Summary of Benefits 2025 Insurance Plan Information

Cigna Healthcare Dental Insurance

The Cigna Healthcare℠ Dental Family + Pediatric Plan provides comprehensive dental coverage for your entire family. The plan is available for purchase independently or alongside a Cigna Healthcare Medical plan on the Health Insurance Marketplace. The plan does not have age purchase restrictions.[1]

	CIGNA HEALTHCARE DENTAL FAMILY + PEDIATRIC PLANS			
	Up to age 19[2]		Age 19 and older	
Dental Benefit	**Advantage Network**	**Out-of-network*** Out-of-pocket expenses may be higher; these providers do not offer Cigna Healthcare customers our contracted or discounted fees.	**Advantage Network**	**Out-of-network*** Out-of-pocket expenses may be higher; these providers do not offer Cigna Healthcare customers our contracted or discounted fees.
Individual calendar-year deductible	$150 per person		$150 per person	
Family calendar-year deductible	$300 per family		$150 per family	
Calendar-year out-of-pocket maximum	$425 per person/$850 per family		Not applicable	
Calendar-year maximum	Not applicable		$1,000 per person	
Payment levels	Based on provider's contracted fees for covered services	Based on provider's actual billed charges and the contracted fee	Based on provider's contracted fees for covered services	Based on provider's actual billed charges and the contracted fee
Class I: Preventative/Diagnostic services				
Preventive/diagnostic services waiting period	Not applicable		Not applicable	
Preventive/diagnostic services Routine cleanings, oral exams, routine X-rays, nonroutine X-rays (also part of Class II), sealants, fluoride treatment, space maintainers (non-orthodontic), emergency treatment (also part of Class II)	You pay $0.	You pay the difference between the provider's actual billed charges and 100% of the contracted fee.	You pay $0.	You pay the difference between the provider's actual billed charges and 100% of the contracted fee.

This summary contains highlights only.

* If you choose to visit a dentist out-of-network, you will pay the out-of-network benefit and the difference in the amount that Cigna Healthcare reimburses for such services (contracted fee) and the amount charged by the dentist (actual billed charged), except for emergency services.[3] This is known as balance billing. See Cigna Healthcare Dental terms on the last page for actual billed charges, balance billing and contracted fee.

1. Dependent age coverage restrictions may apply. See policy for details or call 866.Get.Cigna.
2. Pediatric coverage may continue through the end of the calendar year in which the individual turns 19.
3. Emergency services as defined by your plan.

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Cigna Healthcare Dental plans

Dental Benefit	CIGNA HEALTHCARE DENTAL FAMILY + PEDIATRIC PLANS			
	Up to age 19[2]		Age 19 and older	
	Advantage Network	**Out-of-network*** Out-of-pocket expenses may be higher; these providers do not offer Cigna Healthcare customers our contracted or discounted fees.	**Advantage Network**	**Out-of-network*** Out-of-pocket expenses may be higher; these providers do not offer Cigna Healthcare customers our contracted or discounted fees..
Class II: Basic Restorative Services				
Basic restorative services waiting period	Not applicable		6-month waiting period for age 20 and older[4]	
Basic restorative services fillings, routine tooth extraction, wisdom tooth extraction (also part of Class III in family plan), nonroutine X-rays (also part of Class I in pediatric plan), periodontal deep cleaning (also part of Class III in family plan), periodontal maintenance (also part of Class III in family plan), emergency treatment (also part of Class I in pediatric plan)	You pay 50% of provider's contracted fee (after deductible).	You pay the difference between the provider's actual billed charges and 50% of the contracted fee (after deductible).	You pay 20% of provider's contracted fee (after deductible).	You pay the difference between the provider's actual billed charges and 80% of the contracted fee (after deductible).
Class III: Major Restorative Services				
Major restorative services waiting period	Not applicable		Not applicable	
Major restorative services root canal therapy, crowns, routine tooth extraction, wisdom tooth extraction (also part of Class II in pediatric plan), periodontal deep cleaning (also part of Class II in pediatric plan), periodontal maintenance (also part of Class II in pediatric plan)	You pay 50% of provider's contracted fee (after deductible).	You pay the difference between the provider's actual billed charges and 50% of the contracted fee (after deductible).	You pay 50% of provider's contracted fee (after deductible).	You pay the difference between the provider's actual billed charges and 50% of the contracted fee (after deductible).
Class IV: Orthodontia				
Orthodontia waiting period	Not applicable		Not applicable	
Orthodontia (medically/dentally necessary)	You pay 50% of provider's actual billed charges.	You pay the difference between the provider's actual billed charges and 50% of the contracted fee (after deductible).	Not covered.	Not covered.

This summary contains highlights only.

* If you choose to visit a dentist out-of-network, you will pay the out-of-network benefit and the difference in the amount that Cigna Healthcare reimburses for such services (contracted fee) and the amount charged by the dentist (actual billed charges), except for emergency services.[2] This is known as balance billing. See Cigna Healthcare Dental terms on the last page for actual billed charges, balance billing and contracted fee.

4. 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 valid dental insurance plan. The previous plan's termination datemust be within 63 days of the effective date of this Cigna Healthcare plan.

Cigna Healthcare Dental plans

Procedure	CIGNA HEALTHCARE DENTAL FAMILY + PEDIATRIC PLANS	
	Up to age 19[2]	Age 19 and older
	Frequency/Limitation	
Class I: Preventative/Diagnostic services		
Routine cleanings	1 per consecutive 6-month period	1 routine prophylaxis or periodontal maintenance procedure per consecutive 6-month period (routine prophylaxis falls under Class I; periodontal maintenance procedure falls under Class III)
Oral exams	1 per consecutive 6-month period	1 per consecutive 6-month period
Routine X-rays	Bitewings: 1 set in any consecutive 6-month period	See Class II
Nonroutine X-rays (also part of Class II)	Full mouth or Panorex: 1 per consecutive 60-month period	See Class II
Sealants	1 treatment per tooth per consecutive 36 month period; payable on unrestored permanent molar teeth only	Not covered
Flouride treatment	2 per consecutive 12-month period	Not covered
Space maintainers (non-orthodontic)	Limited to non-orthodontic treatment for prematurely removed or missing teeth	Not covered
Emergency treatment	Limited to non-orthodontic treatment for prematurely removed or missing teeth	See Class II
Class II: Basic Restorative Services		
Fillings	No limitation	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
Routine tooth extraction	Includes an allowance for local anesthesia and routine postoperative care	Includes an allowance for local anesthesia and routine postoperative care
Wisdom tooth extraction (also part of Class III)	Includes an allowance for local anesthesia and routine postoperative care	Includes an allowance for local anesthesia and routine postoperative care
Nonroutine x-rays (also part of Class I)	See Class I	Full mouth or Panorex: 1 per consecutive 60-month period
Periodontal deep cleaning (also part of Class III)	Not covered	See Class III
Periodontal maintenance (also part of Class III)	Not covered	See Class III
Emergency treatment (also part of Class III)	See Class I	Paid as a separate benefit only if no other service, except X-rays, is rendered during the visit

This summary contains highlights only.

Cigna Healthcare Dental plans

Procedure	CIGNA HEALTHCARE DENTAL FAMILY + PEDIATRIC PLANS	
	Up to age 19[2]	Age 19 and older
	Frequency/Limitation	
Class III: Major Restorative Services		
Root canal therapy	1 per tooth per lifetime; applies to primary ("baby") teeth only	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
Crowns	1 per tooth per consecutive 60-month period; replacement must be indicated by inability to restore by an amalgam or a composite filling due to major decay or a fracture	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 crowns or bridges; replacement must be indicated by major decay
Wisdom tooth extraction (also part of Class II)	See Class II	Includes an allowance for local anesthesia and routine postoperative care
Periodontal deep cleaning (also part of Class II)	See Class II	1 per quadrant per consecutive 36-month period
Periodontal maintenance (also part of Class II)	See Class II	Payable only if at least a consecutive 6-month period has passed since the completion of active periodontal surgery; 1 periodontal maintenance or routine prophylaxis procedure per consecutive 6-month period (periodontal maintenance procedure is Class III; routine prophylaxis is Class I)
Class IV: Orthodontia		
Orthodontia (medically/dentally necessary)	No limitation	Not covered under this plan

This summary contains highlights only.

Cigna Healthcare Dental Family + Pediatric plans

2025 Plan Exclusions and Limitations – may vary by state

What is not covered by this plan

Missing Teeth Limitation – Age 19 and older

There is no payment for replacement of teeth that are missing prior to coverage. In Florida, payment limitation no longer applies after 12 months.

Excluded services: Age 19 and older

Covered expenses do not include expenses incurred for:

- Procedures which are not included in the list of covered dental expenses in the policy.
- Procedures which are not necessary and which do not have uniform professional endorsement.
- Procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- Procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- The alteration or restoration of occlusion.
- The restoration of teeth which have been damaged by erosion, attrition or abrasion.
- Bite registration or bite analysis.
- Any procedure, service or supply provided primarily for cosmetic purposes. Facings, repairs to facings, or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- The initial placement of a full denture or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan (the removal of only a permanent third molar will not qualify a full or partial denture for benefit).
- The initial placement of a fixed bridge, unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. If a bridge replaces teeth that were missing prior to the date the person's coverage became effective and also teeth that are extracted after the person's effective date, benefits are payable only for the pontics replacing those teeth which are extracted while the person is insured under this plan. The removal of only a permanent third molar will not qualify a fixed bridge for benefit under this provision.
- 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.
- 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.
- Core build-ups.
- Replacement of a partial denture, full denture or fixed bridge, or the addition of teeth to a partial denture unless:
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture;
  - The partial denture is less than 84 consecutive months old and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old and replacement is needed due to an additional necessary extraction of a functioning natural tooth while the person is covered under this plan; benefits will be considered only for the pontic replacing the additionally extracted tooth).
- The removal of only a permanent third molar, which will not qualify an initial or replacement partial denture, full denture, or fixed bridge for benefits.

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- The replacement of crowns, cast restoration, inlay, onlay or other laboratory-prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory-prepared restorations regardless of age unless necessitated by major decay or fracture of the underlying natural tooth.
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- Replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- Replacement of lost or stolen appliances.
- Replacement of teeth beyond the normal complement of 32.
- Prescription drugs.
- Any procedure, service, supply or appliance used primarily for the purpose of splinting.
- Athletic mouth guards.
- Myofunctional therapy.
- Precision or semiprecision attachments.
- Denture duplication.
- Separate charges for acid etch.
- Labial veneers (laminate).
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars.
- Treatment of jaw fractures and orthognathic surgery.
- Orthodontic treatment.
- Sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies, and infection control.
- Travel time or transportation costs.
- Temporary, transitional or interim dental services.
- Any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least three years, as determined by Cigna Healthcare.
- Diagnostic casts, diagnostic models or study models.
- Any treatment performed outside of the United States other than emergency treatment (any benefits for emergency treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period).
- Oral hygiene and diet instruction, broken appointments, completion of claim forms, personal supplies (water flosser, toothbrush, floss holder), duplication of X-rays and exams required by a third party.
- Services provided by a hospital, an ambulatory surgical center or similar facility, including ancillary charges.
- Services that are deemed to be medical services.
- Services for which benefits are not payable according to the "General limitations" section.

General limitations: age 19 and older

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 this policy.
- For services or supplies that are not dentally necessary.
- For services received before the effective 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, except a licensed 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 (not applicable in AZ).
- 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

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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 (not applicable in FL).
- 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 is 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.
- For procedures that are a covered expense under any other dental plan which provides dental benefits.
- For any services covered under both a medical plan and this dental plan and reimbursed under the medical plan.
- 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 Healthcare will take into account any adjustment option chosen under such part by you or any one of your dependents. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

Excluded services: up to age 19

Covered expenses do not include expenses incurred for:

- Procedures and services which are not included in the list of covered dental expenses in the policy.
- Procedures which are not necessary and which do not have uniform professional endorsement.
- Procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- Any procedure, service or supply provided primarily for cosmetic purposes. Facings, repairs to facings, or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- 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, except in cases where it is dentally necessary (not applicable in AZ).
- Replacement of lost or stolen appliances.
- Replacement of teeth beyond the normal complement of 32.
- Prescription drugs.
- Any procedure, service, supply or appliance used primarily for the purpose of splinting.
- Orthodontic treatment, except in cases where it is dentally necessary.
- Sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies, and infection control.
- Travel time or transportation costs.
- Temporary, transitional or interim dental services.
- Any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least three years, as determined by Cigna Healthcare.
- Any treatment performed outside of the United States other than emergency treatment.
- Oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (water flosser, toothbrush, floss holder, etc.); duplication of X-rays and exams required by a third party.
- Services provided by a hospital, an ambulatory surgical center or similar facility, including ancillary charges.
- Services that are deemed to be medical services.
- Services for which benefits are not payable according to the "General limitations" subsection below.

General limitations: up to age 19

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

- For services or supplies that are not dentally necessary.

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- For services received before the effective 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, except a licensed 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 (not applicable in AZ).
- 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 (not applicable in FL).
- 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 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.
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- For procedures that are a covered expense under any other dental plan which provides dental benefits (not applicable in AZ).
- For any services covered under both a medical plan and this dental plan and reimbursed under the medical plan.
- 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 Healthcare will take into account any adjustment option chosen under such part by you or any one of your dependents. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

Cigna Healthcare Dental plans

Cigna Healthcare Dental terms

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

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 an Advantage Network provider, the provider charges the negotiated rate/contracted fee for covered services.

Balance billing: When an out-of-network provider bills you for the difference between the charges for a service and what Cigna Healthcare will pay for that service after coinsurance and the contracted fee have been applied. For example, an out-of-network provider may charge $100 to fill a cavity. If the contracted fee is $50 for that service, assuming the calendar-year deductible has already been met and the coinsurance is 50%, Cigna Healthcare 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 could be $75. Balance billing 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 and orthodontia, if covered by your plan.

Calendar-Year out-of-pocket 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 services.

Advantage network: A network made up of dentists who have contracted with Cigna Healthcare and agreed to accept a predetermined contracted fee for the services provided to Cigna Healthcare 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 Healthcare. If you have already met your annual deductible amount, Cigna Healthcare may pay 80% ($160) and you will pay a coinsurance of 20% ($40).

Contracted fee: The fee to be charged for a service that Cigna Healthcare has negotiated with a contracted provider on your behalf. The most Cigna Healthcare will pay a dentist for a covered service or procedure for out-of-network dental care is based on a basic Advantage fee schedule within a specified area. See example provided under balance billing.

Out-of-network providers: Providers who have not contracted with Cigna Healthcare to offer you savings. They charge their own standard fees, also referred to as actual billed charges.

Waiting period (applies to adult family members only): 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 basic (Class II) and major (Class III) services if you have continuous 12 months of prior coverage from a valid dental insurance plan.

Cigna Healthcare Dental plans

2025 Important Plan Disclosures

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 Arizona and Tennessee and 45 days' prior notice in Florida. Some covered services are determined by age, including topical application of fluoride or sealant, space maintainers, materials for crowns and bridges, and orthodontia.

This plan includes a combination of insurance coverage and discounted services. The insurance coverage shall be only for the classes of services referred to in the Schedule of a purchased plan.

Waiting periods do not apply to eligible children. Waiting periods may apply to adult family members for covered basic (6 months) and major (12 months) dental care services. Waiting periods do not apply to covered preventive/diagnostic dental care services.

Preferred provider dental insurance policies (INDDENCOMB.AZ.3, INDDENCOMB.FL.3, INDDENCOMB.TN.3) have exclusions, limitations, reduction of benefits and terms under which policies may be continued in force or discontinued. The policy may be cancelled by Cigna Healthcare due to failure to pay premium, fraud, or 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 the state, in accordance with applicable law. You may cancel the policy, and the cancellation will take effect on the first of the month following our receipt of your written notice. We reserve the right to modify the policy, including policy provisions, benefits and coverages, consistent with state or federal law. The policy renews on a calendar-year basis.

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

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

Product availability may vary by location and plan type and is subject to change. All dental insurance policies contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

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