

# NY State Fraternal Order of Police

CIGNA Dental PPO Benefit Summary Effective 07/01/2007



CIGNA Dental

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

Benefits	CIGNA Dental PPO	
	In-Network	Out-of-Network
<b>Calendar Year Maximum</b>		
(Class I, II, and III Expenses)	\$1,000	\$1,000
<b>Calendar Year Deductible</b>		
Per Individual	\$50	\$50
Per Family	\$150	\$150
<b>Class I Expenses - Preventive &amp; Diagnostic Care</b>		
Oral Exams Cleanings Bitewing X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment)	100%, No Deductible	100%, No Deductible
<b>Class II Expenses - Basic Restorative Care</b>		
Full Mouth X-rays Panoramic X-Rays Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions	80%, After Deductible	80%, After Deductible
<b>Class III Expenses - Major Restorative Care</b>		
Oral Surgery - All Except Simple Extraction 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	50%, After Deductible	50%, After Deductible
<b>Class IV Expenses - Orthodontia</b>		
	Not Covered	Not Covered
<b>Missing Tooth Provision</b>	No Limitation (teeth missing prior to the effective date of coverage are covered)	
<b>Pretreatment Review</b>	Available on a voluntary basis when extensive work in excess of \$500 is proposed.	
<b>Out-of-Network Reimbursement</b>	60th Percentile	
<b>Student Age</b>	23	

## **CIGNA Dental EPO / PPO / Indemnity Exclusions and Limitations**

<b>Procedure</b>	<b>Exclusions &amp; Limitations</b>
Late Entrants Limit	No coverage except for Class I (as defined in these plans) for 12 months.
Exams	1 per 6-month consecutive period.
Prophylaxis (Cleanings)	1 routine prophylaxis or perio maintenance procedure per 6-month consecutive period (routine prophylaxis is Class I; perio prophylaxis is Class II).
Fluoride Treatments	1 per consecutive 12 months for participants younger than age 14.
Histopathologic Exams	Payable if the biopsy is covered. No coverage for other diagnostic tests.
X-rays (routine)	Bitewings: 1 set in any consecutive 12 month period. Limited to a maximum of 4 films per set.
X-rays (non-routine)	Full mouth or Panorex: 1 per 60 consecutive months.
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	1 treatment per tooth per lifetime. Payable on unrestored permanent bicuspid or molar teeth only.
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 84 consecutive months. 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.
Alternate Benefits	When more than one covered Dental Service could provide suitable treatment based on common dental standards, CG will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.

### **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 implant of any type;
- \* 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;
- \* Charges in excess of the reasonable and customary allowances;
- \* 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;
- \* 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. Connecticut General Life Insurance Company will take into account any adjustment option chosen under such part by you or any one of your Dependents.
- \* Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;