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 over 89,000[1] in-network dental providers in our Cigna DPPO Advantage Network
- Nearly 200,000[1] office locations across the nation
- No referral needed to see a specialist
- 15% discount on monthly premiums for any additional family members on the plan
- Available for all ages, including those 65 and older
- No application or processing fees
- If you have had dental insurance for 12 or more consecutive months prior to your new plan effective date, you may be eligible to waive the waiting period so you won't have to wait for benefits to begin[2]
- No need to submit claims when you use a Cigna DPPO Advantage Network provider
- 24/7 live customer service at **800.Cigna24**
- 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.

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.

		Chart A1		
PROCEDURE	CLASS CATEGORY	CIGNA DPPO ADVANTAGE NETWORK	OUT-OF-NETWORK	WITHOUT DENTAL INSURANCE[4]
Cleaning (Adult Prophy) – D1110	Class I	$0[3]	$80[3]	$127
Filling (2 Surfaces) – D2392	Class II	$27[3]	$184[3]	$248
Crown (Porcelain & High Noble Metal) – D2750	Class III	$352[3]	$1,006[3]	$1,295
Orthodontics (Braces) – D8080	Class IV	$6,750[3]	$6,750[3]	$6,750

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. Data as of July 2017.
2. Excludes orthodontia benefits. View Dental Benefit details on Page 3 for applicable Waiting Periods. Eligibility for waiting period waiver is on a per person basis.
3. Estimate based on the New York average of a standard Cigna Dental 1000 plan; subject to deductible and coinsurance (as applicable). If you visit an out-of-network provider, you are responsible for the difference in the amount that Cigna reimburses (i.e. MAC) for such services and the amount charged by the dentist.
4. Estimate based on 2016 Cigna Dental internal claims data, projected to 7/1/2017.

Together, all the way.®

Cigna®

Cigna Dental Plans

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 Maximum Allowable Charge (MAC) have been applied. For example, an out-of-network provider may charge $100 to fill a cavity. If MAC 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 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 1, 2 and 3.

Lifetime Maximum: The most your plan will pay during your lifetime. You'll need to pay 100% out of pocket for any services after you reach your lifetime maximum. A lifetime maximum typically applies to Class 4 services. (Applicable to Cigna Dental 1500 plan.)

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, and major restorative care services, if covered by your plan.

Lifetime Orthodontia Deductible: The dollar amount you must pay once in your lifetime for eligible dental expenses before the insurance plan begins paying for Orthodontia, if covered by your plan.

Maximum Allowable Charge (MAC): The most Cigna will pay a dentist for a covered service or procedure based on average a Cigna DPPO Advantage Network amount 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 Network provider, the provider charges the negotiated rate/contracted fee.

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

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 continuous 12 months of prior coverage from a valid dental insurance plan.

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DENTAL BENEFIT	Cigna Dental 1000 Plan	
	CIGNA DPPO ADVANTAGE NETWORK Offers the most savings, 37%[1] national average.	**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 in chart A1.
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	
Lifetime Deductible (Separate per person for Orthodontia)	Not applicable	
Lifetime Maximum (Separate per person for Orthodontia)	Not applicable	
Payment levels	Based on provider's **contracted fees** for covered services	Based on provider's **standard fees** and the **MAC**
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES	
Preventive/Diagnostic Services Waiting Period	Not applicable	
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 **standard fee** and **100% of the MAC**
	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 **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	12-month waiting period[2]	
Major Restorative Services Periodontal (Deep Cleaning), Periodontal Maintenance, Crowns, Root Canal Therapy, Wisdom Tooth Extraction, Dentures/Partials, Bridges	You pay 50% of the 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	
Orthodontia	You pay 100% of the provider's **standard fee**	You pay 100% of the provider's **standard fee**

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.

1. Based upon 1/1/2016–12/31/2016 National Average Charges projected by Cigna Dental to 7/1/2017. Fees vary by region.

2. 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**.

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PROCEDURE	Cigna Dental 1000 Plan FREQUENCY/LIMITATION
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES
Oral Exams	1 per consecutive 6-month period
Routine Cleanings	1 routine prophylaxis or periodontal maintenance procedure per consecutive 6-month period (routine prophylaxis falls under Class 1; 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
	CLASS II: BASIC RESTORATIVE SERVICES
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
Routine Tooth Extraction	Includes an allowance for local anesthesia and routine postoperative care
Emergency Treatment	Paid as a separate benefit only if no other service, except x-rays, is rendered during the visit
	CLASS III: MAJOR RESTORATIVE SERVICES
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 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
Wisdom Tooth Extraction	Includes an allowance for local anesthesia and routine postoperative care
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
	CLASS IV: ORTHODONTIA
Orthodontia	Not covered under this plan

This summary contains highlights only.

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 basic (6-months), major (12-months) and orthodontic (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.

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.