# Individual & Family Plans

Cigna Health and Life Insurance Company

**Arizona, Florida, Tennessee**

# SUMMARY OF BENEFITS
# 2022 PLAN INFORMATION

## Cigna Dental Insurance

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

| DENTAL BENEFIT | Cigna Dental Family + Pediatric Plans | | | |
|---|---|---|---|---|
| | THROUGH AGE 19 | | AGE 20 AND OLDER | |
| | **CIGNA DPPO ADVANTAGE NETWORK** Offers the most savings, 39%[2] national average. | **OUT-OF-NETWORK** Providers charge standard fees Out-of-pocket expenses may be higher; these providers do not offer Cigna customers our contracted or discounted fees. | **CIGNA DPPO ADVANTAGE NETWORK** Offers the most savings, 39%[2] national average. | **OUT-OF-NETWORK** Providers charge standard fees Out-of-pocket expenses may be higher; these providers do not offer Cigna customers our contracted or discounted fees. |
| Individual Calendar Year Deductible | $150 per person | | $50 per person | |
| Family Calendar Year Deductible | $300 per family | | $150 per family | |
| Calendar Year Out-of-Pocket Maximum | $375 per person/$750 per family | | Not applicable | |
| Calendar Year Maximum | Not applicable | | $1,000 per person | |
| Payment levels | Based on provider's **contracted fees** | Based on provider's **standard fees** and **MAC** (Maximum Allowable Charge) | Based on provider's **contracted fees** | Based on provider's **standard fees** and **MAC** |
| **CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES** | | | | |
| Preventive/Diagnostic Services Waiting Period | Not applicable | | Not applicable | |
| Preventive/Diagnostic Services<br>Routine Cleanings, Oral Exam, Routine X-Rays, Nonroutine X-Rays (also part of Class II in family plan), Emergency Treatment (also part of Class II in family plan)<br>Pediatric Plan Only: Sealants, Flouride Treatment, Space Maintainers (non-orthodontic) | You pay $0 | You pay the difference between the provider's **standard fee** and **100% of the MAC** | You pay $0 | You pay the difference between the provider's **standard fee** and **100% of the MAC** |

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 reimburses for such services and the amount charged by the dentist, except for emergency services.* This is known as balance billing.

* Emergency services as defined by your plan

1. Dependent age coverage restrictions may apply. See policy for details or call **866.Get.Cigna**.
2. Based upon 1/1/2018–12/31/2018 National Average Charges projected by Cigna Dental to 7/1/2019. Fees vary by region.

**Together, all the way.®**

Cigna®

# Cigna Dental Plans

| DENTAL BENEFIT | Cigna Dental Family + Pediatric Plans | | | |
|---|---|---|---|---|
| | THROUGH AGE 19 | | AGE 20 AND OLDER | |
| | **CIGNA DPPO ADVANTAGE NETWORK** Offers the most savings, 39%[2] national average. | **OUT-OF-NETWORK** Providers charge standard fees Out-of-pocket expenses may be higher; these providers do not offer Cigna customers our contracted or discounted fees. | **CIGNA DPPO ADVANTAGE NETWORK** Offers the most savings, 39%[2] national average. | **OUT-OF-NETWORK** Providers charge standard fees Out-of-pocket expenses may be higher; these providers do not offer Cigna customers our contracted or discounted fees. |
| **CLASS II: BASIC RESTORATIVE SERVICES** | | | | |
| Basic Restorative Services Waiting Period | Not applicable | | 6 month waiting period[3] | |
| **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 **standard fee** and **50% of the MAC** (after deductible) | You pay 20% of provider's **contracted fee** (after deductible) | You pay the difference between the provider's **standard fee** and **80% of the MAC** (after deductible) |
| **CLASS III: MAJOR RESTORATIVE SERVICES** | | | | |
| Major Restorative Services Waiting Period | Not applicable | | 12 month waiting period[3] | |
| **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) | You pay 50% of provider's **contracted fee** (after deductible) | You pay the difference between the provider's **standard fee** and **50% of the MAC** (after deductible) | You pay 50% of provider's **contracted fee** (after deductible) | You pay the difference between the provider's **standard fee** and **50% of the MAC** (after deductible) |
| **CLASS IV: ORTHODONTIA** | | | | |
| Orthodontia Waiting Period | Not applicable | | Not applicable | |
| **Orthodontia** (Medically/dentally necessary) | You pay 50% of provider's **contracted fee** (after deductible) | You pay the difference between the provider's **standard fee** and **50% of the MAC** (after deductible) | Not covered | Not covered |

2. Based upon 1/1/2018–12/31/2018 National Average Charges projected by Cigna Dental to 7/1/2019. Fees vary by region.
3. 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. The previous plan's termination date must be within 60 days of the effective date of this Cigna plan.

# Cigna Dental Plans

| PROCEDURE | Cigna Dental Family + Pediatric Plans<br>THROUGH AGE 19<br>FREQUENCY/LIMITATION | <br>AGE 20 AND OLDER<br> |
|---|---|---|
| | **CLASS I: PREVENTIVE/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 | Bite wings: 1 set in any consecutive 12 month period. Limited to a maximum of 4 films per set |
| Nonroutine X-Rays | 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 |
| Fluoride 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 | Paid as a separate benefit only if no other service, except X-rays, is rendered during the visit | 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 | Includes an allowance for local anesthesia and routine postoperative care | See Class III |
| Nonroutine X-Rays | See Class I | Full mouth or Panorex: 1 per consecutive 60 month period |
| Periodontal Deep Cleaning | 1 per consecutive 24 month period | See Class III |
| Periodontal Maintenance | No limitation | See Class III |
| Emergency Treatment | See Class I | Paid as a separate benefit only if no other service, except X-rays, is rendered during the visit |

# Cigna Dental Plans

| | Cigna Dental Family + Pediatric Plans | |
|---|---|---|
| | THROUGH AGE 19 | AGE 20 AND OLDER |
| PROCEDURE | FREQUENCY/LIMITATION | |
| | **CLASS III: MAJOR RESTORATIVE SERVICES** | |
| Root Canal Therapy | 1 per tooth per lifetim; 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 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 Dental Family + Pediatric Plans

## 2022 PLAN EXCLUSIONS AND LIMITATIONS – MAY VARY BY STATE

### What Is Not Covered By This Plan

**Missing Teeth Limitation** – Age 20 and older

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

### Excluded Services: Age 20 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 was 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; or
  - 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 will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- 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 restoration 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.
- Charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- Charges for travel time, transportation costs, or professional advice given on the phone.
- 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 3 years, as determined by Cigna.

# Cigna Dental Family + Pediatric Plans

- Diagnostic casts, diagnostic models or study models.
- Any charge for any treatment performed outside of the United States other than for 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 pick, toothbrush, floss holder, etc.), duplication of x-rays and exams required by a third party.
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- Services that are deemed to be medical services.
- Services for which benefits are not payable according to the "General Limitations" section.

**General Limitations: Age 20 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 the 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 related to a military-service-connected condition.
- 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.
- Procedures that are a covered expense under any other dental plan which provides dental benefits.
- Any services covered under both a medical plan and this dental plan and reimbursed under the medical plan will not be reimbursed under this 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 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: Through 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
- Charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- Charges for travel time; transportation costs; or professional advice given on the phone.
- 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 3 years, as determined by Cigna.
- Any charge for any treatment performed outside of the United States other than for emergency treatment.

# Cigna Dental Family + Pediatric Plans

- Oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party.
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- Services that are deemed to be medical services.
- Services for which benefits are not payable according to the "General Limitations" section.

**General Limitations: Through 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.
- 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.
- 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.
- Procedures that are a covered expense under any other dental plan which provides dental benefits (not applicable in AZ).
- Any services covered under both a medical plan and this dental plan and reimbursed under the medical plan will not be reimbursed under this 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 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 Dental Plans

## CIGNA DENTAL TERMS

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

**Cigna DPPO Advantage Network:** Dentists that 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.

**Out-of-Network:** Providers who have not contracted with Cigna to offer you savings. They charge their own standard fees.

**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 MAC have been applied. For example, an out-of-network provider may charge $100 to fill a cavity. If Maximum Allowable Charge is $50 for that service, assuming the calendar year deductible has already been met 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 could be $75. Balance billing charges are separate from any applicable deductible and coinsurance.

**Calendar Year Out of Pocket Maximum:** The most your plan will pay during a calendar year (12-month period beginning each January 1st). 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.

**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).

**Calendar Year Deductible:** The dollar amount you must pay each year for eligible dental expenses before the insurance begins paying for basic, major restorative care services and orthodontia, if covered by your plan.

**Maximum Allowable Charge (MAC):** 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 Cigna DPPO Advantage fee schedule within a specified area. See example provided under Balance Billing.

**Standard Fee:** 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 provider, the provider charges the negotiated rate/contracted fee for covered services.

**Contracted Fee:** The fee to be charged for a service that Cigna has negotiated with a contracted provider on your behalf.

## 2022 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.2, INDDENCOMB.FL.2, INDDENCOMB.TN.2) 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 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 the 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 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 call 866.GET.Cigna (866.438.2446).

Health Insurance Marketplace

Cigna®



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