

Cigna Dental Benefit Summary

Mount Sinai Health System – Basic Plan

Plan Renewal Date: 01/01/2021



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.

Benefit Plan Features	Total Cigna DPPO Network		Non-Network
Network Options	Mount Sinai Network	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: Class I, II, III & VIII expenses	\$1,500	\$1,500	\$1,500
Calendar Year Deductible			
Individual	\$75	\$100	\$100
Family	\$225	\$300	\$300
Benefit Highlights	Plan Pays	Plan Pays	Plan Pays
Class I: Diagnostic & Preventive	100%	80%	80%
Oral Evaluations	No Deductible	No Deductible	No Deductible
Prophylaxis: routine cleanings			
X-rays: routine			
X-rays: non-routine			
Fluoride Application			
Sealants: per tooth			
Space Maintainers: non-orthodontic			
Emergency Care to Relieve Pain			
Class II: Basic Restorative	80%	60%	60%
Restorative: fillings	After Deductible	After Deductible	After Deductible
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			
Class III: Major Restorative	60%	50%	50%
Inlays and Onlays	After Deductible	After Deductible	After Deductible
Prosthesis Over Implant			
Crowns: prefabricated stainless steel / resin			
Crowns: permanent cast and porcelain			
Bridges and Dentures			
Class IV: Orthodontia	50%	Not covered	Not covered
Coverage for Employee and All Dependents	No Deductible		
Lifetime Benefits Maximum: \$1,500			
Class V: TMJ	60%	50%	50%
Occlusal orthotic device & adjustment	After Deductible	After Deductible	After Deductible
Lifetime Benefits Maximum: Unlimited			
Class VIII: Brush Biopsy	100%	80%	80%
	No Deductible	No Deductible	No 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 Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.		
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.		
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 extensive dental work in \$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 (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program. Those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical 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: Benefit frequency limitations are based on date of service.	
Missing Tooth Limitation	Teeth missing prior to coverage effective date are not covered until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations	2 per calendar year
X-rays (routine)	Bitewings: 2 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
Inlays, Crowns, Bridges, Dentures and Partial	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;	
Prosthodontics: 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; 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 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.

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