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 October 1, 2025

Plan Name: 0655106 DPPO / Dental PPO Plan
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 **OR CALL** 1-800-Cigna24.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	Per individual - $25 / Per family - $75	Per individual - $50/ Per family - $150
Orthodontia	Per individual - $0 / Per family - $0	Per individual - $0 / Per family - $0

- **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

Maximums	In-Network	Out-of-Network
Annual Maximum	Level 1: $1500, Level 2: $1650, Level 3: $1800, Level 4: $1950	Level 1: $1500, Level 2: $1650, Level 3: $1800, Level 4: $1950
Lifetime Maximum for Orthodontia	$1500	$1500

- **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.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions For complete coverage details, exclusions and limitations, please see your Plan Certificate.
Oral Exam	Preventive & Diagnostic Class I	0%, deductible does not apply	0%, deductible does not apply	1 per 6-month consecutive period
Bitewing X-ray	Preventive & Diagnostic Class I	0%, deductible does not apply	0%, deductible does not apply	1 set in any consecutive 12 month period. Limited to a maximum of 4 films per set.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions For complete coverage details, exclusions and limitations, please see your Plan Certificate.
Cleaning	Preventive & Diagnostic Class I	0%, deductible does not apply	0%, deductible does not apply	1 routine prophy or perio maintenance procedure per 6-month consecutive period
Filling	Basic Class II	20%	20%	1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only) No white-colored fillings on bicuspid or molar teeth.
Extraction, Erupted Tooth or Exposed Root	Basic Class II	20%	20%	Not applicable
Root Canal	Basic Class II	20%	20%	Not applicable
Scaling and Root Planing	Basic Class II	20%	20%	Minor Perio (non-surgical) Root planning-1 per quadrant per 36 consecutive months Perio Surgery 1 per 36 consecutive months per area of the mount (same service)
Ceramic Crown	Major Class III	40%	40%	Replacement limited to 1 per 84 consecutive months. 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. For participants younger than age 16, benefits are limited to resin or stainless steel.
Removable Partial Denture	Major Class III	40%	40%	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired.
Extraction, Erupted Tooth with Bone Removal	Basic Class II	20%	20%	Not applicable

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions For complete coverage details, exclusions and limitations, please see your Plan Certificate.
Orthodontia	Orthodontia Class IV	50%, deductible does not apply	50%, deductible does not apply	For dependent children, up to age 19

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.

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

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
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: $25 Out-of-network: $50	Deductible	In-network: $25 Out-of-network: $50
Annual Maximum (Plan Will Pay)	In-network: L1 $1500, L2 $1650, L3 $1800, L4 $1950 Out-of-network: L1 $1500, L2 $1650, L3 $1800, L4 $1950	Annual Maximum (Plan Will Pay)	In-network: L1 $1500, L2 $1650, L3 $1800, L4 $1950 Out-of-network: L1 $1500, L2 $1650, L3 $1800, L4 $1950	Annual Maximum (Plan Will Pay)	In-network: L1 $1500, L2 $1650, L3 $1800, L4 $1950 Out-of-network: L1 $1500, L2 $1650, L3 $1800, L4 $1950
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 0%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 40% Out-of-network: 40%
In this example, Dana would pay	**In-network:** $0*	**In this example, Sam would pay**	**In-network:** $50*	**In this example, Maria would pay**	**In-network:** $535*

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
(includes copays/coinsurance and deductible, if applicable):	**Out-of-network:** $16*	**(includes copays/coinsurance and deductible, if applicable):**	**Out-of-network:** $80*	**(includes copays/coinsurance and deductible, if applicable):**	**Out-of-network:** $760*
Summary of what is not covered or subject to a limitation:	Oral exams are limited to 1 per 6-month consecutive period and Prophylaxis (cleanings) are limited to 1 routine prophy or perio maintenance procedure per 6-month consecutive period. A complete series of full mouth or Panorex X-rays are limited to 1 per 60 consecutive months. *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	Summary of what is not covered or subject to a limitation:	Fillings are limited to 1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only). No white-colored fillings on bicuspid or molar teeth. The following may apply: if more than one covered service will treat a dental condition, payment is limited to the least costly service. *These Coverage Examples are based on a standard plan which may not reflect your coverages as described in Sections I – V. Please see the	Summary of what is not covered or subject to a limitation:	Crowns and Inlays replacement limited to 1 per 84 consecutive months. 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. For participants younger than age 16, benefits are limited to resin or stainless steel. The following may apply: if more than one covered service will treat a dental condition, payment is limited to the least costly service.

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
	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. For plans that include Wellness Plus features, the first-year benefits were utilized in this summary.		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. For plans that include Wellness Plus features, the first-year benefits were utilized in this summary.		*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. For plans that include Wellness Plus features, the first-year benefits were utilized in this summary.