANNUAL PLAN PREMIUM COSTS | DENTAL PPO (DPPO) HIGH PLAN OPTION ANNUAL PLAN PREMIUM COSTS |
|---|---|---|---|
| Employee Only | $119.28 | $253.20 | $410.40 |
| Employee & Spouse | $226.32 | $649.68 | $1,053.84 |
| Employee & Children | $238.32 | $666.72 | $1,081.20 |
| Employee +2 or more dependents | $369.84 | $879.36 | $1,426.32 |

Costs are subject to change.

### PLAN COVERAGE*

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

| PLAN DETAILS* | DENTAL PPO (DPPO) HIGH PLAN OPTION | DENTAL PPO (DPPO) LOW PLAN OPTION | CIGNA DENTAL CARE (DHMO) |
|---|---|---|---|
| | In-network | In-network | |
| Deductible | $50 Individual<br>$150 Family | $50 Individual<br>$150 Family | No deductible |
| Class I: Diagnostic & Preventive | 100%<br>covered by the plan | 100%<br>covered by the plan | Outside of the office visit copay, you incur no charge for the following services: routine cleaning, x-rays, oral exams, topical fluoride. |
| Class II: Basic Restorative | 80%<br>covered by the plan | 80%<br>covered by the plan | 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 (P7XV0) for the costs. |
| Class III: Major Restorative | 50%<br>covered by the plan | 50%<br>covered by the plan | |
| Class IV: Orthodontia | 50%<br>covered by the plan for dependents up to age 19 | Not Covered | |
| Class IX: Implants | 50%<br>covered by the plan | 50%<br>covered by the plan | |
| Policy year maximum | $1,800 | $1,800 | No maximum |
| Ortho lifetime maximum | $1,500 | N/A | No maximum |

## 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? | ☐ YES | ☐ NO |
| Do you prefer a dental plan that has no policy year maximums, so you don't have to worry about your benefits running out if you reach a certain amount? | ☐ YES | ☐ 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? | ☐ YES | ☐ NO |
| Would you change dentists if it meant spending less out-of-pocket for your dental care costs? | ☐ YES | ☐ 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 plans to see if they fit 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, 7 days a week | 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[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
- 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[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
- 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 (non-routine) | Full mouth: 1 every 3 policy years. Panorex: 1 every 3 policy 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; Bridges, 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 |
| Prosthesis over implant | If covered, replacement limited to once every 5 years if unserviceable and cannot be repaired |
| Surgical placement of implant | If covered, surgical placement of implants (D6010, D6012, D6040, and D6050) have a limit of 1 implant per policy 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. |

**DPPO Low Exclusions:**

- 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: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting
- Periodontics: bite registrations; splinting
- Prosthodontic: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines
- Implants: implants or implant related services; Orthodontics: orthodontic treatment
- Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (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; Drugs: prescription drugs
- Charges in excess of the Maximum Allowable Charge.

## DPPO Low Limitations

| PROCEDURE | LIMIT |
|---|---|
| Missing Tooth Limitation | For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense. |
| Oral Evaluations | 2 per policy year |
| X-rays (routine) | Bitewings: 2 per policy year |
| X-rays (non-routine) | Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months |
| Cleanings | 2 per policy year, including periodontal maintenance procedures following active therapy |
| Fluoride Application | 1 per policy year for children under age 19 |
| Sealants (per tooth) | Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14 |
| Space Maintainers | Limited to non-orthodontic treatment for children under age 19 |
| Inlays, Crowns, Bridges, Dentures and Partials | Replacement every 60 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. |
| Denture and Bridge Repairs | Reviewed if more than once |
| Denture Relines, Rebases and Adjustments | Covered if more than 6 months after installation |
| Prosthesis Over Implant | 1 every 60 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. |

**DPPO High Exclusions:**

- 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: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting
- Prosthodontic: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines
- Implants: implants or implant related services
- Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (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; Drugs: prescription drugs
- Charges in excess of the Maximum Allowable Charge.

## DPPO High Limitations

| PROCEDURE | LIMIT |
|---|---|
| Missing Tooth Limitation | For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense. |
| Oral Evaluations | 2 per policy year |
| X-rays (routine) | Bitewings: 2 per policy year |
| X-rays (non-routine) | Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months |
| Diagnostic Casts | Payable only in conjunction with orthodontic workup |
| Cleanings | 2 per policy year, including periodontal maintenance procedures following active therapy |
| Fluoride Application | 1 per policy year for children under age 19 |
| Sealants (per tooth) | Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14 |
| Space Maintainers | Limited to non-orthodontic treatment for children under age 19 |
| Inlays, Crowns, Bridges, Dentures and Partials | Replacement every 60 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. |
| Denture and Bridge Repairs | Reviewed if more than once |
| Denture Relines, Rebases and Adjustments | Covered if more than 6 months after installation |
| Prosthesis Over Implant | 1 every 60 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. |

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 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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