



# CIGNA Dental PPO Benefit Summary for Airbus Americas, Inc.

All deductibles, plan maximum, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

## CIGNA Dental PPO

Benefits	In-Network		Out-of-Network	
	Plan Pays	You Pay	Plan Pays	You Pay
Calendar Year Maximum (Class I, II and III expenses)	\$2,000		\$2,000	
Annual Deductible	\$50 per person \$ 150 per family		\$50 per person \$ 150 per family	
Reimbursement Levels	Based on reduced contracted fees		Based on the 90th percentile of Reasonable & Customary allowances	
<b>Class I – Preventive and diagnostic services</b>	100%	0%	100%	0%
Oral Exams Routine Cleanings Full Mouth / Bitewing / Panoramic X-rays Fluoride Application Sealants Space Maintainers Emergency Care to Relieve Pain Major / Minor Periodontics Root Canal / Therapy Histopathologic Exams Habit Breaking Appliances for ages 1 – 14				
<b>Class II – Basic restorative services</b>	80%*	20%*	80%*	20%*
Fillings Osseous Surgery Denture Adjustments and Repairs Oral Surgery Repairs to Crowns, Inlays, Bridges Surgical Extractions of Impacted Teeth Anesthetics Simple extractions				
<b>Class III – Major restorative services</b>	50%*	50%*	50%*	50%*
Crowns Dentures Bridges Implants Prosthesis over Implants				
<b>Class IV – Orthodontia*</b> (dependent children to age 19) Lifetime maximum	50%	50%	50%	50%
		\$1,000		\$1,000
<b>Student Age</b>	23			

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.

\*Deductible applies

## Plan Exclusions and Limitations

### *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;
- 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.
- For services of supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- For charges which would not have been made if the person had no insurance
- 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.

*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.*

**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 and affiliates. 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. In Texas, the CIGNA Dental PPO product is referred to as the CIGNA Dental Choice Plan. In Arizona and Louisiana, the CIGNA Dental PPO product is referred to as the CG Dental PPO.

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## Plan Exclusions and Limitations

<i>Procedure</i>	<i>Exclusions and Limitations</i>
<b>Late Entrants</b>	50% coverage on Class III and IV for 12 or 24 month
<b>Exams</b>	Two per calendar year
<b>Prophylaxis (Cleanings)</b>	Two per calendar year
<b>Fluoride Treatments</b>	1 per calendar year for people under 19
<b>Histopathologic Exams</b>	Various limits per calendar year depending on specific test
<b>X-rays (routine)</b>	Bitewings: 2 per calendar year
<b>X-rays (non-routine)</b>	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar year.
<b>Models</b>	Payable only when in conjunction with Ortho workup and extensive Perio treatment
<b>Sealants</b>	Limited to posterior tooth. One treatment per tooth every three years
<b>Space Maintainers</b>	Limited to non-Orthodontic treatment
<b>Minor Perio (nonsurgical)</b>	various limitations depending on the service
<b>Perio Surgery</b>	various limitations depending on the service
<b>Crowns and Inlays</b>	Replacement every 5 years.
<b>Bridges</b>	Replacement every 5 years.
<b>Dentures and Partial</b>	Replacement every 5 years.
<b>Relines, Rebases</b>	Covered if more than 6months after installation
<b>Adjustments</b>	Covered if more than 6months after installation
<b>Repairs - Bridges</b>	Reviewed if more than once
<b>Repairs - Dentures</b>	Reviewed if more than once
<b>Alternate Benefits</b>	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, and 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;
- 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;

- 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;
- Procedures which are not necessary and which do not have uniform professional endorsement 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. Connecticut General Life Insurance Company will take into account any adjustment option chosen under such part by you or any one of your Dependents.

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