Individual and Family Plans
Insured by Cigna Health and Life Insurance Company

SUMMARY OF BENEFITS PLAN INFORMATION

Cigna Dental 5000/200 Plan

With Cigna, there is more to smile about.

You get flexible benefits and premium levels to meet your needs and budget, plus:

- Access to one of the nation's top networks, the **Total Cigna DPPO Network**, which has 147,000 dentists at more than 740,000 locations across the U.S.[1]
- No referral needed to see a specialist
- Available for all ages, including those 65 and older
- No application or processing fees
- Waiting periods may be waived for select procedures if you have had prior similar dental coverage[2]
- No need to submit claims when you use a Total Cigna DPPO Network provider
- 24/7/365 customer service
- Online access with **myCigna.com**®. You can view bills and claims online, anytime – and make a payment too
- Mobile access on the go. Find a dentist, check coverage and show your ID card with the **myCigna**® **App**

You have freedom.

You are free to choose a provider from our large national network or one from outside the network. Keep in mind, you'll save the most if you visit a Total Cigna DPPO Network provider. Find providers in our network at **Cigna.com/ifp-providers**.

In the chart below, you can see how your savings may be greater when visiting a **Total Cigna DPPO Network** provider with a **Cigna Dental 5000/200 Plan** compared with your other options.

		SAMPLE OUT-OF-POCKET COSTS		
PROCEDURE	**CLASS CATEGORY**	**TOTAL CIGNA DPPO NETWORK[3]**	**OUT-OF-NETWORK[3]**	**WITHOUT DENTAL INSURANCE[4]**
Cleaning (Adult Prophy) – D1110	Class I (preventive)	$0	$66	$109
Filling (2 Surfaces) – D2392	Class II (basic)	$38	$180	$255
Crown (Porcelain & High Noble Metal) – D2750	Class III (major)	$309	$982	$1,283

If you have a different plan, services may not be covered and discounts may vary. Chart is estimated; benefits may vary by provider and location. Out-of-network expenses may be lower in Alaska and Massachusetts.

1. Cigna internal data as of July 2022. Subject to change.
2. View Dental Benefit details on page 3 for applicable waiting periods. The previous plan's termination date must be within 63 days of the start date of this Cigna plan. The prior plan must have been effective 12 or more consecutive months prior to your new plan start date and must have included coverage for Class III, Major Restorative services. Any prior dental insurance plan that did not include Class III services will not count toward waiting period waiver. Waiting periods are waived for Class II and Class III in Maine if under the age of 19.
3. Estimate based on the national average of a standard Cigna Dental 5000/200 Plan; subject to deductible and coinsurance (as applicable), results in specific states may vary. If you visit an out-of-network provider, you are responsible for the difference in the amount that Cigna reimburses (i.e., Contracted Fee) for such services and the amount charged by the dentist.
4. Estimates based on 2021 Cigna Dental internal claims data, projected to 2022. Subject to change.

Dental Terms

Below you will find easy-to-understand definitions for commonly used words.

Actual Billed Charges: The fee that a provider charges a patient who does not have dental insurance. If a patient has dental insurance and visits a Total Cigna DPPO Network provider, the provider charges the negotiated rate/ contracted fee.

Balance Billing: When an out-of-network provider bills you for the difference between the charges for a service and what Cigna will pay for that service after coinsurance and Contracted Fee (CF), or Maximum Reimbursable Charge (MRC) in AK and MA, have been applied. For example, an out-of-network provider may charge $100 to fill a cavity. If CF is $50 for that service and the coinsurance is 50%, Cigna will pay $25 and you will pay $25. Because you are visiting an out-of-network provider, the provider may bill you the remaining $50; thus, your total out-of-pocket cost will be $75. These charges are separate from any applicable deductible and coinsurance.

Calendar-Year Deductible: The dollar amount you must pay each year for eligible dental expenses before the insurance begins paying for all dental services, if covered by your plan.

Calendar-Year Maximum: The most your plan will pay during a calendar year (12-month period beginning each January 1). You'll need to pay 100% out of pocket for any services after you reach your calendar-year maximum. This typically applies to Class I, II and III.

Total Cigna DPPO Network: Dentists who have contracted with Cigna and agreed to accept a predetermined contracted fee for the services provided to Cigna customers. Visiting a provider in this network means you'll save the most money because the fee is discounted.

Coinsurance: Your share of the cost of a covered dental service (a percentage amount). You pay coinsurance plus any deductible amount not met yet for that calendar year. For example, if you go to the dentist and your visit costs $200, the dentist sends a claim to Cigna. If you have already met your annual deductible amount, Cigna may pay 80% ($160) and you will pay a coinsurance of 20% ($40).

Contracted Fee (CF): The most Cigna will pay a dentist for a covered service or procedure for out-of-network dental care that is based on a basic Total Cigna DPPO fee schedule within a specified area. See example provided under Balance Billing.

Maximum Reimbursable Charge (MRC) – *applies in AK and MA only:* Also referred to as U&C, R&C and UCR. The most Cigna will pay a dentist for a covered service or procedure for out-of-network dental care. Normally applies as a percentile, based on the published prevailing HealthCare charges designated by zip code data. See example provided under Balance Billing.

Non-participating Providers (Out-of-Network): Providers who have not contracted with Cigna to offer you savings. They charge their own fees. Covered expenses for non-participating providers are based on the contracted fee, which may be less than actual billed charges. Non-participating providers can bill you for amounts exceeding covered expenses.

Waiting Period: The amount of time that you must be enrolled in the plan before certain benefits are payable. Waiting periods may vary by state. You may be eligible to waive the waiting period for Classes II & III if you have a continuous 12 months of prior coverage from a valid dental insurance plan which included coverage for Class III, Major Restorative services, and not more than 63 days have lapsed between the prior coverage and this plan. Any prior dental insurance plan that did not include Class III services will not count toward waiting period waiver. Waiting periods are waived for Class II and Class III in Maine if under the age of 19.

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DENTAL BENEFIT	Cigna Dental 5000/200 Plan	
	TOTAL CIGNA DPPO NETWORK	OUT-OF-NETWORK Your out-of-pocket expenses will be higher; these providers have not agreed to offer Cigna customers our contracted or discounted fees. Example provided on page 1.
Individual Calendar-Year Deductible	$200 per person	
Calendar-Year Maximum (For Class I, II and III Services)	$5,000 per person	
Payment Levels	Based on provider's **contracted fees**	Based on provider's **actual billed charges** and the **contracted fee**[5]
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES	
Preventive/Diagnostic Services Waiting Period	None	
Preventive/Diagnostic Services Oral Exams, Routine Cleanings, Routine X-rays Nonroutine X-rays, Fluoride Application, Sealants, Space Maintainers (Non-orthodontic), Emergency Care to Relieve Pain	You pay $0 (after deductible)	You pay the difference between the provider's **actual billed charges** and **100% of the contracted fee**[5] (after deductible)
	CLASS II: BASIC RESTORATIVE SERVICES	
Basic Restorative Services Waiting Period	6-month waiting period[6]	
Basic Restorative Services Fillings, Root Canal Therapy/Endodontics, Minor Periodontics, Major Periodontics, Oral Surgery, Simple Extractions, Oral Surgery, All Except Simple Extractions, Surgical Extraction of Impacted Teeth, Relines, Rebases, and Adjustments, Repairs - Bridges, Crowns, and Inlays, Repairs - Dentures, Anesthetics	You pay 20% of the provider's **contracted fee** (after deductible)	You pay the difference between the provider's **actual billed charges** and **80% of the contracted fee**[5] (after deductible)
	CLASS III: MAJOR RESTORATIVE SERVICES	
Major Restorative Services Waiting Period	12-month waiting period[6]	
Major Restorative Services Crowns/Inlays/Onlays, Prosthesis Over Implant, Dentures, Bridges	You pay 40% of the provider's **contracted fee** (after deductible)	You pay the difference between the provider's **actual billed charges** and **60% of the contracted fee**[5] (after deductible)

This summary contains highlights only. For additional plan information, including out-of-network benefits, please refer to the Policy for details.

5. If you choose to visit a dentist out-of-network, you will pay the out-of-network benefit and the difference between the amount that Cigna reimburses for such services (CF, or MRC in AK and MA) and the amount charged by the dentist, except for emergency services as defined in the policy. This is known as balance billing. See the definitions for Contracted Fee (CF), Maximum Reimbursable Charge (MRC; applies in AK and MA only) and Balance Billing on the previous page. Refer to the policy for more details.

6. Waiting periods may vary by state. Refer to the policy for more details. You may be eligible to waive the waiting period for Classes II and III if you had 12 continuous months of prior coverage from a dental coverage which included coverage for Class III, Major Restorative Services, and not more than 63 days have lapsed between the prior coverage and this plan. Any prior dental insurance plan that did not include Class III services will not count toward waiting period waiver. Waiting periods are waived for Class II and Class III in Maine if under the age of 19.

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	Cigna Dental 5000/200 Plan
PROCEDURE	**FREQUENCY/LIMITATION**
Oral Exams	2 per person per calendar year
Routine Cleanings	2 routine prophylaxis or periodontal maintenance procedure per person per calendar year
Routine X-rays	Bitewings: 2 sets per person per calendar year
Sealants	1 treatment per tooth in any 3 consecutive years, on a posterior tooth for a person less than 14 years old
Fluoride Treatment	Limited to persons less than 19 years old. Only 1 per person per calendar year
Space Maintainers (Non-orthodontic)	Limited to non-orthodontic treatment for prematurely removed or missing teeth for participants less than 19
Nonroutine X-rays	Only 1 per person, including panoramic film, in any 36 consecutive months
Crowns	1 per tooth per consecutive 60-month period. Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
Root Canal Therapy	Re-treatment of a previous root canal is covered if 180 days have passed since the original root canal.
Dentures and Partials	Limited to 1 complete/partial denture per arch per 60 consecutive months unless there is a necessary extraction of an additional functioning natural tooth.
Bridges	1 per consecutive 60-month period if not serviceable and cannot be repaired

This summary contains highlights only. Please refer to the Covered Expenses section of the Policy for details.

PLAN EXCLUSIONS AND LIMITATIONS

What is not covered by this plan
Excluded services

Covered expenses do not include expenses incurred for:

- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the 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 and third molars;
- Bite registrations, precision or semiprecision 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;
- Orthodontic treatment;
- The surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- Services for which benefits are not payable according to the "General Limitations" section.

General Limitations

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

- For services not specifically listed as covered services in the policy.
- For services or supplies that are not dentally necessary.
- For services received before the start date of coverage.
- For services received after coverage under this policy ends.
- For services for which you have no legal obligation to pay or for which no charge would be made if you did not have dental insurance coverage.
- For professional services or supplies received or purchased directly or on your behalf by anyone, including a dentist, from any of the following.
  - Yourself or your employer.
  - A person who lives in the insured person's home or that person's employer.
  - A person who is related to the insured person by blood, marriage or adoption or that person's employer.
- 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.
- For services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
- 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.
- For charges which would not have been made if the person had no insurance.
- To the extent that billed charges exceed the rate of reimbursement as described in the schedule.
- For charges for unnecessary care, treatment or surgery.
- To the extent that you or any of your dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- 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. Cigna will take into account any adjustment option chosen under such part by you or any one of your dependents.

PLAN IMPORTANT DISCLOSURES

Cigna Dental insurance coverage shall be only for the classes of service referred to in the Schedule of a purchased plan.

Dental plans are insured by Cigna Health and Life Insurance Company with network management services provided by Cigna Dental Health, Inc. Rates may vary based on age, family size, geographic location (residential zip code) and plan design.

Rates are subject to change upon 30 days' prior notice in AK, AL, AR, CO, CT, DC, DE, HI, IA, ID, IL, KS, KY, MA, ND, NE, NJ, OK, PA, SD, TN, UT, VT, WI and WY; 45 days' prior notice in FL; 75 days' prior notice in MS; and 60 days' prior notice in NV, TX and WV. In NC, dental rates are guaranteed for a 12-month period. **Dental plans apply waiting periods to covered basic (6 months) and major (12 months) dental care services.** In ME, waiting periods are waived for Class II and Class III if under the age of 19. Waiting periods may vary by state. Refer to the policy or outline of coverage for details. Some covered services are determined by age: topical application of fluoride or sealant, space maintainers, and materials for crowns and bridges.

Notice to Buyer: This policy provides dental coverage only. Review your policy carefully.

Dental preferred provider insurance policies (AL, CO, CT, DE, HI, IA, IL, ND, PA, WV and WY: HC-NOT11 et al., AK: HC-NOT53, et al., AR: HC-NOT36 et al., DC: HC-NOT42, et al., FL: HC-NOT15 et al., ID: HC-NOT51 et al., KS: HC-NOT49 et al., KY: HC-NOT44, et al., MA: HC-NOT11 et al., MS: HC-NOT48 et al., NC: HC-NOT18, et al., NE HC-NOT47 et al., NJ: HC-NOT46, et al., NV: HC-NOT39 et al., OK: HC-NOT26 et al., SD HC-NOT59 et al., TN: HC-NOT20 et al., TX: HC-NOT21 et al., UT: HC-NOT50 et al., VT HC-NOT56 et al., WI HC-NOT54 et al.) have exclusions, limitations, reduction of benefits and terms under which a policy may be continued in force or discontinued.

The policy may be cancelled by Cigna due to failure to pay premium, fraud, ineligibility, when the insured no longer lives in the service area, or if we cease to offer policies of this type or any individual dental plans in this state, in accordance with applicable law. You may cancel the policy on the first of the month following our receipt of your written notice. We reserve the right to modify this policy, including policy provisions, benefits and coverages, consistent with state or federal law. This individual plan is renewable monthly or quarterly.

For costs and additional details about coverage, contact Cigna Health and Life Insurance Company at 900 Cottage Grove Rd, Hartford, CT 06152 or call **866.GET.Cigna (866.438.2446)**.

Please contact your insurance carrier, agent/producer or the Health Insurance Marketplace if you wish to purchase PPACA-compliant pediatric dental coverage.