Dental/Vision FAQs — Plan Administrator

What groups are eligible for the dental/vision plan?

The Corps Network member groups that are enrolled in the medical/prescription drug plan or groups that enroll in the medical/prescription drug plan concurrently with the dental/vision.

Can our group add dental/vision benefits to our existing medical/prescription drug plan at any time in the year?

Yes. Dental/vision can be added anytime during the year, but benefits will be based on a September – August plan year (deductible, benefit maximum, etc.), regardless of the effective date of your program or your members.

How does dental/vision member eligibility compare with the medical/prescription drug benefits?

It is designed to mirror the medical/prescription plan eligibility. This includes the definitions for eligible corpsmembers, exclusions for a covered member's dependents and a program's permanent staff. If your program provides coverage for part-time members or imposes a waiting period on new members, the same rules will apply to both the medical/prescription plan and dental/vision plans.

Can a member waive dental/vision coverage?

Not if they are enrolled in the medical plan. Both the medical and dental/vision plans will have common eligibility, meaning anyone enrolled in one plan must be enrolled in the other as well. No member can have medical/prescription only or dental/vision only.

How does continuation of coverage work with the dental/vision plan?

It works the same as the medical. COBRA is Employer/Employee legislation and corpsmembers are not considered employees. Therefore, COBRA coverage will not be offered.

"Gap" coverage for up to 2 months between one service term and the next is offered for corpsmembers who sign up for a second term of service.

Who will administer the dental/vision benefits?

Cigna has been selected to insure the dental/vision program. Cigna will process claims, perform customer service and distribute coverage information. Since eligibility on the dental/vision plan must mirror medical enrollment, SMIC will be the contact for any eligibility changes (additions, terminations) and will also handle monthly invoicing.

Will I have to make separate changes for medical and dental/vision enrollments?

Enrollment changes are made through SMIC's online system and will apply to both medical and dental.

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Who should I contact with administrative questions?

Eligibility and billing questions should be directed to SMIC. All other questions regarding claims, benefits, network providers, etc. should be directed to Cigna. Inquiries prior to enrolling or for general issues, please call Willis Towers Watson.

Is there a list of contracted vision providers?

Yes. You will find Cigna contracted vision providers at myCigna.com. Services billed by non-contracted providers are filed by the member using a vision claim form found on myCigna.com.

What are the differences between Plan 1 and Plan 2?

Plan 1 is designed to maximize benefits when a program's members have network dentists available. Plan 2 is intended for programs that have members serving in areas where network dentists are not available.

What are the strengths/weaknesses of Plan 1?

Plan 1 is less expensive than plan 2 and, when services are received from network dentists, will still provide as much or more benefit than plan 2. Type II services such as fillings, oral surgery and root canals are covered at 70% in-network rather than 50%. If care is received from non-network dentists, payment drops to 50% for Type II and all benefits will only be considered up to the negotiated fee. This will often result in balance billing (see description below) and additional cost for the member.

What is balance billing?

Balance billing refers to amounts over the allowance that Cigna considers for payment for a procedure. Network providers, according to their contract with Cigna, are not allowed to bill a patient any amount of their normal charges that exceed the network negotiated fee. However, non-network dentists are under no such obligation. If their charges exceed those considered by Cigna for payment, they will bill the 'balance' remaining to the member.

What are the strengths/weaknesses of Plan 2?

Plan 2 is more expensive than Plan 1 but covers out-of-network services to the 90th percentile of the Usual and Customary (U&C) fee. This higher allowed amount on non-network claims will result in less balance billing. This is the only advantage that Plan 2 has over Plan 1.

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What is Usual and Customary (U&C)?

The U&C allowance is determined by Cigna using prevailing charges in a geographical area. Plan members are reimbursed according to the appropriate charges in the dentist's ZIP code. The 90th percentile of U&C means that 90% of the dentists in a ZIP code charge at or below the plan allowance for a given procedure.

Which dental/vision plan should our group choose?

As a general guideline, if your members have access to providers in the Cigna DPPO network and a reasonable expectation they will use them, Plan 1 is the best choice. If you have a significant number of members that will not have access to network dentists or you suspect they will be using the services of non-network dentists, Plan 2 is worth considering to minimize the effect of balance billing.

How do I tell if there are Cigna DPPO network dental providers in my area?

Prior to placing the dental plan with Cigna, an analysis of enrollee locations showed that approximately 95% of members had at least two network dentists within 10 miles. The best way for a group to determine network availability is to check online. Go to http://hcpdirectory.cigna.com/web/public/providers and click on 'find a dentist'. Enter your search criteria to access a list of DPPO dentists.

Can we offer both plans and let members choose which one they prefer?

No. Only one plan can be offered per group. Vision benefits are included with both plans.

What if I have any other questions about adding dental/vision coverage or how the plan will work?

Email Julie Nelson at Willis Towers Watson at julie.nelson@wtwco.com.