



This is a summary of benefits for your dental plan.

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Your plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.

| Plan Design                                                                                                                                                                                                                                                  | Total Network**                    | Out-of-Network                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <b>Calendar Year Maximum</b><br>(Class I, II, III, IX Expenses)                                                                                                                                                                                              | \$1500, Class I Applies            | \$1500, Class I Applies                                                                                      |
| <b>Calendar Year Deductible</b>                                                                                                                                                                                                                              |                                    |                                                                                                              |
| Per Individual                                                                                                                                                                                                                                               | \$50                               | \$50                                                                                                         |
| Per Family                                                                                                                                                                                                                                                   | \$150                              | \$150                                                                                                        |
| <b>Class I Expenses - Preventive &amp; Diagnostic Care</b>                                                                                                                                                                                                   |                                    |                                                                                                              |
| Oral Exams<br>Cleanings<br>Routine X-rays<br>Fluoride Application<br>Sealants<br>Space Maintainers (limited to non-orthodontic treatment)<br>Non-Routine X-rays<br>Emergency care to relieve pain (administrated at In Network coinsurance)                  | 100%, No Deductible                | 80%, No Deductible                                                                                           |
| <b>Class II Expenses - Basic Restorative Care</b>                                                                                                                                                                                                            |                                    |                                                                                                              |
| Fillings<br>Oral Surgery - Simple Extractions<br>Anesthetics<br>Minor Periodontics<br>Major Periodontics<br>Root Canal Therapy / Endodontics<br>Brush Biopsy                                                                                                 | 80%, After Deductible              | 80%, After Deductible                                                                                        |
| <b>Class III Expenses - Major Restorative Care</b>                                                                                                                                                                                                           |                                    |                                                                                                              |
| Oral Surgery - All Except Simple Extraction<br>Surgical Extraction of Impacted Teeth<br>Relines, Rebases, and Adjustments<br>Repairs - Bridges, Crowns, and Inlays<br>Repairs - Dentures<br>Crowns/Inlays/Onlays<br>Stainless Steel/Resin Crowns<br>Dentures | 50%, After Deductible              | 50%, After Deductible                                                                                        |
| <b>Class IV Expenses - Orthodontia</b>                                                                                                                                                                                                                       |                                    |                                                                                                              |
| Coverage for Eligible Children Only<br>Lifetime Maximum                                                                                                                                                                                                      | 50%, No Ortho Deductible<br>\$1000 | Not Covered                                                                                                  |
| <b>Class IX Expenses - Implants</b>                                                                                                                                                                                                                          |                                    |                                                                                                              |
| Plan Calendar Year Max                                                                                                                                                                                                                                       | 50%, After Deductible<br>\$1500    | 50%, After Deductible<br>\$1500                                                                              |
| <b>Dental Plan Reimbursement Levels</b>                                                                                                                                                                                                                      | Based on Contracted Fees           | 90th Percentile of Submitted Charges***                                                                      |
| <b>Additional Member Responsibility in excess of Coinsurance</b>                                                                                                                                                                                             | None                               | Yes, the difference between the member's dentist's billed charges and the dental plan reimbursement level*** |
| <b>Student/Dependent Age</b>                                                                                                                                                                                                                                 | 26/26                              |                                                                                                              |

**Current****Buy Up Plan - TX Residents**

Effective Date: January 01, 2026

**Cigna Dental Exclusions and Limitations:**

| <b>Procedure</b>           | <b>Exclusions &amp; Limitations</b>                                                                                                                                                                                                                                |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Exams                      | Two per calendar year                                                                                                                                                                                                                                              |
| Prophylaxis (cleanings)    | Two per calendar year                                                                                                                                                                                                                                              |
| Fluoride                   | 1 per calendar year for people under 19                                                                                                                                                                                                                            |
| X-Rays (routine)           | Bitewings: 2 per calendar year                                                                                                                                                                                                                                     |
| X-Rays (non-routine)       | Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years                                                                                                                                                                                            |
| Cone Beams                 | Not covered                                                                                                                                                                                                                                                        |
| Model                      | Payable only when in conjunction with Ortho workup                                                                                                                                                                                                                 |
| Minor Perio (non-surgical) | Various limitations depending on the service                                                                                                                                                                                                                       |
| Perio Surgery              | Various limitations depending on the service                                                                                                                                                                                                                       |
| Crowns and Inlays          | Replacement every 5 years                                                                                                                                                                                                                                          |
| Prosthesis over Implants   | 1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.                                                                  |
| Bridges                    | Replacement every 5 years                                                                                                                                                                                                                                          |
| Dentures and Partial       | Replacement every 5 years                                                                                                                                                                                                                                          |
| Relines, Rebases           | Covered if more than 6 months after installation                                                                                                                                                                                                                   |
| Adjustments                | Covered if more than 6 months after installation                                                                                                                                                                                                                   |
| Repairs - Bridges          | Reviewed if more than once                                                                                                                                                                                                                                         |
| Repairs - Dentures         | Reviewed if more than once                                                                                                                                                                                                                                         |
| Sealants                   | Limited to posterior tooth. One treatment per tooth every three years up to age 14                                                                                                                                                                                 |
| Space Maintainers          | Limited to non-Orthodontic treatment. No frequency limit for participants under age 19.                                                                                                                                                                            |
| Alternate Benefit          | When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. |
| Orthodontia                | For dependent children, up to age 19                                                                                                                                                                                                                               |
| Missing Tooth Provision    | The amount payable is 50% of the amount otherwise payable until insured for 12 Months; thereafter, considered a Class III expense                                                                                                                                  |
| Late Entrant Limit****     | 50% coverage on Class III, IV (if applicable), and IX for 12 months                                                                                                                                                                                                |
| Pre-Treatment Review       | Available on a voluntary basis when extensive work in excess of \$200 is proposed                                                                                                                                                                                  |

**Benefit Exclusions:**

- \* Services performed primarily for cosmetic reasons
- \* Replacement of a lost or stolen appliance
- \* Replacement of a bridge or denture within five years following the date of its original installation
- \* Replacement of a bridge or denture which can be made useable according to accepted dental standards
- \* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- \* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- \* Bite registrations; precision or semi-precision attachments; splinting
- \* Instruction for plaque control, oral hygiene and diet
- \* Dental services that do not meet common dental standards
- \* Services that are deemed to be medical services
- \* Services and supplies received from a hospital
- \* Charges which the person is not legally required to pay
- \* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
- \* Experimental or investigational procedures and treatments
- \* Any injury resulting from, or in the course of, any employment for wage or profit
- \* Any sickness covered under any workers' compensation or similar law
- \* Charges in excess of the reasonable and customary allowances
- \* To the extent that payment is unlawful where the person resides when the expenses are incurred;
- \* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- \* For charges which would not have been made if the person had no insurance; 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;
- \* 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.
- \* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

\*\* In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.

\*\*\*Charges are based upon an independent third party organization that is the industry standard. Percentile data is based upon the third party organization's aggregated industry-wide claims data

\*\*\*\*Late Entrant coverage limitation does not apply to New Mexico Residents for Insured Dental Products.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that most of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can access articles on behavioral conditions that impact oral health.

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Prepared by Underwriting.

Cigna Total Network (P0010)

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# Discrimination is against the law Dental Coverage

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

## Cigna Healthcare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English in a timely manner, such as:
  - Qualified interpreters
  - Information written in other languages



Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries, including Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a **Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes**, Cigna Dental Health of Kansas, Inc. (KS & NE), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. .  
ATTENTION: If you speak languages other than English, language assistance service, free of charge are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

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If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator

P.O. Box 188016, Chattanooga, TN 37422,  
877.822.6561 (TTY: Dial 711)

[ACAGrievance@CignaHealthcare.com](mailto:ACAGrievance@CignaHealthcare.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

**U.S. Department of Health and Human Services**  
200 Independence Avenue,  
SW Room 509F, HHH Building  
Washington, DC 20201  
**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at  
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

## Proficiency of Language Assistance Services

**English – ATTENTION:** If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

**Spanish – ATENCIÓN:** Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

**Chinese – 注意:** 如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224 (TTY: 拨打 711) 或与您的服务提供者联系。

**Vietnamese – XIN LƯU Ý:** Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

**Korean – 주의:** 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십시오.

**Tagalog – PAUNAWA:** Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

**Russian – ВНИМАНИЕ:** Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

**Arabic - تنبيه:** إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مسددة قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: اطلب 711) أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711).

**French Creole – ATANSYON:** Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòm ki aksesib yo disponib tou gratis. Rele 1-800-244-6224 (TTY: Rele 711) oswa pale ak founisè ou a.

**French – ATTENTION :** Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

**Portuguese – ATENÇÃO:** Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

**Polish – UWAGA:** Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

**Japanese – 注意:** 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224 (TTY: 711 にダイヤル) に電話するか、提供者に話してください。

**Italian – ATTENZIONE:** Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: componi il 711) o parla con il tuo fornitore.

**German – Achtung:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

**Persian (Farsi) - همچنین، وسایل و خدمات کمکی مناسب برای در دسترس ست. خدمات رایگان کمک زبان ری شم صحبت می‌کنید، وجه: گر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید: TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224. ارائه‌دهنده خود صحبت کنید**