2021 Cigna Spotlight Event FAQ's

Dental Customer Support

(Hover over each logo to link to access website)

Cigna Customer Support: 1.800.244.6224

HEALTH NAVIGATOR

1.866.611.8005

CareCompass dental page has all the dental benefit information, including the Find-A Dentist tool, Biweekly payroll rates, plan comparisons, and Cigna dental service links.

Contents

General Dental Benefits

When does the new plan year start?
All benefit updates elected during Open Enrollment are effective July 1, 2021- June 30, 2022.

If I do not wish to change my current plan option, do I need to do anything, or will it just continue?
If you are happy with your current plan, then do nothing and it will continue for the new plan year.

Where do I find the name of the plan I am currently in?
Look at the very top of your Dental ID card. It's also listed in the timecard system under Health Care Summary.

Where do I find a list of services covered for these plans?
Dental - Care Compass (ct.gov) and click on compare plans (beneath the toothbrush). New this year there is an online decision tool to help you view common dental services (fillings, crowns, braces) coverage and costs across all four plans.

Where to I find the biweekly costs for the plans offered?
Dental - Care Compass (ct.gov) and click on Rates (beneath the toothbrush).

Where can I get a list of the dentists that participate in each plan?
Simply go to: https://stateofct.cigna.com/ and click on '**Find a Dentist.'**

What is the difference between DHMO and DPPO?
An DHMO stands for Dental Health Maintenance Organization, while PPO stands for Preferred Provider Organization. The major differences between the two plans are the cost, size of the plan network, your ability to see specialists without in-network referral, and coverage for out-of-network services.

Do the new Total Care DHMO plan and the Cigna DHMO plan use the same network?
Yes, they share the same network.

How often does a dentist change network? If my dentist were to drop out of my network, how would I know?
If your dentist were to drop off from your plan network, you would be notified in advance. This does not happen very often, but it is good to check your dentist every open enrollment using the Find a Dentist tool.

Do all the plans cover out of state visits?
The Basic and Enhanced plans will cover services across the country, it would be beneficial to stay with a network provider even when you are out of your home state. The DHMO options will require an assigned dental office for treatment, if you are outside of your home state and have a dental emergency our customer service team can assist with access to emergency palliative care.

Under what plan is dental work in foreign countries covered?
The Basic and enhanced plans will cover both in and out of network services including out of the country. With a foreign provider you would be responsible to pay the claim up front and submit to Cigna for reimbursement.

If you go to a dentist that is part of large practice, is it the individual dentist that is covered or the total practice?
Individual provider

If I am receiving treatment (i.e., a crown, braces) and change plans before it is complete, is that considered a pre-existing condition that won't be covered?
Any services completed prior to the new plan effective date would be excluded. Regarding orthodontia services, the plan would begin with a monthly contribution from the effective date moving forward. It is important to note that the patient (adult or child) will most likely experience an increased out of pocket expense since the plans have changed from the initial contract. The Orthodontist would re-do the contract and estimate the new out of pocket expense.

Return to Table of Contents

Enrollment / Eligibility / Dependents

If I do not wish to change my current plan option, do I need to do anything, or will it just continue?
You do not need to do a thing. Your current enrollment will roll into the new year unchanged.

Can I enroll in just dental without medical?
Yes. You just need to 'waive' the medical plans on the change form.

What age do children stay on Dental insurance?
Dental coverage ends at the end of the month in which the dependent turns age 19. Regardless of student status, the maximum age for dental benefits is 19 unless your charge is deemed disabled by Anthem.

Can a special needs child stay on post 19?
Yes, a COBRA Notice that will be generated for the 19-year-old dependent that will include information in the 1st page about certifying a dependent as disabled. All dependents must be certified disabled by Anthem. The dependent will need to be recertified disabled every 1 to 2 years by Anthem.

Which insurance covers pediatric dentist past 13 years old?
The Enhanced plan and Basic plan will allow pediatrics over age 13.

Which plan covers pediatric dentistry in and out of network?
Both Basic and Enhanced. Remember, Total Care DHMO and DHMO does not have out of network benefits.

Who does Employee +1 cover?
The employee plus one dependent, spouse or child.

How can I add my child to my dental plan?
Contact your agency HR/payroll department. They will send you a form to complete and return before the end of open enrollment. You have the option to add them to just dental or to dental and medical/pharmacy.

Can different family members be on different plans?
No. All dependents must be on the same dental plan as the benefit holder.

What are my options my after child turns 19? Any sort of plans that can be purchased or extensions?
The dependent will be sent a COBRA Notice after they are removed from dental coverage by the agency. An employee can enroll their dependent in COBRA coverage, the enrollment information is included in the COBRA Notice. The COBRA notice also includes information about Access Health. You can also investigate other dental insurance options or contact an outside broker for rates.

If you have dental insurance for yourself and a spouse, can you opt out for your spouse if it is not needed? Or do both have to get the insurance?
You can remove your spouse from your dental if it is no longer needed Contact your agency HR/payroll staff for the form and instructions before the end of open enrollment. You can only make changes to your dependent coverage outside of open enrollment if there is a qualifying event (i.e., loss of coverage, divorce, marriage, etc.).

What if I never had state insurance and need to get coverage sooner than July 1... Do I need to wait until July 1 to be enrolled?
To be enrolled prior to July 1st, you would have to provide proof of a qualifying event. Within 30 days of either a marriage, divorce, or loss of other coverage you should contact your agency HR/payroll office to adjust your current benefit enrollment.

Would I choose FLES or Family plan if both spouse and I work for the state, however I cover our son's dental insurance?
You would choose FLES (Family Less Employed Spouse) and enroll yourself and your son under your benefit and your spouse would carry the same plan under their own record as Employee Only.

Can my husband and myself who work for the state and have dental?
Yes, you may. While we do not allow double coverage for medical and prescription benefits, you may opt for double coverage of dental benefits.

Return to Table of Contents

Covered Services /Plan Selection

For braces, fillings, crowns, oral surgery, dentures, fixed bridges, and implant coverage:

- Go to Dental - Care Compass (ct.gov) to view plan comparison grid for specific dental services.
- Use the Cigna online decision tool to view common dental services (fillings, crowns, braces) coverage and cost across all four plans.
- For other plan coverage, contact Health Navigator (1.866.611.8005) or the Cigna support team at 1.800.318.2572

Is anesthesia included in the enhanced plan?
Anesthesia would be covered by your medical plan. If needed for oral surgery, your dentist can coordinate your medical coverage accordingly.

Is bone grafting a covered benefit?
Bone grafting will be reviewed on a case-by-case basis, typically done in conjunction with periodontal work, in that case it will be reviewable for possible coverage and other times it is with Dental Implants. The Basic plan would fully exclude implant related services, but the Enhanced plan would review. Pre- treatment estimates are suggested since approval is based on clinical review.

Which plans cover braces for both adults and children?
The Enhanced, DHMO, and Total Care DHMO each offer orthodontic benefits for both adults and covered children.

Does the dental plan cover Invisalign for adults?
Yes, Invisalign is a payable orthodontia service under the Enhanced, DHMO and Total Care DHMO plans. Invisalign will be covered under the same benefit as orthodontics if services are rendered in an office setting with a dentist overseeing the care and not via a mail order program. The plan will process and pay at the same rate of standard bracket style braces, the dentist may have an upgrade charge when moving to Invisalign. Any upgrade charges would be determined by the orthodontic office.

Do any of the plans cover appliances for clenching or grinding?
Occlusal Guards are covered on all plans.

Do any of these plans totally cover implants or partials?
The Enhanced, DHMO and Total Care DHMO each offer benefits for dentures and partials.

How much or tooth extraction and dental implants is covered by the newest DHMO plan?
Check out the new plan Dental Decision Guide tool for help viewing common services across all four dental plans.

Does the dental plan cover Invisalign for adults?
Yes, Invisalign is a payable orthodontia service under the Enhanced, DHMO and Total Care DHMO plans
tool can be found on https://stateofct.cigna.com

Are dental implants covered by any of the dental plans?
There are implant benefits available under the Enhanced, DHMO, and Total Care DHMO plans.

Is teeth whitening covered by any of the plans?
Yes, Total Care DHMO and DHMO have coverage for this benefit.

Which plan is the best for covering Endodontics, root canals?
On the Copayment DHMO plan, root canals range in cost from $200-$320, the Total Care DHMO plan covers at 15%, Enhanced and Basic cover at 80%. The Enhanced plan has a $25.00 Deductible and $3000.00 maximum while the others do not.

Are sleep apnea mouth guards covered?
No, this is medical in nature, so excluded on dental coverage. For Anthem (medical), this item requires prior authorization. Additional information would be needed to determine coverage.

My periodontist recommends 3 cleanings per year to reduce gum recession. I have followed this recommendation and gums have improved. Why won't the plan cover the 3rd cleaning if it is medically necessary.
The Basic or Enhanced plan will cover for 2 standard cleanings per calendar year along with 2 periodontal cleanings per calendar year when the patient has past periodontal history.

Return to Table of Contents

Switching Plans while in-treatment / HEP

When will the new plan year start?
The new plan year runs from July 1, 2021 – June 30, 2022.

If we change plans, but need to see a dentist prior to the effective date of July 1st are we covered under the old plan?
Yes, all services done prior to July 1, 2021, will be covered on your current dental plan.

Are dental cleanings at no cost to all HEP participant members in all our dental plans?
Yes, these are preventive care services. To fulfill your HEP requirement, you will need to get one cleaning for each plan year.

If you are enrolled in HEP, isn't there no copay now?
The effects of **HEP** on your plan are unchanged. If you are enrolled and compliant with HEP, then you have no-cost for twice per year cleanings. Most other services do have a co-insurance or co-pay depending on which plan you are enrolled in.

Total Care DHMO (*the new plan*)

What is covered in the Total Care DHMO Plan?
[Suggestion: Refer to the Covered Dental Services section of this FAQ]
The Decision Guide tool may be the best option so services you are planning for can be noted and guided benefits provided**.** The Total Care DHMO plan will cover crowns at 70% and dentures at 55%.

What is the new Total Care DHMO option?
The new Total Care DHMO plan is a coinsurance plan that utilizes the current DHMO network. There are some additional benefits, such as mouthguards and veneers available under this plan.

Total Care says coinsurance. What is coinsurance?
Co-insurance is the percentage of the cost for covered services that you are responsible for paying.

How do we know how much coinsurance we will need to pay for a dental service?
You can see these details here: cigna-total-care-dental-(dhmo)-plan.pdf

What are the benefits to switching to the new DHMO and if I switch from Basic plan? Will my current dentist still be in network?
The DHMO plans offer additional benefits including orthodontia, dentures, and bridges, to name a few. To see if your dentist participates in the DHMO network, go to: https://stateofct.cigna.com/ and click on **Find a Dentist.**

I looked up my dentist on the Cigna site and it says that they are not in the DHMO or Enhanced, just the Basic plan. Does this mean they are not going to be in either DHMO plans?
Yes, the Total Care DHMO and the Cigna DHMO plans utilize the same network.

With Total care plan is there a yearly limit on implants?
Yes. Covered at 55%. 1 implant per year.

If you are on one of the DHMO plans and need to see a specialist, does that dentist also need to be in network?
Yes. You will need a referral by your primary care dentist.

Enhanced Plan

What is covered in the Enhanced Plan?
[Suggestion: Refer to the Covered Dental Services section of this FAQ]
The Decision Guide tool may be the best option so services you are planning for can be noted and guided benefits provided**.** The Enhanced plan will cover major services such as crowns at 67% and prosthetics at 50% with a $25.00 deductible and $3000 maximum.

Is the Enhanced Plan $500 limit on Implants annual or lifetime?
Plan limit is per calendar year.

Enhanced has reimbursement of $1,500 for braces. Is this the total cost for braces?
For orthodontia, the maximum benefit is $1,500. The patient is responsible for any amount beyond that. [Refer to the Cigna online decision tool to compare costs estimates across plans for orthodontia].

When is the annual deductible charged for the Enhanced plan?
The annual deductible is $25 for an individual plan and $75 for the family plan; if the coverage is emp + 1, the maximum deductible is $50. The deductible resets on the calendar year (January 1st) and the benefit schedule also runs on calendar year (ex – 2 cleanings covered per calendar year). The deductible does NOT apply to Class 1 services (preventive and diagnostic OR periodontal maintenance). The deductible would be charged by your provider for services like fillings, crowns, orthodontia, etc.

My current dentist only accepts our Basic Plan. I am interested in Orthodontia coverage. Does this mean if I switch plans to Enhanced can I STILL see my Basic Plan only dentist with the understanding there is balance billing that could happen?
You can still see your provider that is covered under the Basic plan, but it will increase the out-of-pocket expense. It is encouraged while on the Enhanced plan to seek care with an Enhanced provider to help lower out of pocket expenses.

Cigna Dental Care DHMO Plan

Is the network more limited for the DMHO or Total DMHO?
It does matter if your dentist or orthodontist is in this network. Use the Cigna **Find A Dentist tool** [Index - Cigna Employer Site (adis-glb.com)] or call your providers to confirm which plans they cover before selecting a DHMO plan. If they are in-network, these plan options offer great value and the same great care with your in-network provider.

DHMO dental plan has the term "covered". Does this mean that is 100% covered and we do not pay anything?
No, the DHMO has a charge schedule which means that you pay a set co-pay as opposed to a percentage of billed amount. The charge schedule can be found here: **https://stateofct.cigna.com/static/stateofct-cigna-com/docs/cigna-dhmo.pdf**

Do the Total Care DHMO and the Cigna DHMO utilize the same network?
Yes. The DHMO plans are comprehensive plans utilizing the DHMO network. You and each participant dependent must assign yourselves an in-network dentist that participates in the Cigna DHMO or Total Care DHMO network.

If you are presently in the enhanced plan and that plan has started the payments for braces and you change to the new DHMO plan how will that affect the already payments made and what you are entitled to under the new plan?
Any services completed prior to the effective date would be excluded. The plan would begin with a monthly contribution from the effective date moving forward. It is important to note that the patient will most likely experience an increased out of pocket expense since the plans have changed from the initial contract. The Orthodontist would re-do the contract and estimate the new out of pocket expense.

I really like my dentist, but he is out of network for the Enhanced plan. Is it possible for this dentist to join the network?
He sure can! Advise your dentist that you wish to continue to see them and ask that they reach out to Cigna's provider services team.

Basic Plan

What is covered in the Basic Plan?
[Suggestion: Refer to the Covered Dental Services section of this FAQ]
The Decision Guide tool may be the best option so services you are planning for can be noted and guided benefits provided**.** The Basic plan excludes some major services such as bridges and dentures.

If my dentist is considered Basic but not Enhanced or DHMO, are they considered out of network for DHMO?
Yes, they would be out-of-network for DHMO.

Return to Table of Contents

Copays / Coinsurance / Deductibles

What is a set "copay"?
The copay is the fixed dollar amount that you owe directly to the dentist. Your out-of-pocket cost for any covered procedure with a copay is only that exact dollar amount.

Where can we see the "set copays"?
The current DHMO payment schedule may be found here: https://stateofct.cigna.com/static/stateofct-cigna-com/docs/cigna-dhmo.pdf

What is "coinsurance"?
The coinsurance is listed as a percentage of the total cost that you owe directly to the dentist and is calculated based on the network dentist's contracted fee schedule, which is the amount Cigna agrees to pay dentists for their services. The contracted fee schedules vary by network dentist. Your exact out-of-pocket costs are calculated by multiplying the coinsurance percentage for a given procedure by the dentist's contracted fee for that same procedure. If you'd like more information about your specific out-of-pocket costs, call us 24/7 at 1.800.Cigna24 or the phone number on your ID card.

What if you have duplicate Cigna plans with a spouse who works for different employer? How does the coordination of benefits work? Both CIGNA plans.
Typically, coordination of benefits will note that each of you are your own primary benefit. If you have children on your coverage, then either you or your spouse's birthday will determine whose benefit is primary for them.

I had a claim for orthodontic work and my insurance covered $1500 of it. Cigna is paying out small amounts monthly and has not fulfilled their $1500 share. can i change plans even though Cigna hasn't paid their full $1500?
Payments of the $1,500 lifetime orthodontia benefit are prorated over the anticipated treatment period for your braces. If you terminate your participation in the Enhanced plan prior to completing your full treatment the prorated payments will cease.

If I wanted to get a second opinion on some dental procedures, does the insurance cover this cost? If so, what is the process to follow?

This will vary depending on the services performed at the second opinion. In most cases the dental office will bill this as a professional consultation, the Total care DHMO plan covers this at 85%. The copayment plan covers at $0 copayment. It is important to contact customer service to have a referral noted for the second opinion. The Enhanced plan covers this as a Basic service at 80% and the Basic plan excludes this service. If the dental office bills as an examination, it will count against one of your standard exams per year.

Return to Table of Contents