Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Cigna Dental Health of California, Inc.
Type of Product Line: DHMO
Effective Date: Beginning on or after **01.01.2026**
Name of Product: P7IVX
Plan Phone #: 1-800-Cigna24
Plan 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 PLAN WEBSITE 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	None	None
Orthodontia	None	None

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan 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 plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	Not applicable	Not applicable
Lifetime Annual Maximum for Orthodontia	Not applicable	Not applicable

- **Annual maximum** is the maximum dollar amount your plan 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 plan 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 or services for all or certain dental treatments. **Your dental benefit package has no waiting periods for covered services, once you are enrolled.**

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 Patient Charge Schedule and your Plan Booklet.
Oral Exam	Preventive & Diagnostic	$0	Not Covered	Oral evaluations are limited to a combined total of 4 comprehensive or periodic evaluations during a 12 consecutive month period.
Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	Not applicable

Cleaning	Preventive & Diagnostic	$0	Not Covered	Limited to 2 per year; additional cleanings per year are available at the co-pay listed on your Patient Charge Schedule.
Filling	Basic	$0	Not Covered	Not applicable
Extraction, Erupted Tooth or Exposed Root	Basic	$6	Not Covered	Not applicable
Root Canal	Basic	$305	Not Covered	Not applicable
Scaling and Root Planing	Basic	$50	Not Covered	Limited to 4 quadrants per consecutive 12 months
Ceramic Crown	Major	$285	Not Covered	Porcelain/ceramic substrate crowns on molar teeth are not covered.
Removable Partial Denture	Major	$240	Not Covered	Not applicable
Extraction, Erupted Tooth with Bone Removal	Basic	$40	Not Covered	Not applicable
Orthodontia	Orthodontia	$1,608	Not Covered	Co-pay reflects twenty-four (24) months of active child comprehensive treatment. Cases beyond 24 months require an additional payment by the patient.

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 product to other dental products 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 (full-mouth x-ray) 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 Covered	Deductible	In-network: Not applicable Out-of-network: Not Covered	Deductible	In-network: Not applicable Out-of-network: Not Covered
Annual Maximum (Plan Will Pay	In-network: Not applicable Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: Not applicable Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: Not applicable Out-of-network: Not applicable

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: $550	Patient Cost (copayment or coinsurance)	In-network: $70 Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: $285 Out-of-network: $1,750
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $70 **Out-of-network:** $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $285 **Out-of-network:** $1,750

Summary of what is not covered or subject to a limitation:	Oral evaluations are limited to a combined total of 4 comprehensive or periodic evaluations during a 12 consecutive month period. A complete series of full mouth X-rays are limited to 1 every 3 years. Cleanings are limited to 2 per year; additional cleanings per year are available at the co-pay listed on your Patient Charge Schedule.	Summary of what is not covered or subject to a limitation:	Not Applicable	Summary of what is not covered or subject to a limitation:	Porcelain/ceramic substrate crowns on molar teeth are not covered.