Cigna Dental Benefit Summary
City of Medford – Base Plan
Plan Renewal Date: 07/01/2022

Administered 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.

Receiving regular dental care can not only catch minor problems before they become major and expensive to treat - it may even help improve your overall health. Gum disease is increasingly being linked to complications for pre-term birth, heart disease, stroke, diabetes, osteoporosis and other health issues. That's why this dental plan includes **Cigna Dental WellnessPlus**[SM] features. When you or your family members receive any preventive care service in one plan year, the annual dollar maximum will increase in the following plan year. When you or your family members remain enrolled in the plan and continue to receive preventive care, the annual dollar maximum will increase in the following plan year, until it reaches the level specified below. Please refer to your plan materials for additional information on this plan feature. **Your plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental PPO				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Out-of-Network:*** **Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Based on Billed Charge	
WellnessPlus [SM] ***Progressive Maximum Benefit:*** When you or your family members receive any preventive care service during one plan year, the annual dollar maximum will increase in the following plan year, until it reaches the highest level specified below. Please refer to your plan materials for additional information on this plan feature.				
Policy Year Benefits Maximum Applies to: Class I, II, III & IX expenses	Year 1: $750 Year 2: $850 Year 3: $950 Year 4 & Beyond: $1,050		Year 1: $750 Year 2: $850 Year 3: $950 Year 4 & Beyond: $1,050	
Policy Year Deductible Individual Family	$25 $75		$25 $75	
Benefit Highlights	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments Emergency Care to Relieve Pain Crowns: prefabricated stainless steel / resin	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: permanent cast and porcelain Bridges and Dentures	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 19 and to age 23 for Full time student Lifetime Benefits Maximum: $1,000	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible
Class IX: Implants	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible

Benefit Plan Provisions:	
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 Billed Charge.
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.
Policy 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.
Policy 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.
Late Entrant Limitation Provision	No coverage until group's next open enrollment period.
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 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	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. 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	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Oral Evaluations/Exams	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 routine and 4 periodontal maintenance procedures following active therapy (minus the number of routine cleanings) per policy year.
Fluoride Application	2 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 19.
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.

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;
- 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 Billed 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

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

Cigna Dental Enrollment Form

Employer: Complete Section A
Employee: Complete Sections B, C, D & E

Insured and/or Administered by
Cigna Health and Life Insurance Company

Cigna.

NHF - 11

Please print and thank you for providing this information

A

☐ OPEN ENROLL. ☐ CHANGE ☐ NEW ENROLL. ☐ REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME: City of Medford	EMPLOYER ADDRESS: 85 George P. Hassett Drive, Medford, MA 02155
CIGNA ACCOUNT NO.: 3342720	DATE OF HIRE (MM/DD/CCYY)	BRANCH CODE	DENTAL BENEFIT OPTION: ☐ DPPO High ☐ DPPO Base

B

TYPE OF CHANGE:
☐ New Enrollment* Date: _____ ☐ Address Change
☐ Add Dependent(s) * Date: _____
☐ Cancel Employee Last Date of Coverage: _____
☐ Cancel Dependent(s) * Last Date of Coverage: _____
Reason for Cancellation: ☐ Leave employment

* List Names in Section D

C

EMPLOYEE NAME (Last) (First) (M.I.)			SOCIAL SECURITY NO.
EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE ( )	WORK PHONE ( )	HOME E-MAIL ADDRESS / EMPLOYEE IDENTIFICATION NUMBER
ADDRESS (Street)	(City)	(State)	(Zip Code)

SELECT PLAN:
☐ Cigna Dental PPO High ☐ Cigna Dental PPO Base ☐ Decline Coverage

D

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. (Specify last name if different from yours) Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	(check one)
Employee			☐ M ☐ F	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	☐ Add ☐ Cancel
Dependent — Relationship			☐ M ☐ F	☐ Add ☐ Cancel
Dependent — Relationship			☐ M ☐ F	☐ Add ☐ Cancel
Dependent — Relationship			☐ M ☐ F	☐ Add ☐ Cancel

Proof of student or handicapped status for overage dependents may be required.
The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

E

SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE'S SIGNATURE / DATE

NOTE: Not all products are available for all clients or all states. Check your enrollment materials carefully to see what is offered for your group.