SUMMARY OF BENEFITS PLAN INFORMATION

Cigna Dental 1000 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 the Cigna DPPO Advantage Network with 89,000+ unique dental providers at more than 300,000 locations across the U.S.[1]
- No referral needed to see a specialist
- 15% discount on monthly premiums for any additional eligible dependents[2] on the plan
- 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[3]
- No need to submit claims when you use a Cigna DPPO Advantage 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® Mobile App.[4]

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 Cigna DPPO Advantage 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 **Cigna DPPO Advantage Network** provider with a **Cigna Dental 1000 Plan** compared with your other options.

		SAMPLE OUT-OF-POCKET COSTS		
PROCEDURE	**CLASS CATEGORY**	**CIGNA DPPO ADVANTAGE NETWORK[5]**	**OUT-OF-NETWORK[5]**	**WITHOUT DENTAL INSURANCE[6]**
Cleaning (Adult Prophy) – D1110	Class I (preventive)	$0	$66	$109
Filling (2 Surfaces) – D2392	Class II (basic)	$28	$175	$255
Crown (Porcelain & High Noble Metal) – D2750	Class III (major)	$357	$1,032	$1,283
Orthodontics (Braces) – D8080	Class IV (orthodontia)	Not Covered	Not Covered	$6,909

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.

1. Cigna internal data as of May 2022. Subject to change.
2. For each additional eligible dependent, as defined by the policy, added to a primary policy, a 15% discount is applied to the standard rate. Discount is applied in the quote tool.
3. View Dental Benefit details on Page 3 for applicable Waiting Periods. Waiting Periods for Class II and III will be waived at the individual member level if the application indicates that there was 12 months or more of prior dental coverage which included coverage for Class III, Major Restorative services and not more than 63 days has 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.
4. App/online store terms and mobile phone carrier/data charges apply.
5. Estimate based on the national average of a standard Cigna Dental 1000 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 (Allowed Amount) for such services and the amount charged by the dentist.
6. Estimates based on 2021 Cigna Dental internal claims data, projected to 2022.

Together, all the way.®

Cigna®

Cigna Dental Plans

Dental Terms

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

Actual Billed Charges: The fee that a provider charges to a patient for a service who does not have dental insurance. If a patient has dental insurance and visits a Cigna DPPO Advantage Network provider, the provider charges the negotiated rate/Allowed Amount.

Allowed Amount (contracted fee): The maximum amount Cigna will pay for services or supplies covered under this policy, before any applicable copayment, deductible, or coinsurance amounts are subtracted. The Allowed Amount for Participating Providers will be the amount Cigna has negotiated (sometimes called a contracted fee). The Allowed Amount for Non-Participating Providers will be based on the rate we have negotiated with Participating Providers in the area. See example provided under Balance Billing.

Balance Billing: When a Non-Participating Provider bills you for the difference between the charges for a service, and the Allowed Amount. A Participating Provider may not Balance Bill you for covered services. The actual billed charge of a Non-Participating Provider may exceed Cigna's Allowed Amount and you must pay the difference. For example, an out-of-network provider may charge $100 to fill a cavity. If the Allowed Amount 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 basic, and major restorative care 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.

Cigna DPPO Advantage Network (Participating Provider): Dentists that have contracted with Cigna and agreed to accept a predetermined Allowed Amount 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).

Non-Participating Providers (Out-of-Network): Providers who have not contracted with Cigna to provide services to you. You will pay more to see a Non-Participating Provider. Covered expenses for Non-Participating Providers are based on the Allowed Amount 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. You may be eligible to waive the waiting period for Classes II & III if you have continuous 12 months of prior coverage from a valid dental insurance plan which included Class III, Major Restorative services, and not more than 63 days has 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.

Cigna Dental Plans

DENTAL BENEFIT	Cigna Dental 1000 Plan	
	CIGNA DPPO ADVANTAGE 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	$50 per person	
Family Calendar Year Deductible	$150 per family	
Calendar Year Maximum (For Class I, II, and III services)	$1,000 per person	
Payment levels	Based on provider's **allowed amount** for covered services	Based on provider's **actual billed charges** and the **allowed amount**[1]
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES	
Preventive/Diagnostic Services Waiting Period	None	
Preventive/Diagnostic Services Oral Exams, Routine Cleanings, Routine X-Rays, Sealants, Fluoride Treatment, Space Maintainers (non-orthodontic)	You pay $0	You pay the difference between the provider's **actual billed charges** and **100% of the allowed amount**[1]
	CLASS II: BASIC RESTORATIVE SERVICES	
Basic Restorative Services Waiting Period	6-month waiting period[2]	
Basic Restorative Services Nonroutine X-Rays, Fillings, Routine Tooth Extraction, Emergency Treatment	You pay 20% of the provider's **allowed amount** (after deductible)	You pay the difference between the provider's **actual billed charges** and **80% of the allowed amount**[1] (after deductible)
	CLASS III: MAJOR RESTORATIVE SERVICES	
Major Restorative Services Waiting Period	12-month waiting period[2]	
Major Restorative Services Periodontal (Deep Cleaning), Periodontal Maintenance, Crowns, Root Canal Therapy, Extraction of Impacted Tooth, Complex Tooth Extraction, Dentures/Partials, Bridges	You pay 50% of the provider's **allowed amount** (after deductible)	You pay the difference between the provider's **actual billed charges** and **50% of the allowed amount**[1] (after deductible)
	CLASS IV: ORTHODONTIA	
Orthodontia	Not covered	

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

1. 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 (Allowed Amount) 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 Allowed Amount and Balance Billing on the previous page. Refer to the policy for more details.
2. Refer to the policy for details. You may be eligible to waive the waiting period for Classes II & III if you had 12 continuous months of prior coverage from a valid dental insurance plan which 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. The previous plan's termination date must be within 63 days of the effective date of this Cigna plan.

Cigna Dental Plans

	Cigna Dental 1000 Plan
PROCEDURE	FREQUENCY/LIMITATION
Oral Exams	1 per person per consecutive 6-month period
Routine Cleanings	1 routine prophylaxis or periodontal maintenance procedure per person per consecutive 6-month period (routine prophylaxis falls under Class I; periodontal maintenance procedure falls under Class III)
Routine X-Rays	Bitewings: 1 set in any consecutive 12-month period. Limited to a maximum of 4 films per set
Sealants	1 treatment per tooth per lifetime. Payable on unrestored permanent bicuspid or molar teeth for participants less than age 14
Fluoride Treatment	1 per consecutive 12-month period for participants less than age 14
Space Maintainers (non-orthodontic)	Limited to non-orthodontic treatment for prematurely removed or missing teeth for participants less than age 14
Nonroutine X-Rays	Full mouth or Panorex: 1 per consecutive 60-month period
Fillings	1 per tooth per consecutive 12-month period (applies to replacement of identical surface fillings only). No white/tooth colored fillings on bicuspid or molar teeth
Periodontal (Deep Cleaning)	1 per quadrant per consecutive 36-month period
Periodontal Maintenance	Payable only if a consecutive 6-month period has passed since the completion of active periodontal surgery. 1 periodontal maintenance or routine prophylaxis procedure per person per consecutive 6-month period (periodontal maintenance procedure is Class III; routine prophylaxis is Class I)
Crowns	1 per tooth per consecutive 84-month period. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crown or bridges. Replacement must be indicated by major decay. For participants less than age 16, benefits limited to resin or stainless steel
Root Canal Therapy	1 per tooth per lifetime; re-treatment of a previous root canal is covered if 24 consecutive months have passed since the original root canal and dental necessity is confirmed by professional review.
Dentures and Partials	1 per arch per consecutive 84-month period
Bridges	1 per consecutive 84-month period. Benefits will be considered for the initial replacement of a necessary functioning natural tooth extracted while the person was covered under this plan
Missing Teeth Limitation	There is no coverage for replacement of teeth that are missing prior to coverage. In NY, this payment limitation no longer applies after 12 months of continuous coverage.

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

Cigna Dental Plans

PLAN EXCLUSIONS AND LIMITATIONS

No coverage is available under this Policy for the following:

A. Cosmetic Services.

We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Policy unless medical information is submitted.

B. Coverage in Canada or Mexico or Outside of the United States.

We do not Cover care or treatment provided in Canada or Mexico, or outside of the United States and its possessions, except for Emergency Dental Care as described in the Policy.

C. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Policy for non-investigational treatments. See the Utilization Review and External Appeal sections of this Policy for a further explanation of Your Appeal rights.

D. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

E. Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

F. Medical Services.

We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

G. Medically Necessary.

In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure, treatment, test or device, is otherwise Covered under the terms of this Policy.

H. Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

I. Military Service.

We do not Cover an illness, treatment or medical condition due to service in the armed forces or auxiliary units.

J. No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

K. Services not Listed.

We do not Cover services that are not listed in this Policy as being Covered.

L. Services Provided by a Family Member.

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your Spouse.

M. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

N. Services with No Charge.

We do not Cover services for which no charge is normally made.

O. War.

We will not Cover an illness, treatment or medical condition due to war, declared or undeclared.

P. Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

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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.

In NY, dental rates are subject to change upon 30 days' prior notice. **Dental plans apply waiting periods to covered Class II basic (6-months), and Class III major (12-months) dental care services.** Some covered services are determined by age: topical application of fluoride or sealant, space maintainers, and materials for crowns and bridges. **If the plan covers replacement of teeth, there is no payment for replacement of teeth that are missing prior to coverage.** In NY, payment limitation no longer applies after 12 months of continuous coverage. Temporomandibular Joint Dysfunction will be included to the extent that it is determined that such treatment is dental in nature and such treatment is regularly covered under the listed covered services.

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

Dental preferred provider insurance policies (NY: INDDENTPOLNY) 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.

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