

**Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)**

**Part I: GENERAL INFORMATION**

**Insurer Name:** Cigna (Loyal American Life Insurance Company)  
**Policy Type:** DPPO  
**Effective Date:** Beginning on or after 01/01/2022

**Plan Name:** Flexible Choice Dental, Vision and Hearing  
**Insurer Phone #:** 866-459-4272  
**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](http://www.cigna.com) OR CALL 866-459-4272.**

**THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.**

**Part II: DEDUCTIBLES**

<b>Deductible</b>	<b>All Providers</b>
Dental	None
Orthodontia	Not Covered

- **There is no 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**

<b>Maximums</b>	<b>All Providers</b>
Annual Maximum	\$4,000
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.**

<b>Common Dental Procedures</b>	<b>Category</b>	<b>All Providers</b>	<b>Benefit Limitations and Exclusions</b>
			For complete coverage details, exclusions and limitations, please see your Plan Certificate.
<i>Oral Exam</i>	Preventive	Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%	Limited to 1 per 6 months.

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

<b>Common Dental Procedures</b>	<b>Category</b>	<b>All Providers</b>	<b>Benefit Limitations and Exclusions</b>  For complete coverage details, exclusions and limitations, please see your Plan Certificate.
<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%	Up to 4 teeth per policy year.
<i>Orthodontia</i>	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.

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

<b>Dana's Visit</b>	<b>Dana's Cost</b>	<b>Sam's Visit</b>	<b>Sam's Cost</b>	<b>Maria's Visit</b>	<b>Maria's Cost</b>
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: \$0  Out-of-network: \$0	Deductible	In-network: \$0  Out-of-network: \$0	Deductible	In-network: \$0  Out-of-network: \$0
Annual Maximum (Plan Will Pay)	In-network: \$4,000  Out-of-network: \$4,000	Annual Maximum (Plan Will Pay)	In-network: \$4,000  Out-of-network: \$4,000	Annual Maximum (Plan Will Pay)	In-network: \$4,000  Out-of-network: \$4,000
Patient Cost (copayment or coinsurance)	In-network: Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%  Out-of-network: Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%	Patient Cost (copayment or coinsurance)	In-network: Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%  Out-of-network: Year 1: 40% Year 2: 30% Year 3: 20% Years 4+: 10%	Patient Cost (copayment or coinsurance)	In-network: All Years: 40%  Out-of-network: All Years: 40%

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
<p><b>In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):</b></p>	<p><b>In-network:</b>  Year 1: \$160  Year 2: \$120  Year 3: \$80  Years 4+: \$40</p> <p><b>Out-of-network:</b>  Year 1: \$310  Year 2: \$270  Year 3: \$230  Years 4+: \$190</p>	<p><b>In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):</b></p>	<p><b>In-network:</b>  Payment is based on the cost of an amalgam filling.</p> <p><b>Out-of-network:</b>  Payment is based on the cost of an amalgam filling.</p>	<p><b>In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):</b></p>	<p><b>In-network:</b>  All Years: \$520</p> <p><b>Out-of-network:</b>  All Years: \$970</p>
<p>Summary of what is not covered or subject to a limitation:</p>	<p>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.</p> <p>*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</p>	<p>Summary of what is not covered or subject to a limitation:</p>	<p>This policy downgrades resin-based posterior fillings to pay based on amalgam cost.</p> <p>*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</p>	<p>Summary of what is not covered or subject to a limitation:</p>	<p>The following may apply: if more than one covered service will treat a dental condition, payment is limited to the least costly service.</p> <p>*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</p>

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
	difference between the amount Cigna reimburses for such services under your specific plan and the amount charged by the dentist.		the amount Cigna reimburses for such services under your specific plan and the amount charged by the dentist.		difference between the amount Cigna reimburses for such services under your specific plan and the amount charged by the dentist.