

**Cigna Dental Benefit Summary**  
**UT Graduate Medical Education Program - DPPO**  
**Plan Renewal Date: 07/01/2022**



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.

**Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

| <b>Cigna Dental PPO</b>  |  |                         |  |                         |
|--|--|-------------------------|--|-------------------------|
| <b>Network Options</b>   | <b>In-Network:<br/>Total Cigna DPPO Network</b>  |                         | <b>Out-of-Network:<br/>Non-Network</b> |                         |
| <b>Reimbursement Levels</b>  | Based on Contracted Fees   |                         | Maximum Allowable Charge               |                         |
| <b>Policy Year Benefits Maximum</b><br>Applies to: Class II and III expenses   | \$1,000  |                         | \$1,000                                |                         |
| <b>Policy Year Deductible</b><br>Individual<br>Family  | \$50<br>\$150  |                         | \$50<br>\$150                          |                         |
| <b>Benefit Highlights</b>  | <b>Plan Pays</b>   | <b>You Pay</b>          | <b>Plan Pays</b>                       | <b>You Pay</b>          |
| <b>Class I: Diagnostic &amp; Preventive</b><br>Oral Evaluations<br>Prophylaxis: routine cleanings<br>X-rays: bitewing<br>X-rays: full mouth<br>X-rays: panoramic<br>X-rays: periapical<br>Fluoride Application<br>Sealants: per tooth<br>Space Maintainers: non-orthodontic  | 100%<br>No Deductible  | No Charge               | 100%<br>No Deductible                  | No Charge               |
| <b>Class II: Basic Restorative</b><br>Emergency Care to Relieve Pain<br>Restoration: fillings<br>Oral Surgery: simple extractions  | 80%<br>After Deductible  | 20%<br>After Deductible | 80%<br>After Deductible                | 20%<br>After Deductible |
| <b>Class III Benefit Waiting Period applies for 12 months.</b>   |  |                         |  |                         |
| <b>Class III: Major Restorative</b><br>Periodontal Maintenance<br>Anesthesia: general and IV sedation<br>Endodontics: root canal therapy<br>Periodontics: scaling & root planing<br>Periodontics: osseous surgery<br>Oral Surgery: oral surgical procedures<br>Oral Surgery: extractions of impacted teeth<br>Repairs: bridges, crowns and inlays<br>Repairs: dentures<br>Denture Relines, Rebases and Adjustments<br>Inlays and Onlays<br>Stainless Steel and Resin Crowns<br>Crowns, Bridges and Dentures<br>Prosthesis Over Implant | 50%<br>After Deductible  | 50%<br>After Deductible | 50%<br>After Deductible                | 50%<br>After Deductible |
| <b>Benefit Plan Provisions:</b>  |  |                         |  |                         |
| <b>In-Network Reimbursement</b>  | For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.   |                         |  |                         |
| <b>Non-Network Reimbursement</b>   | For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Allowable Charge. The dentist may balance bill up to their usual fees.  |                         |  |                         |
| <b>Cross Accumulation</b>  | 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. |                         |  |                         |

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| <b>Policy Year Benefits Maximum</b>  | The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.  |
| <b>Policy Year Deductible</b>  | This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.  |
| <b>Benefit Waiting Period</b>  | No benefits will be paid for charges that are incurred during any applicable Benefit Waiting Period.  |
| <b>Late Entrant Limitation Provision</b>   | No coverage until the next open enrollment period. This provision does not apply to new hires.  |
| <b>Pretreatment Review</b>   | Pretreatment review is available on a voluntary basis when dental work in excess of \$500 is proposed.  |
| <b>Alternate Benefit Provision</b>   | 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.   |
| <b>Oral Health Integration Program*</b>  | 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 <a href="http://www.mycigna.com">www.mycigna.com</a> or call customer service 24/7 at 1-800-Cigna24. |
| <b>Timely Filing</b>   | Out of network claims submitted to Cigna after 365 days from date of service will be denied.  |
| <b>Benefit Limitations:</b>  |   |
| 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 24 months; thereafter, considered a Class III expense.  |
| Oral Evaluations/Exams   | 1 per 6 consecutive months.   |
| X-rays: bitewing   | 1 set per 12 consecutive months, limited to 4 films per set.  |
| X-rays: full mouth or panoramic  | 1 per 60 consecutive months.  |
| X-rays: periapical   | 4 per 12 consecutive months if not in conjunction with an operative procedure.  |
| X-rays: intraoral occlusal   | 2 per 12 consecutive months.  |
| Cleaning: routine  | 1 prophylaxis (Class I) or periodontal maintenance (Class III) per 6 consecutive months.  |
| Fluoride Application   | 1 per 12 consecutive months for children under age 14.  |
| Sealants: per tooth  | 1 treatment per lifetime for children under age 14; payable on unrestored permanent bicuspid or molar teeth only.   |
| Space Maintainers  | Limited to non-orthodontic treatment for children under age 14.   |
| Restoration: fillings  | 1 per 12 consecutive months; applies to replacement of identical surface fillings only, no composite, white/tooth colored fillings on bicuspid or molar teeth.  |
| Inlays and Crowns  | 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. For people under age 16, benefits for crowns and inlays are limited to resin or stainless steel.   |
| Stainless Steel and Resin Crowns   | 1 per 36 consecutive months for children under age 16.  |
| Endodontic Treatment   | Root canal retreatment 1 per 24 consecutive months, based on necessity.   |
| Periodontal Scaling and Root Planning  | 1 per quadrant per 36 consecutive months.   |
| Dentures and Partials  | Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired.  |
| Denture Adjustments  | Covered if more than 12 consecutive months after installation; 1 per 12 consecutive months.   |
| Denture Repairs  | Covered if more than 12 consecutive months after installation.  |
| Denture Rebases and Relines  | Covered if more than 12 consecutive months after installation; 1 per 36 consecutive months.   |
| Prosthesis Over Implant  | 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.   |
| 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.   |
| <b>Benefit Exclusions:</b>   |   |
| Covered Expenses will not include, and no payment will be made for the following:  |   |
| <ul style="list-style-type: none"> <li>• Procedures and services not included in the list of covered dental expenses;</li> <li>• Diagnostic: cone beam imaging;</li> <li>• Preventive Services: instruction for plaque control, oral hygiene and diet;</li> <li>• Restorative: core buildup; veneers; precious or semi-precious metals for crowns, bridges and abutments; restoration of teeth which have been damaged by erosion, attrition or abrasion;</li> </ul> |   |

- Periodontics: bite registrations; splinting;
- Prosthodontics: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Orthodontics: orthodontic treatment;
- Anesthesia: general anesthesia or intravenous sedation, when used for the purposes of anxiety control or patient management is not covered; may be considered only when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- Procedures, appliances or restorations, 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 Allowable 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.