

Vanderbilt University

CIGNA Dental PPO Plan Benefit Summary Effective July 1, 2009

This is a summary of benefits for your CIGNA PPO plan. All deductibles, plan maximums and service specific maximums (dollar and occurrences) cross-accumulate between in and out of network.

Coordination of Benefits provision is Coordination of Benefits with Benefit Credit.

Benefits	CIGNA Dental PPO	
	In-Network	Out-of-Network
Calendar year maximum (Classes I, II and III expenses)	\$1,500	\$1,500
Calendar year deductible		
Per Individual	\$50 per person	\$50 per person
Per Family	No Limit	No Limit
Class I – Preventive and Diagnostic Services	100%, no deductible	100%, no deductible
Oral exams Cleanings Bitewing X-rays Fluoride Application Sealants Space maintainers (non-orthodontic treatment)		
Class II – Basic Restorative Care	80% after deductible	80% after deductible
Full Mouth X-rays Panoramic (Panorex) X-rays Emergency Care to Relieve Pain Fillings Oral Surgery – simple extractions		



Benefits	CIGNA Dental PPO	
	In-Network	Out-of-Network
Class III Expenses – Major Restorative Care	50% after deductible	50% after deductible
Oral Surgery – all except simple extractions Surgical Extraction of Impacted Teeth Anesthetics Major Periodontics Minor Periodontics Root Canal/Therapy Relines, Rebases and Adjustments Repairs – Bridges, Crowns and Inlays Repairs – Dentures Crowns Dentures Bridges Histopathologic exams Prosthesis over implants		
Class VI – Orthodontia	12 month waiting period	
Coverage for Dependent children less than 19 years of age	50% after deductible (no separate deductible)	50% after deductible (no separate deductible)
Lifetime Maximum	\$1,000	\$1,000
Missing Tooth Provision	Teeth missing prior to coverage under the CIGNA Dental plan are not covered	
Pretreatment Review	Available on a voluntary basis when extensive work in excess of \$500 is proposed	
Out of Network Reimbursement	90 th Percentile	
Dependent End Age		
Dependent Child	25 years	
Dependent Student	25 years	
Benefits for a Dependent child or student will continue until the last day of the birth month in which the limiting age is reached		



CIGNA Dental Preferred Provider Exclusions and Limitations

Covered expenses will not include, and no payment will be made for, expenses incurred for:

Procedure	Exclusions & Limitations
Late Entrants Limit	No coverage until your group's next open enrollment period
Clinical Oral Exams	2 per person per calendar year
Fluoride Treatments	Topical Application of fluoride (excluding prophylaxis): Limited to persons less than 19 years old. Only 1 per person per calendar year
Histopathologic Exams	Payable if the biopsy is covered. No coverage for other diagnostic tests
X-rays (routine)	Bitewings: Only 2 charges per person per calendar year
X-rays (non-routine)	Complete Series - Only 1 per person, including panoramic film, in any 3 calendar years
Periapical x-rays:	4 in 12 consecutive months if not performed in conjunction with an operative procedure
Intraoral occlusal x-rays	2 in 12 consecutive months
Models	Not covered
Fillings	1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only)
Sealants	Per tooth, on a posterior tooth for a person less than 14 years old – Only one treatment per tooth in any 3 calendar years
Minor Perio (non-surgical)	Root planing - 1 per quadrant per 36 consecutive months
Perio Surgery	1 per 36 consecutive months per area of the mouth (same service)
Crowns and Inlays	Replacement limited to 1 per 5 years. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. Replacement must be indicated by major decay
Bridges	Replacement limited to 1 per 84 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
Dentures and Partial	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired
Relines, Rebases	Covered if more than 12 months after installation; 1 per 36 consecutive months
Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months
Repairs – Bridges	Covered if more than 12 months after installation
Repairs – Dentures	Covered if more than 12 months after installation
Endodontics	Root canal re-treatment 1 per 24 consecutive months, if necessity demonstrated
Prosthesis Over Implant	1 per 84 consecutive months is 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:

- Services performed primarily for cosmetic reasons; replacement of a lost or stolen appliance;
- Initial placement of a full or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan; removal of only a permanent third molar will not qualify for an initial or replacement denture or bridge;
- Overdentures, personalization, precision or semi-precision attachments;
- Replacement of a bridge, denture or crown within 84 months following its initial date of insertion;
- Replacement of a bridge, denture or crown which can be made useable according to 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, the restoration of teeth which have been damaged by erosion, attrition or abrasion; bite registration; or bite analysis;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- Core buildup, labial veneers; 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;
- Bite registrations; precision or semi-precision attachments; splinting; Surgical implants of any type including any prosthetic device attached to it;
- 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;
- Procedures for which a charge would not have been made in the absence of coverage, for 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; Procedures which are not necessary and which do not have uniform professional endorsement;
- 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;
- Reasonable and Customary other than the defined percentile;
- IV sedation or general anesthesia, except when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- Fees charged for broken appointments, claim form submission or sterilization;
- Services not included in the list of covered dental expenses, unless Connecticut General agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- 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;
- Replacement of teeth beyond the normal complement of 32;
- Prescription drugs; athletic mouth guards; myofunctional therapy;
- Charges for travel time; transportation costs; or professional advice given on the phone;





- 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);
- Any procedure, service, or supply which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least three years, as determined by CG; Temporary, transitional or interim dental services; 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 (\$100.00-\$200.00) per 12 consecutive month period);
- Procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- Any charges, including ancillary charges, made by hospital, ambulatory surgical center or similar facility;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- 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;
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- No payment will be made for expenses incurred by you or any one of your Dependents 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.

Benefits are insured and/or administered by Connecticut General Life Insurance Company.