Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Cigna (Loyal American Life Insurance Company)
Plan Name: Flexible Choice Dental, Vision and Hearing
Policy Type: DPPO
Insurer Phone #: 866-459-4272
Effective Date: Beginning on or after 01/01/2022
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** 866-459-4272.
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THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	All Providers
Dental	Year 1: $100 Year 2: $67 Year 3: $33 Years 4+: $0
Orthodontia	Not Covered

- **There is a disappearing deductible.**
- 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	All Providers
Annual Maximum	$3,500
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.

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	All Providers	Benefit Limitations and Exclusions For complete coverage details, exclusions and limitations, please see your Plan Certificate.
Oral Exam	Preventive	All Years: 0%	Limited to 1 per 6 months.
Bitewing X-ray	Preventive	All Years: 0%	Limited to 1 per 6 months.

Common Dental Procedures	Category	All Providers	Benefit Limitations and Exclusions For complete coverage details, exclusions and limitations, please see your Plan Certificate.
Cleaning	Preventive	All Years: 0%	Limited to 1 per 6 months.
Filling	Basic	Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%	Limited to 1 per 2 policy years.
Extraction, Erupted Tooth or Exposed Root	Basic	Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%	Limited to 4 teeth per policy year.
Root Canal	Major	All Years: 40%	Limited to 1 per tooth in any 3 policy years.
Scaling and Root Planing	Basic	Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%	Limited to 1 treatment per quadrant in any 2 policy years.
Ceramic Crown	Major	All Years: 40%	Replacements are covered after 5 years.
Removable Partial Denture	Major	All Years: 40%	Replacements are covered after 8 years.
Extraction, Erupted Tooth with Bone Removal	Basic	Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%	Up to 4 teeth per policy year.
Orthodontia	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.

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: Year 1: $100 Year 2: $67 Year 3: $33 Years 4+: $0 Out-of-network: Year 1: $100 Year 2: $67 Year 3: $33 Years 4+: $0	Deductible	In-network: Year 1: $100 Year 2: $67 Year 3: $33 Years 4+: $0 Out-of-network: Year 1: $100 Year 2: $67 Year 3: $33 Years 4+: $0	Deductible	In-network: Year 1: $100 Year 2: $67 Year 3: $33 Years 4+: $0 Out-of-network: Year 1: $100 Year 2: $67 Year 3: $33 Years 4+: $0
Annual Maximum (Plan Will Pay)	In-network: $3,500 Out-of- network: $3,500	Annual Maximum (Plan Will Pay)	In-network: $3,500 Out-of- network: $3,500	Annual Maximum (Plan Will Pay)	In-network: $3,500 Out-of- network: $3,500
Patient Cost (copayment or coinsurance)	In-network: All Years: 0% Out-of-network:	Patient Cost (copayment or coinsurance)	In-network: Year 1: 40% Year 2: 30% Year 3: 20%	Patient Cost (copayment or coinsurance)	In-network: All Years: 40%

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
	All Years: 0%		Years 4+: 10% Out-of-network: Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%		Out-of-network: All Years: 40%
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** Year 1: $100 Year 2: $67 Year 3: $33 Years 4+: $0 **Out-of-network:** Year 1: $250 Year 2: $217 Year 3: $183 Years 4+: $150	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** Payment is based on the cost of an amalgam filling. **Out-of-network:** Payment is based on the cost of an amalgam filling.	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** Year 1: $620 Year 2: $587 Year 3: $553 Years 4+: $520 **Out-of-network:** Year 1: $1,070 Year 2: $1,037 Year 3: $1,003 Years 4+: $970
Summary of what is not covered or subject to a limitation:	Oral exams and cleanings are limited to 1 per 6 months. A complete series of full mouth X-rays are limited to 1 per 6 months. *These Coverage Examples are based on a standard plan which may not reflect your coverages as	Summary of what is not covered or subject to a limitation:	This policy downgrades resin-based posterior fillings to pay based on an amalgam cost. *These Coverage Examples are based on a standard plan which may not reflect your coverages as described in	Summary of what is not covered or subject to a limitation:	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

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
	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.		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.		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.