

**Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)**

**Part I: GENERAL INFORMATION**

**Insurer Name:** Cigna Health and Life Insurance Company  
**Policy Type:** DPPO  
**Effective Date:** Beginning on or after 01/01/2026

**Plan Name:** 0608150 DPPO Base  
**Insurer Phone #:** 1-800-Cigna24  
**Insurer Website:** www.cigna.com

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE AT [www.cigna.com](http://www.cigna.com) OR CALL 1-800-Cigna24.**

**THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.**

**Part II: DEDUCTIBLES**

<b>Deductible</b>	<b>All Providers</b>
Dental	Per individual - \$50/ Per family - \$150
Orthodontia	Not Covered

- **The deductible applies to all services except preventive/diagnostic and orthodontic services.**
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

**Part III: MAXIMUMS POLICY WILL PAY**

<b>Maximums</b>	<b>All Providers</b>
Annual Maximum	Class I applies Level 1: \$1500, Level 2: \$1650 Level 3: \$1800, Level 4: \$1950
Lifetime Maximum for Orthodontia	Not Covered

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

**Part IV: WAITING PERIODS**

**Waiting Periods:** A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments. **There is no waiting period.**

**Part V: WHAT YOU WILL PAY**

**All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.**

<b>Common Dental Procedures</b>	<b>Category</b>	<b>All Providers</b>	<b>Benefit Limitations and Exclusions</b>
			For complete coverage details, exclusions and limitations, please see your Plan Certificate.
<i>Oral Exam</i>	Preventive & Diagnostic	0%, deductible does not apply	Limited to two oral exams per year.
<i>Bitewing X-ray</i>	Preventive & Diagnostic	0%, deductible does not apply	Limited to 2 sets per year.

<b>Common Dental Procedures</b>	<b>Category</b>	<b>All Providers</b>	<b>Benefit Limitations and Exclusions</b> For complete coverage details, exclusions and limitations, please see your Plan Certificate.
<i>Cleaning</i>	Preventive & Diagnostic	0%, deductible does not apply	Limited to 2 per year.
<i>Filling</i>	Basic	10%	Not applicable
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	10%	Not applicable
<i>Root Canal</i>	Basic	10%	Not applicable
<i>Scaling and Root Planing</i>	Basic	10%	Not applicable
<i>Ceramic Crown</i>	Major	40%	Replacement is limited to 1 per tooth, per 60 consecutive months.
<i>Removable Partial Denture</i>	Major	40%	Replacement is limited to 1 partial denture per arch per 60 consecutive months.
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	10%	Not applicable
<i>Orthodontia</i>	Orthodontia	Not Covered	Not Covered

## Part VI: COVERAGE EXAMPLES

**THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT.** The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this policy to other dental policies you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

<b>Dana Has a Dental Appointment with a New Dentist</b>	<b>Sam Needs a Tooth Filled</b>	<b>Maria Needs a Crown</b>
New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

<b>Dana's Visit</b>	<b>Dana's Cost</b>	<b>Sam's Visit</b>	<b>Sam's Cost</b>	<b>Maria's Visit</b>	<b>Maria's Cost</b>
Total Cost of Care	In-network: \$400 Out-of-network: \$550	Total Cost of Care	In-network: \$150 Out-of-network: \$200	Total Cost of Care	In-network: \$1,300 Out-of-network: \$1,750
Deductible	In-network: Not Applicable  Out-of-network: Not Applicable	Deductible	In-network: \$50  Out-of-network: \$50	Deductible	In-network: \$50  Out-of-network: \$50
Annual Maximum (Plan Will Pay)	In-network: <small>Class I applies Level 1: \$1500, Level 2: \$1650 Level 3: \$1800, Level 4: \$1950</small>  Out-of-network: <small>Class I applies Level 1: \$1500, Level 2: \$1650 Level 3: \$1800, Level 4: \$1950</small>	Annual Maximum (Plan Will Pay)	In-network: <small>Class I applies Level 1: \$1500, Level 2: \$1650 Level 3: \$1800, Level 4: \$1950</small>  Out-of-network: <small>Class I applies Level 1: \$1500, Level 2: \$1650 Level 3: \$1800, Level 4: \$1950</small>	Annual Maximum (Plan Will Pay)	In-network: <small>Class I applies Level 1: \$1500, Level 2: \$1650 Level 3: \$1800, Level 4: \$1950</small>  Out-of-network: <small>Class I applies Level 1: \$1500, Level 2: \$1650 Level 3: \$1800, Level 4: \$1950</small>
Patient Cost (copayment or coinsurance)	In-network: 0%  Out-of-network: 0%	Patient Cost (copayment or coinsurance)	In-network: 10%  Out-of-network: 10%	Patient Cost (copayment or coinsurance)	In-network: 40%  Out-of-network: 40%
<b>In this example, Dana would pay (includes</b>	<b>In-network: \$0*</b>	<b>In this example, Sam would pay (includes</b>	<b>In-network: \$60*</b>	<b>In this example, Maria would pay (includes</b>	<b>In-network: \$550*</b>

<b>Dana's Visit</b>	<b>Dana's Cost</b>	<b>Sam's Visit</b>	<b>Sam's Cost</b>	<b>Maria's Visit</b>	<b>Maria's Cost</b>
<b>copays/coinsurance and deductible, if applicable):</b>	<b>Out-of-network:</b> \$16*	<b>copays/coinsurance and deductible, if applicable):</b>	<b>Out-of-network:</b> \$65*	<b>copays/coinsurance and deductible, if applicable):</b>	<b>Out-of-network:</b> \$760*
Summary of what is not covered or subject to a limitation:	<p>Oral exams and cleanings are limited to 2 per year. A complete series of full mouth X-rays are limited to 2 sets per year.</p> <p>*These Coverage Examples are based on a standard plan which may not reflect your coverages as described in Sections I – V. Please see the applicable Plan Certificate for details. For out-of-network benefits, you may be charged the difference between the amount Cigna reimburses for such services under your specific plan and the amount charged by the dentist.</p>	Summary of what is not covered or subject to a limitation:	<p>The following may apply: if more than one covered service will treat a dental condition, payment is limited to the least costly service.</p> <p>*These Coverage Examples are based on a standard plan which may not reflect your coverages as described in Sections I – V. Please see the applicable Plan Certificate for details. For out-of-network benefits, you may be charged the difference between the amount Cigna reimburses for such services under your specific plan and the amount charged by the dentist.</p>	Summary of what is not covered or subject to a limitation:	<p>Crowns are limited to 1 per tooth, per 60 consecutive months. The following may apply: if more than one covered service will treat a dental condition, payment is limited to the least costly service.</p> <p>*These Coverage Examples are based on a standard plan which may not reflect your coverages as described in Sections I – V. Please see the applicable Plan Certificate for details. For out-of-network benefits, you may be charged the difference between the amount Cigna reimburses for such services</p>

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
	<p>For plans that include Wellness Plus features, the first-year benefits were utilized in this summary.</p>		<p>For plans that include Wellness Plus features, the first-year benefits were utilized in this summary.</p>		<p>under your specific plan and the amount charged by the dentist.</p> <p>For plans that include Wellness Plus features, the first-year benefits were utilized in this summary.</p>