



CIGNA Dental

# What

# you'll save.

## Your Fee Overview *For Employees of Miami Dade College*

*This Fee Overview highlights some of the benefits available under your plan. A complete description regarding the terms of coverage, exclusions and limitations, including benefits will be provided in your insurance certificate or plan description. In case of discrepancy between this Fee Overview and your plan documents, the plan documents will prevail.*

### Compare for yourself.

## Porcelain Crown

National Average Dentist's Fee	\$ 777.00
CIGNA Dental Care Patient Charge	\$ 335.00
<b>Savings</b>	<b>\$ 442.00</b>

F1-04  
Cat # BSD06567

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental Care plan is provided by CIGNA Dental Health Plan of Arizona, Inc.; CIGNA Dental Health of California, Inc.; CIGNA Dental Health of Colorado, Inc.; CIGNA Dental Health of Delaware, Inc.; CIGNA Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes; CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska); CIGNA Dental Health of Kentucky, Inc.; CIGNA Dental Health of Maryland, Inc.; CIGNA Dental Health of New Jersey, Inc.; CIGNA Dental Health of New Mexico, Inc., (available only in Albuquerque and Santa Fe); CIGNA Dental Health of North Carolina, Inc.; CIGNA Dental Health of Ohio, Inc.; CIGNA Dental Health of Pennsylvania, Inc.; CIGNA Dental Health of Texas, Inc., CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company and administered by CIGNA Dental Health, Inc. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries. The CIGNA Traditional plan is underwritten or administered by Connecticut General Life Insurance Company.

## See, we weren't kidding when we said savings:

	<i>What You'll Pay</i>			
	<i>National Average Dentist's Fees</i>	<i>CIGNA Dental Care F1-04 Patient Charges</i>	<i>CIGNA Dental PPO Average In-Network Patient Charges</i>	<i>CIGNA Dental PPO Average Out-of-Network Patient Charges</i>
<b>Typical Adult Annual Cost</b>				
Two Periodic Exams	\$ 54.00	\$ 0.00	\$ 7.60	\$ 10.80
Four Bitewing X-rays	48.00	0.00	7.20	9.60
Two Quadrants of Periodontal Scaling and Root Planing	296.00	110.00	41.40	59.20
Two Routine Cleanings	116.00	0.00	16.20	23.20
One Resin/composite 1-surface Filling (Anterior)	91.00	0.00	12.80	18.20
Anterior Root Canal	465.00	0.00	65.00	93.00
Porcelain Crown	777.00	335.00	271.00	388.50
<b>Subtotal</b>	<b>1,847.00</b>	<b>445.00</b>	<b>421.20</b>	<b>602.50</b>
<b>Add'l Patient Charges Above Annual Maximum</b>	<b>None</b>	<b>None</b>	<b>0.00</b>	<b>194.50</b>
<b>Typical Child Annual Cost</b>				
Two Periodic Exams	\$ 54.00	\$ 0.00	\$ 7.60	\$ 10.80
Two Bitewing X-rays	24.00	0.00	3.60	4.80
Two Routine Cleanings	82.00	0.00	11.40	16.40
Two Fluoride Treatments	44.00	0.00	6.20	8.80
Single Extraction	83.00	0.00	11.60	16.60
Orthodontic Evaluation	68.00	40.00	24.00	34.00
Orthodontic Treatment Plan and Records	194.00	150.00	68.00	97.00
Banding for Comprehensive Orthodontic Treatment	816.00	300.00	285.00	408.00
12 Months Comprehensive Orthodontic Treatment- Child*	1,532.50	800.00	535.00	766.25
<b>Subtotal</b>	<b>2,897.50</b>	<b>1,290.00</b>	<b>952.40</b>	<b>1,362.65</b>
<b>Add'l Patient Charges Above Ortho Maximum</b>	<b>None</b>	<b>None</b>	<b>0.00</b>	<b>0.00</b>
<b>Deductible for two people</b>	<b>None</b>	<b>None</b>	<b>100.00</b>	<b>100.00</b>
<b>Grand Total</b>	<b>\$ 4,744.50</b>	<b>\$ 1,735.00</b>	<b>\$ 1,473.60</b>	<b>\$ 2,259.65</b>

**Total Savings with CIGNA Dental Care: \$ 3,009.50**

\* Orthodontic treatment is limited to a lifetime maximum benefit of 24 months. Additional charges apply for retention and/or interceptive orthodontic treatment. For orthodontic treatment started before you enrolled in the CIGNA Dental Care plan, please call Member Services to determine if benefits apply.

The fees listed in the National Average Dentist's Fee column are determined by Connecticut General Life Insurance Company claims analysis.

The fees listed in the CIGNA Dental Care Patient Charge column are what you'll pay for covered services when you visit a network dentist.

The fees listed in the CIGNA Dental PPO In-Network Patient Charge column are estimated based on national average CIGNA Dental PPO contracted fees.

The fees listed in the CIGNA Dental PPO Out-of-Network Patient Charge column are estimated based on national average dentist's fees.

## Summary of Benefits

### CIGNA Dental Care

### CIGNA Dental PPO

Benefits		In-Network		Out-of-Network	
		You Pay	Plan Pays	You Pay	Plan Pays
<b>Calendar Year Maximum</b> (Class I, II and III expenses)	No dollar maximum		\$1,000		\$1,000
<b>Annual Deductible</b> Individual Family	None None		\$50 per person \$150 per family		\$50 per person \$150 per family
<b>Reimbursement Levels</b>			Based on Reduced Contracted Fees		Based on Reasonable & Customary Allowances
<b>Class I - Preventive &amp; Diagnostic Care</b> Oral Exams (Two per year) Routine Cleanings (Two per year) Full Mouth X-rays (One complete set every three years) Bitewing X-rays (Two per year) Panoramic X-ray (One every three years) Fluoride Application (One per year for persons under 19) Sealants (Limited to posterior teeth for a person less than 14; one treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to Relieve Pain	Reduced, fixed, pre-set charges for all covered services. See the last two pages for specific charges.		80%	20%	80%* 20%*
<b>Class II - Basic Restorative Care</b> Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	Reduced, fixed, pre-set charges for all covered services. See the last two pages for specifics. Certain limitations apply.		80%*	20%*	80%* 20%*
<b>Class III - Major Restorative Care</b> Crowns Dentures Bridges	Reduced, fixed, pre-set charges for all covered services. See the last two pages for specifics. Certain limitations apply.		50%*	50%*	50%* 50%*
<b>Class IV - Orthodontia</b>  Lifetime Maximum	Reduced, fixed, pre-set charges for all covered services. See the last two pages for specifics. Certain limitations apply. Lifetime maximum of 24 months of interceptive/comprehensive treatment Available for children and adults.		50%* \$1,500	50%*	50%* \$1,500

Pretreatment review is suggested when dental work in excess of \$200 is proposed.

All plan deductibles and maximums (dollar and occurrence) cross-accumulate between In-Network and Out-of-Network unless otherwise noted.

\* Subject to annual deductible

## ***CIGNA Dental PPO***

### ***Exclusions***

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

- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second or third molars;
- Bite registrations; precision or semi-precision attachments; or splinting;
- A surgical implant 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;
- Services for which benefits are not payable according to the “General Limitations” section.

In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

### ***General Limitations***

No payment will be made for expenses incurred for you or any one of your Dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers’ compensation or similar law;
- For charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military service connected condition;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- To the extent that they are more than either the applicable Contracted Fee, applicable Reasonable or Customary Charges or applicable Scheduled Amount;
- 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; or
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

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. Connecticut General Life Insurance Company will take into account any adjustment option chosen under such part by you or any one of your Dependents.

## ***CIGNA Dental Care Exclusions and Limitations***

### **Limitations on Covered Services:**

Listed below are limitations on services covered by the Dental Plan:

- A. **Frequency** – The frequency of certain covered services, such as cleanings, is limited. The Patient Charge Schedule lists any limitations on frequency.
- B. **Specialty Care** – Payment authorization is required for coverage of services by a Network Specialist.
- C. **Pediatric Dentistry** – Coverage for referral to a Pediatric Dentist ends on an enrolled child's 7<sup>th</sup> birthday; however, exceptions for medical reasons may be considered on an individual basis. The Network General Dentist shall provide care after the child's 7<sup>th</sup> birthday.
- D. **Oral Surgery** – The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

### **Exclusions**

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- a) Services not listed on the Patient Charge Schedule.
- b) Services provided by a non-Network Dentist except as described in your plan document or as otherwise required by law.
- c) Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- d) Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- e) Services relating to injuries which are intentionally self-inflicted. (Ohio and Texas residents: Services relating to injuries which are intentionally self-inflicted are not excluded.)
- f) Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- g) Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
- h) General anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.)
- i) Prescription drugs.
- j) Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) diagnose or treat abnormal conditions of the temporomandibular joint ("TMJ"), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or (3) restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- k) The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage. ( Texas residents: Pre-existing conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule.)
- l) Replacement of fixed and/or removable prosthodontic or orthodontic appliances that have been lost; stolen; or damaged due to patient abuse, misuse or neglect.
- m) Services associated with the placement or prosthodontic restoration of a dental implant.
- n) Services considered to be unnecessary or experimental in nature. (Maryland residents: This exclusion should read "Services considered to be unnecessary." Pennsylvania residents: This exclusion should read "Services considered experimental in nature.")
- o) Procedures or appliances for minor tooth guidance or to control harmful habits.
- p) Hospitalization, including any associated incremental charges for dental services performed in a hospital.
- q) Services to the extent you, or your Dependent, are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy. (Arizona and Pennsylvania residents: Services compensated under group medical plan, no fault auto insurance policies or insured motorists policies are not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or insured motorists policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)
- r) Crowns and bridges used solely for splinting.
- s) Resin bonded retainers and associated pontics.

Except as set forth above, preexisting conditions are not excluded.

	<i>CIGNA Dental Care Patient Charges</i>	<i>National Average Dentists' Fees</i>
<b>Diagnostic/Preventive</b>		
Periodic Oral Evaluation	\$ 0	27
Limited Oral Evaluation - Problem Focused	0	45
Comprehensive Oral Evaluation	0	43
Re-evaluation – Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	0	45
X-Rays Intraoral – Complete Series (including bitewings)*	0	85
X-Rays Intraoral – Periapical First Film	0	16
X-Rays Intraoral – Periapical Each Additional Film	0	12
X-Rays (Bitewing) - Single Film	0	16
X-Rays (Bitewing) - Two Films	0	24
X-Rays (Bitewing) - Four Films	0	38
X-Rays (Panoramic)*	0	68
Prophylaxis – Adult**	0	58
Prophylaxis – Child**	0	41
Topical Application of Fluoride - (prophylaxis not included) – Child (up to 19 <sup>th</sup> birthday)**	0	22
Oral Hygiene Instructions	0	36
Sealant - Per Tooth***	0	34
<b>Restorative (Fillings)</b>		
Amalgam - One Surface, Primary	\$ 0	64
Amalgam - Two Surfaces, Primary	0	81
Amalgam - One Surface, Permanent	0	71
Amalgam - Two Surfaces, Permanent	0	90
Amalgam - Three Surfaces, Permanent	0	110
Amalgam - Four or More Surfaces, Permanent	0	131
Resin-Based Composite - One Surface, Anterior	0	91
Resin-Based Composite - Two Surfaces, Anterior	0	112
Resin-Based Composite - Three Surfaces, Anterior	0	139
Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	75	165
Resin-Based Composite - One Surface, Posterior – Primary	30	84
Resin-Based Composite - Two Surfaces, Posterior – Permanent	40	134
Resin-Based Composite - Three Surfaces, Posterior – Permanent	55	168
<b>Crown &amp; Bridge (Including Temporaries)</b>		
<i>All charges for crown and bridge are per unit (each replacement or supporting tooth equals one unit) - Replacement limit 1 every 5 years.</i>		
Crown - Porcelain/Ceramic Substrate	\$ 335	777
Crown - Porcelain Fused to High Noble Metal	325	741
Crown - Porcelain Fused to Predominantly Base Metal	255	637
Crown - Porcelain Fused to Noble Metal	315	687
Crown - Full Cast Noble Metal	315	642
Recement Crown	0	59
Sedative Filling	0	63
Core Buildup, Including Any Pins	85	156
Prefabricated Post and Core In Addition to Crown	85	210
<b>Endodontics (Root Canal Treatment, Excluding Final Restorations)</b>		
Pulp Cap - Direct (Excluding Final Restoration)	\$ 0	51
Pulp Cap - Indirect (Excluding Final Restoration)	0	42
Therapeutic Pulpotomy (Excluding Final Restoration)	0	105
Anterior Root Canal (Excluding Final Restoration)•	0	465
Bicuspid Root Canal (Excluding Final Restoration)•	0	547
Molar Root Canal (Excluding Final Restoration) •	200	704
<b>Periodontics (Treatment of Supporting Tissues[Gum &amp; Bone] of the Teeth)</b>		
Periodontal Evaluation and Treatment Plan	\$ 35	68
Periodontal Scaling and Root Planing, (Per Quadrant) ●●●	55	148
Periodontal Scaling and Root Planing (Per Quadrant) (1 tooth) ●●●	20	59
Periodontal Scaling and Root Planing (Per Quadrant) (2-4 teeth) ●●●	35	88
Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis●●	55	135
Periodontal Maintenance Procedure (Following Active Therapy) ●●●●	40	91

	<i>CIGNA Dental Care Patient Charges</i>	<i>National Average Dentists' Fees</i>
<b>Prosthetics (Removable Tooth Replacement – Dentures)</b>		
<i>Includes up to 4 adjustments within first 6 months after insertion. Replacement limit 1 every 5 years.</i>		
Complete Denture – Maxillary	\$ 300	805
Complete Denture – Mandibular	300	775
Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	340	970
Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	340	960
<b>Repairs to Prosthetics</b>		
Add Tooth to Existing Partial Denture	\$ 40	102
<b>Oral Surgery (Includes Routine Post-Operative Treatment)</b>		
Extraction (Single Tooth)	0	83
Extraction (Each Additional Tooth)	0	77
Surgical Extraction Erupted Tooth	0	159
<i>Surgical removal of impacted tooth-(Not covered unless pathology [disease] exists). Surgical removal of wisdom tooth/3<sup>rd</sup> molar for orthodontic reasons <u>only</u> is not covered.</i>		
<b>Orthodontics (Tooth Movement)</b>		
Orthodontic Evaluation	\$ 40	68
Orthodontic Treatment Plan and Records	150	194
Removable and/or Fixed Appliance(s) Insertion for Interceptive Treatment	275	475
Fixed Appliance Insertion (Banding) for Comprehensive Treatment	300	816
<b>Orthodontic Treatment (Maximum lifetime benefit of 24 months of interceptive and/or comprehensive treatment) – can include:</b>		
Interceptive Orthodontic Treatment		
Class I, II, III Malocclusion – Comprehensive Treatment – Combination of Primary and Permanent Teeth		
Class I, II, III Malocclusion – Comprehensive Treatment – Permanent Teeth	1,600	3,065
Children (Up to 19 <sup>th</sup> Birthday)	2,200	3,616
Adults		
<i>Atypical cases or cases beyond 24 months require an additional payment by the patient.</i>	300	639
Retention – Post Treatment Stabilization (Includes Appliance(s) and Treatment)		
<b>General Anesthesia/IV Sedation</b>		
<i>Covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule.</i>		
General Anesthesia – First 30 Minutes	\$ 115	230
General Anesthesia – Each Additional 15 Minutes	60	123
Intravenous Sedation/Analgesia – First 30 Minutes	115	230
Intravenous Sedation/Analgesia – Each Additional 15 Minutes	60	123
<b>Emergency Services</b>		
Emergency Exam and Visit – Pain Relief Treatment During Regularly Scheduled Office Hours	\$ 0	65
Office Visit – After Regularly Scheduled Hours	55	83
<b>Broken Appointment</b>		
The following Broken Appointment Section does not apply for Texas residents.		
<i>This fee will <u>not</u> be charged if patient is unable to provide 24-hours' notice through no fault of his or her own.</i>		
Broken Appointment – Less Than 24-hours' Notice (Per 15-Minute Appointment)	\$ 10	N/A
Maximum Fee For Broken Appointment:		
Sealant	10	N/A
Prophylaxis	20	N/A
Any Other Appointment	40	N/A
<i>Exclusions and limitations may apply. Consult your group agreement for details. This Fee Overview reflects the patient charges on your Patient Charge Schedule. In case of any discrepancy between this Dental Fee Overview and your Patient Charge Schedule sent to you after your enrollment, the Patient Charge Schedule will prevail.</i>		
* Limit 1 every 3 years.	• Permanent Tooth.	
** Limit 1 every 6 months .	•• Limit 1 per lifetime.	
*** Up to 14 <sup>th</sup> birthday.	••• Limit 4 quadrants per consecutive 12 months.	
	•••• Limit 2 within 12 months.	

National average charges based on Connecticut General Life Insurance Company claims analysis, prepared March, 2001. This charge may differ from your area charges or local dentist's fees.