# *Cigna Traditional Dental Benefit Summary*
# *Archdiocese of New York – Beacon of Hope - Indemnity Plan*
# *Employee, Employee + Family*
# *Plan Renewal Date: 01/01/2024*

**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.

| ***Cigna Traditional*** | | |
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| ***Calendar Year Benefits Maximum***<br>Applies to: Class I, II & III expenses | $1,000 | |
| ***Calendar Year Deductible***<br>Individual<br>Family | <br>$50<br>$150 | |
| ***Benefit Highlights*** | ***Plan Pays*** | ***You Pay*** |
| ***Class I: Diagnostic & Preventive***<br>Oral Evaluations<br>Prophylaxis: routine cleanings<br>X-rays: routine<br>X-rays: non-routine<br>Fluoride Application<br>Sealants: per tooth<br>Space Maintainers: non-orthodontic<br>Emergency Care to Relieve Pain | 100%<br>No Deductible | No Charge |
| ***Class II: Basic Restorative***<br>Restorative: fillings<br>Endodontics: minor and major<br>Periodontics: minor and major<br>Oral Surgery: minor and major<br>Anesthesia: general and IV sedation<br>Repairs: bridges, crowns and inlays<br>Repairs: dentures<br>Denture Relines, Rebases and Adjustments | 80%<br>After Deductible | 20%<br>After Deductible |
| ***Class III: Major Restorative***<br>Inlays and Onlays<br>Prosthesis Over Implant<br>Crowns: prefabricated stainless steel / resin<br>Crowns: permanent cast and porcelain<br>Bridges and Dentures | 60%<br>After Deductible | 40%<br>After Deductible |
| ***Class IV: Orthodontia***<br>Coverage for Employee and All Dependents<br>Lifetime Benefits Maximum: $1,000 | 60%<br>After Deductible | 40%<br>After Deductible |

| ***Benefit Plan Provisions:*** | |
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| ***Reimbursement Level*** | Cigna Dental will reimburse according to the Maximum Reimbursable Charge. For this plan, the MRC is calculated at the 80th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees. |
| ***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 $200 is proposed. |
| ***Alternate Benefit Provision*** | When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. |

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| ***Oral Health Integration Program®*** | The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum.<br>For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24. |
| ***Timely Filing*** | Claims submitted to Cigna after 365 days from date of service will be denied. |
| ***Benefit Limitations:*** | |
| 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 12 months; thereafter, considered a Class III expense. |
| Oral Evaluations/Exams | 2 per calendar year. |
| X-rays (routine) | Bitewings: 2 sets per calendar 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 calendar year, including periodontal maintenance procedures following active therapy. |
| Fluoride Application | 1 per calendar 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. |
| Tooth-colored (Composite) Fillings | Covered on anterior (non-molar) teeth only. |
| 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. |
| 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. |

***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: 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;
- 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 of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- 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 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.

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.

A copy of the NH Dental Outline of Coverage is available and can be downloaded at Health Insurance & Medical Forms for Customers | Cigna under Dental Forms.

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