Individual & Family Plans

Insured by Cigna Health and Life Insurance Company

Cigna®

myCigna Dental Plans

SUMMARY OF BENEFITS

Your 2015 plan information

	myCigna Dental Preventive		myCigna Dental 1000		myCigna Dental 1500	
DENTAL BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Individual Annual Deductible	Not Applicable		$50 per person		$50 per person	
Family Annual Deductible	Not Applicable		$150 per family		$150 per family	
Annual Benefit Maximum	Not Applicable		$1,000 per person		$1,500 per person	
Separate Lifetime Individual Orthodontia Deductible	Not Applicable		Not Applicable		$50 per person	
CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES						
Preventive/Diagnostic Services Waiting Period	Not Applicable		Not Applicable		Not Applicable	
Preventive/Diagnostic Services Oral Exams, Routine Cleanings, Routine X-Rays, Sealants, Fluoride Treatment, Space Maintainers (non-orthodontic)	You pay 0%	You pay 0%	You pay 0%	You pay 0%	You pay 0%	You pay 0%
CLASS II: BASIC RESTORATIVE SERVICES						
Basic Restorative Services Waiting Period	Not Applicable		6 month waiting period*		6 month waiting period*	
Basic Restorative Services Non-routine X-Rays, Fillings, Routine Tooth Extraction, Emergency Treatment	You pay 100% (discounts may apply)**	You pay 100%	You pay 20% (after deductible)	You pay 20% (after deductible)	You pay 20% (after deductible)	You pay 20% (after deductible)
CLASS III: MAJOR RESTORATIVE SERVICES						
Major Restorative Services Waiting Period	Not Applicable		12 month waiting period*		12 month waiting period*	
Major Restorative Services Periodontal (Deep Cleaning), Periodontal Maintenance, Crowns, Root Canal Therapy, Wisdom Tooth Extraction, Dentures/Partials, Bridges	You pay 100% (discounts may apply)**	You pay 100%	You pay 50% (after deductible)	You pay 50% (after deductible)	You pay 50% (after deductible)	You pay 50% (after deductible)
CLASS IV: ORTHODONTIA						
Orthodontia Waiting Period	Not Applicable		Not Applicable		12 month waiting period*	
Orthodontia	You pay 100% (discounts may apply)**	You pay 100%	You pay 100% (discounts may apply)**	You pay 100%	You pay 50% (after separate lifetime orthodontia deductible)	
Orthodontia Individual Lifetime Maximum	Not Applicable		Not Applicable		$1,000 per person	

If you choose to visit a dentist out-of-network you will pay the out-of-network benefit and the difference in the amount that Cigna reimburses for such services and the amount charged by the dentist, except for emergency services. This is known as balance billing.

* NJ, VT & IL: 6 month waiting period for all Classes; WV: 3 month waiting period for all Classes; MO & RI: no waiting period for all Classes; You may be eligible to waive the waiting period for Classes II & III if you have continuous 12 months of prior coverage **from a valid dental insurance plan**.

** In-network Dentists contracted with Cigna may pass along discounted rates. Discounts are not available in Virginia.

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PROCEDURE	FREQUENCY/LIMITATION
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES
Oral Exams	1 per consecutive 6 month period
Routine Cleanings	1 routine prophylaxis or periodontal maintenance procedure per consecutive 6 month period (routine prophylaxis falls under Class I; periodontal maintenance procedure falls under Class III)
Routine X-Rays	Bitewings: 1 set in any consecutive 12 month period. Limited to a maximum of 4 films per set
Sealants	1 treatment per tooth per lifetime. Payable on unrestored permanent bicuspid or molar teeth for participants less than age 14
Fluoride Treatment	1 per consecutive 12 month period for participants less than age 14
Space Maintainers (non-orthodontic)	Limited to non-orthodontic treatment for prematurely removed or missing teeth for participants less than age 14
	CLASS II: BASIC RESTORATIVE SERVICES
Non-routine X-Rays	Full mouth or Panorex: 1 per consecutive 60 month period
Fillings	1 per tooth per consecutive 12 month period (applies to replacement of identical surface fillings only). No white/tooth colored fillings on bicuspid or molar teeth
Routine Tooth Extraction	Includes an allowance for local anesthesia and routine postoperative care
Emergency Treatment	Paid as a separate benefit only if no other service, except X-rays, is rendered during the visit
	CLASS III: MAJOR RESTORATIVE SERVICES
Periodontal (Deep Cleaning)	1 per quadrant per consecutive 36 month period
Periodontal Maintenance	Payable only if a consecutive 6 month period has passed since the completion of active periodontal surgery. 1 periodontal maintenance or routine prophylaxis procedure per consecutive 6 month period (periodontal maintenance procedure is Class III; routine prophylaxis is Class I)
Crowns	1 per tooth per consecutive 84 month period. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crown or bridges. Replacement must be indicated by major decay. For participants less than 16, benefits limited to resin or stainless steel
Root Canal Therapy	1 per tooth per lifetime
Wisdom Tooth Extraction	Includes an allowance for local anesthesia and routine postoperative care
Dentures and Partials	1 per arch per consecutive 84 month period
Bridges	1 per consecutive 84 month period. Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under this plan
	CLASS IV: ORTHODONTIA
Orthodontia	The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia lifetime maximum

This summary contains highlights only.

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2015 PLAN EXCLUSIONS AND LIMITATIONS – MAY VARY BY STATE

What Is Not Covered By This Plan

Excluded Services

Covered expenses do not include expenses incurred for:

- Procedures which are not included in the policy.
- Procedures which are not necessary and which do not have uniform professional endorsement.
- Procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- Procedures, appliances or restorations whose main purpose is to diagnose or treat dysfunction of the temporomandibular joint (Services are covered in AR*, MN, NM, NV and VT*).
- The alteration or restoration of occlusion.
- The restoration of teeth which have been damaged by erosion, attrition or abrasion.
- Bite registration or bite analysis.
- Any procedure, service or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- The initial placement of a full denture or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan (the removal of only a permanent third molar will not qualify a full or partial denture for benefit under this provision).
- The initial placement of a fixed bridge, unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. If a bridge replaces teeth that were missing prior to the date the person's coverage became effective and also teeth that are extracted after the person's effective date, benefits are payable only for the pontics replacing those teeth which are extracted while the person was insured under this plan. The removal of only a permanent third molar will not qualify a fixed bridge for benefit under this provision.
- The surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.
- Core build-ups.
- Replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or
  - The partial denture is less than 84 consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional necessary extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- The replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying natural tooth.
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- Replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- Replacement of lost or stolen appliances.
- Replacement of teeth beyond the normal complement of 32.
- Prescription drugs.
- Any procedure, service, supply or appliance used primarily for the purpose of splinting.
- Athletic mouth guards.
- Myofunctional therapy.
- Precision or semi-precision attachments.
- Denture duplication.
- Separate charges for acid etch.
- Labial veneers (laminate).
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old.
- Treatment of jaw fractures and orthognathic surgery.
- Orthodontic treatment, except for the treatment of cleft lip and cleft palate. Exclusion does not apply if the plan otherwise covers services for orthodontic treatment.
- Charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- Charges for travel time; transportation costs; or professional advice given on the phone.
- Temporary, transitional or interim dental services.
- Any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least three years, as determined by Cigna.
- Diagnostic casts, diagnostic models or study models.
- Any charge for any treatment performed outside of the United States other than for emergency treatment (any benefits for emergency treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12 month period).
- Oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (water pick, toothbrush, floss holder); duplication of x-rays and exams required by a third party.
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- Services that are deemed to be medical services.
- Services for which benefits are not payable according to the "general limitations" section.

General Limitations

No payment will be made for expenses incurred for you or any one of your dependents:

- For services not specifically listed as covered services in the policy.
- For services or supplies that are not dentally necessary.
- For services received before the effective date of coverage.

* Depending on plan

myCigna Dental Plans

2015 PLAN EXCLUSIONS AND LIMITATIONS

General Limitations ***(continued)***

- For services received after coverage under this policy ends.
- For services for which you have no legal obligation to pay or for which no charge would be made if you did not have dental insurance coverage.
- For professional services or supplies received or purchased directly or on your behalf by anyone, including a dentist from any of the following:
  - Yourself or your employer.
  - A person who lives in the insured person's home, or that person's employer.
  - A person who is related to the insured person by blood, marriage or adoption, or that person's employer.
- For or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.
- For or in connection with a sickness which is covered under any workers' compensation or similar law.
- For charges made by a hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected condition.
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- To the extent that billed charges exceed the rate of reimbursement as described in the schedule.
- 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.
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Procedures that are a covered expense under any other dental plan which provides dental benefits.
- 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 will take into account any adjustment option chosen under such part by you or any one of your dependents.

2015 PLAN IMPORTANT DISCLOSURES

myCigna Dental Preventive and myCigna Dental 1000 plans include a combination of insurance coverage and discounted services. The insurance coverage shall be only for the classes of service referred to in The Schedule of a purchased plan. Discounts are not available in Virginia or Maryland.

Dental plans are insured by Cigna Health and Life Insurance Company with network management services provided by Cigna Dental Health, Inc. Rates may vary based on age, family size, geographic location (residential zip code), and plan design.

All rates are subject to change upon 30 days' prior notice in AK, AL, AR, AZ, CO, CT, DC, DE, HI, ID, IA, IL, IN, KS, KY, MA, ME, MI, MN, MO, MT, ND, NE, NH, NJ, NM, OH, OK, OR, PA, RI, SD, TN, UT, VT, WI and WY, 31 days' prior notice in SC, 45 days' prior notice in FL, and 60 days' prior notice in CA, GA, MS, NV, TX, VA, and WV. In LA rates are guaranteed for the initial 12 months of coverage, except if due to addition of a newly covered person, a change in age or geographic location, or a change in policy coverage. Thereafter, rates are subject to change upon 45 days' prior notice. **Dental plans apply waiting periods to covered basic (6 months), major (12 months) and orthodontic (12 months) dental care services.** In WV, a 3 month waiting period applies to covered basic, major and orthodontic dental care services. In IL, NJ, and VT, a 6 month waiting period applies to covered major and orthodontic dental care services. Waiting periods do not apply in MO and RI. In OH a 12 month waiting period applies. Some covered services are determined by age: topical application of fluoride or sealant, space maintainers, and materials for crowns and bridges. If the plan covers replacement of teeth, there is no payment for replacement of teeth that are missing prior to coverage. In FL, payment limitation no longer applies after 24 months. In OH, payment limitation no longer applies after 12 months of continuous coverage.

Notice to Buyer: This policy provides dental coverage only. Review your policy carefully.

Dental preferred provider insurance policies (AL, CO, DE, CT, GA, IL, MA, MI, PA, UT, VA, WV, and WY: HC-NOT11 et al., AR: HC-NOT36 et al., CA: INDENTPOLCA0713 et al., FL: HC-NOT15 et al., ID HC-NOT51 et al, KS: HC-NOT49 et al., LA: INDDENTPOLLA0713, MS: HC-NOT48 et al., MO: INDDENTPOLMO0713, NE HC-NOT47 et al., NH INDDENPOLNH0713, NM: INDDENPOLNM0713, NV: HC-NOT39 et al., OH: INDDENTPOLOH et al., OK: HC-NOT26 et al., OR: INDDENTPOLOR0713, RI HC-NOT35 et al., SC: HC-NOT19 et al., SD HC-NOT59 et al., TN: HC-NOT20 et al., TX: HC-NOT21 et al., VT HC-NOT56 et al., WI HC-NOT54 et al.) have exclusions, limitations, reduction of benefits and terms under which a policy may be continued in force or discontinued.

The policy may be cancelled by Cigna due to failure to pay premium, fraud, ineligibility, when the insured no longer lives in the service area, or if we cease to offer policies of this type or any individual dental plans in this state, in accordance with applicable law. You may cancel the policy, on the first of the month following our receipt of your written notice. We reserve the right to modify this policy, including policy provisions, benefits and coverages, consistent with state or federal law. This individual plan is renewable monthly or quarterly.

For costs, and additional details about coverage, contact Cigna Health and Life Insurance Company at 900 Cottage Grove Rd, Hartford, CT 06152 or call 1.866.GET.Cigna (1.866.438.2446).

The Dental plans do not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act(PPACA). This coverage is available in the insurance market. Please contact your insurance carrier, agent/producer, or the Health Insurance Marketplace if you wish to purchase PPACA compliant pediatric dental coverage.