Individual and Family Plans
Insured by Cigna Health and Life Insurance Company

All States – except MD & NY.
For MD & NY see state-specific versions.

SUMMARY OF BENEFITS PLAN INFORMATION

Cigna Dental 1500 Plan

With Cigna there is more to smile about.

You get flexible benefits and premium levels to meet your needs and budget, plus:

- Access to the Cigna DPPO Advantage Network with 89,000+ dentists at more than 300,000 locations across the U.S.[1]
- No referral needed to see a specialist
- 15% discount on monthly premiums for any additional eligible dependents[2] on the plan
- Available for all ages, including those 65 and older
- No application or processing fees
- Waiting periods may be waived for select procedures if you have had prior similar dental coverage[3]
- No need to submit claims when you use a Cigna DPPO Advantage Network provider
- 24/7/365 customer service
- Online access with **myCigna.com**®. You can view bills and claims online, anytime – and make a payment, too
- Mobile access on the go. Find a dentist, check coverage and show your ID card with the myCigna® App[4]

You have freedom.

You are free to choose a provider from our large national network or one from outside the network. Keep in mind, you'll save the most if you visit a Cigna DPPO Advantage Network provider. Find providers in our network at **Cigna.com/ifp-providers**.

In the chart below, you can see how your savings may be greater when visiting a **Cigna DPPO Advantage Network** provider with a **Cigna Dental 1500 Plan** compared with your other options.

		SAMPLE OUT-OF-POCKET COSTS		
PROCEDURE	CLASS CATEGORY	CIGNA DPPO ADVANTAGE NETWORK[5]	OUT-OF-NETWORK[5]	WITHOUT DENTAL INSURANCE[6]
Cleaning (Adult Prophy) – D1110	Class I (preventive)	$0	$66	$109
Filling (2 Surfaces) – D2392	Class II (basic)	$28	$175	$255
Crown (Porcelain & High Noble Metal) – D2750	Class III (major)	$357	$1,032	$1,283
Orthodontics (Braces) – D8080	Class IV (orthodontia)	$2,842	$5,909	$6,909

If you have a different plan, services may not be covered and discounts may vary. Chart is estimated; benefits may vary by provider and location. Out-of-network expenses may be higher in North Carolina and lower in Alaska and Massachusetts.

1. Cigna internal data as of May 2022. Subject to change.
2. For each additional eligible dependent, as defined by the policy, added to a primary policy, a 15% discount is applied to the standard rate. Discount is applied in the quote tool.
3. View Dental Benefit details on page 3 for applicable waiting periods. Waiting Periods for Class II and III will be waived at the individual member level if the application indicates that there was 12 months or more of prior dental coverage which included coverage for Class III, Major Restorative services and not more than 63 days has lapsed between the prior coverage and this plan. Any prior dental insurance plan that did not include Class III services will not count toward waiting period waiver. Waiting periods are waived for Class II and Class III in Maine if under the age of 19. Class IV Orthodontia waiting period cannot be waived.
4. App/online store terms and mobile phone carrier/data charges apply.
5. Estimate based on the national average of a standard Cigna Dental 1500 plan; subject to deductible and coinsurance (as applicable), results in specific states may vary. If you visit an out-of-network provider, you are responsible for the difference in the amount that Cigna reimburses (i.e., Contracted Fee) for such services and the amount charged by the dentist.
6. Estimates based on 2021 Cigna Dental internal claims data, projected to 2022.

Together, all the way.®

Cigna®

Cigna Dental Plans

Dental Terms

Below you will find easy-to-understand definitions for commonly used words.

Actual Billed Charges: The fee that a provider charges a patient who does not have dental insurance. If a patient has dental insurance and visits a Cigna DPPO Advantage Network provider, the provider charges the negotiated rate/contracted fee.

Balance Billing: When an out-of-network provider bills you for the difference between the charges for a service, and what Cigna will pay for that service after coinsurance and Contracted Fee (CF), or Maximum Reimbursable Charge (MRC) in AK and MA, have been applied. For example, an out-of-network provider may charge $100 to fill a cavity. If CF is $50 for that service and the coinsurance is 50%, Cigna will pay $25 and you will pay $25. Because you are visiting an out-of-network provider, the provider may bill you the remaining $50; thus, your total out-of-pocket cost will be $75. These charges are separate from any applicable deductible and coinsurance.

Calendar Year Deductible: The dollar amount you must pay each year for eligible dental expenses before the insurance begins paying for basic and major restorative care services, if covered by your plan.

Calendar Year Maximum: The most your plan will pay during a calendar year (12-month period beginning each January 1). You'll need to pay 100% out of pocket for any services after you reach your calendar year maximum. This typically applies to Class I, II, and III.

Cigna DPPO Advantage Network: Dentists who have contracted with Cigna and agreed to accept a predetermined contracted fee for the services provided to Cigna customers. Visiting a provider in this network means you'll save the most money, because the fee is discounted.

Coinsurance: Your share of the cost of a covered dental service (a percentage amount). You pay coinsurance plus any deductible amount not met yet for that calendar year. For example, if you go to the dentist and your visit costs $200, the dentist sends a claim to Cigna. If you have already met your annual deductible amount, Cigna may pay 80% ($160) and you will pay a coinsurance of 20% ($40).

Contracted Fee (CF): The most Cigna will pay a dentist for a covered service or procedure for out-of-network dental care that is based on a basic Cigna DPPO Advantage fee schedule within a specified area. See example provided under Balance Billing.

Lifetime Maximum: The most your plan will pay during your lifetime. You'll need to pay 100% out of pocket for any services after you reach your lifetime maximum. A lifetime maximum typically applies to Class IV Orthodontia services. (Applicable to Cigna Dental 1500 plan.)

Lifetime Orthodontia Deductible: The dollar amount you must pay once in your lifetime for eligible dental expenses before the insurance plan begins paying for Orthodontia, if covered by your plan.

Maximum Reimbursable Charge (MRC) – *applies in AK and MA only:* Also referred to as U&C, R&C and UCR. The most Cigna will pay a dentist for a covered service or procedure for out-of-network dental care. Normally applies as a percentile, based on the published prevailing HealthCare charges designated by zip code data. See example provided under Balance Billing.

Non-participating Providers (Out-of-network): Providers who have not contracted with Cigna to offer you savings. They charge their own fees. Covered expenses for Non-participating Providers are based on the Contracted Fee, which may be less than Actual Billed Charges. Non-participating Providers can bill you for amounts exceeding covered expenses.

Waiting Period: The amount of time that you must be enrolled in the plan before certain benefits are payable. Waiting periods may vary by state. You may be eligible to waive the waiting period for Classes II & III if you have a continuous 12 months of prior coverage from a valid dental insurance plan which included Class III, Major Restorative services, and not more than 63 days has lapsed between the prior coverage and this plan. Any prior dental insurance plan that did not include Class III services will not count toward waiting period waiver. Class IV Orthodontia waiting period cannot be waived. Waiting periods are waived for Class II and Class III in Maine if under the age of 19.

Cigna Dental Plans

DENTAL BENEFIT	Cigna Dental 1500 Plan	
	CIGNA DPPO ADVANTAGE NETWORK	**OUT-OF-NETWORK** Your out-of-pocket expenses will be higher; these providers have not agreed to offer Cigna customers our contracted or discounted fees. Example provided on page 1.
Individual Calendar Year Deductible	$50 per person	
Family Calendar Year Deductible	$150 per family	
Calendar Year Maximum (For Class I, II, and III services)	$1,500 per person	
Lifetime Orthodontia Deductible	$50 per person	
Lifetime Orthodontia Maximum	$1,000 per person	
Payment Levels	Based on provider's **contracted fees**	Based on provider's **actual billed charges** and the **contracted fee**[1]
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES	
Preventive/Diagnostic Services Waiting Period	None	
Preventive/Diagnostic Services Oral Exams, Routine Cleanings, Routine X-Rays, Sealants, Fluoride Treatment, Space Maintainers (non-orthodontic)	You pay $0 (No charge)	You pay the difference between the provider's **actual billed charges** and **100%**/in **NC 95%, of the contracted fee**[1]
	CLASS II: BASIC RESTORATIVE SERVICES	
Basic Restorative Services Waiting Period	6-month waiting period[2]	
Basic Restorative Services Nonroutine X-Rays, Fillings, Routine Tooth Extraction, Emergency Treatment	You pay 20% of the provider's **contracted fee** (after deductible)	You pay the difference between the provider's **actual billed charges** and **80%**/in **NC 75%, of the contracted fee**[1] (after deductible)
	CLASS III: MAJOR RESTORATIVE SERVICES	
Major Restorative Services Waiting Period	12-month waiting period[2]	
Major Restorative Services Periodontal (Deep Cleaning), Periodontal Maintenance, Crowns, Root Canal Therapy, Extraction of Impacted Tooth, Complex Tooth Extraction, Dentures/Partials, Bridges	You pay 50% of the provider's **contracted fee** (after deductible)	You pay the difference between the provider's **actual billed charges** and **50%**/in **NC 45%, of the contracted fee**[1] (after deductible)
	CLASS IV: ORTHODONTIA	
Orthodontia Waiting Period	12-month waiting period[2]	
Orthodontia	You pay 50% of the provider's **contracted fee** (after separate lifetime deductible)	You pay the difference between the provider's **actual billed charges** and **50% of the contracted fee**[1] (after separate lifetime deductible)

This summary contains highlights only. For additional plan information, including out-of-network benefits, please refer to the Policy for details.

1. If you choose to visit a dentist out-of-network, you will pay the out-of-network benefit and the difference between the amount that Cigna reimburses for such services (CF), or MRC in AK and MA and the amount charged by the dentist, except for emergency services as defined in the policy. This is known as balance billing. See the definitions for Contracted Fee (CF), Maximum Reimbursable Charge (MRC; applies in AK and MA only) and Balance Billing on the previous page. Refer to the policy for more details.
2. Waiting periods may vary by state. Refer to the policy for more details. You may be eligible to waive the waiting period for Classes II & III if you had 12 continuous months of prior coverage from a valid dental insurance plan which included coverage for Class III, Major Restorative services. Any prior dental insurance plan that did not include Class III services will not count toward waiting period waiver. The previous plan's termination date must be within 63 days of the start date of this Cigna plan. Waiting periods are waived for Class II and Class III in Maine if under the age of 19. Class IV Orthodontia waiting period cannot be waived.

Cigna Dental Plans

	Cigna Dental 1500 Plan
PROCEDURE	**FREQUENCY/LIMITATION**
Oral Exams	1 per person per consecutive 6-month period
Routine Cleanings	1 routine prophylaxis or periodontal maintenance procedure per person per consecutive 6-month period (routine prophylaxis falls under Class I; periodontal maintenance procedure falls under Class III)
Routine X-Rays	Bitewings: 1 set in any consecutive 12-month period. Limited to a maximum of 4 films per set
Sealants	1 treatment per tooth per lifetime. Payable on unrestored permanent bicuspid or molar teeth for participants less than age 14
Fluoride Treatment	1 per consecutive 12-month period for participants less than age 14
Space Maintainers (non-orthodontic)	Limited to non-orthodontic treatment for prematurely removed or missing teeth for participants less than age 14
Nonroutine X-Rays	Full mouth or Panorex: 1 per consecutive 60-month period
Fillings	1 per tooth per consecutive 12-month period (applies to replacement of identical surface fillings only). No white/tooth colored fillings on bicuspid or molar teeth
Periodontal (Deep Cleaning)	1 per quadrant per consecutive 36-month period
Periodontal Maintenance	Payable only if a consecutive 6-month period has passed since the completion of active periodontal surgery. 1 periodontal maintenance or routine prophylaxis procedure per person per consecutive 6-month period (periodontal maintenance procedure is Class III; routine prophylaxis is Class I)
Crowns	1 per tooth per consecutive 84-month period. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crown or bridges. Replacement must be indicated by major decay. For participants less than age 16, benefits limited to resin or stainless steel
Root Canal Therapy	Re-treatment of a previous root canal is covered if 24 consecutive months have passed since the original root canal
Dentures and Partials	1 per arch per consecutive 84-month period
Bridges	1 per consecutive 84-month period. Benefits will be considered for the initial replacement of a necessary functioning natural tooth extracted while the person was covered under this plan
Orthodontia	The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia lifetime maximum
Missing Teeth Limitation	There is no coverage for replacement of teeth that are missing prior to coverage. In FL, LA, OH, VA, and VT, payment limitation no longer applies after 12 months of continuous coverage. In NM, payment limitation no longer applies after 6 months of continuous coverage.

This summary contains highlights only. Please refer to the Covered Expenses section of the Policy for details.

Cigna Dental Plans

PLAN EXCLUSIONS AND LIMITATIONS

What is not covered by this plan
Excluded services

Covered expenses do not include expenses incurred for:

- Procedures which are not included in the policy.
- Procedures which are not necessary and which do not have uniform professional endorsement.
- Procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- Replacement of teeth that are missing prior to coverage. In, FL, LA, OH, VA, and VT, payment limitation no longer applies after 12 months of continuous coverage. In NM, payment limitation no longer applies after 6 months of continuous coverage.
- Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- Procedures, appliances or restorations whose main purpose is to diagnose or treat dysfunction of the temporomandibular joint (Services are covered in AR, MN, NM, NV, and VT).
- The alteration or restoration of occlusion.
- The restoration of teeth which have been damaged by erosion, attrition or abrasion.
- Bite registration or bite analysis.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance). However, for dependent children, benefits will include coverage of an injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including cleft lip and cleft palate. Benefits are the same for congenital defects or anomalies, including individuals born with cleft lip or cleft palate, as are provided for other dental conditions that are covered by the plan.
- Any procedure, service or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- The initial placement of a fixed bridge, unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. If a bridge replaces teeth that were missing prior to the date the person's coverage became effective and also teeth that are extracted after the person's effective date, benefits are payable only for the pontics replacing those teeth which are extracted while the person was insured under this plan. The removal of only a permanent third molar will not qualify a fixed bridge for benefit under this provision.
- The surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.
- Core build-ups.
- Replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or
  - The partial denture is less than 84 consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional necessary extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- The replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying natural tooth.
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- Replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- Replacement of lost or stolen appliances.
- Replacement of teeth beyond the normal complement of 32.
- Prescription drugs.
- Any procedure, service, supply or appliance used primarily for the purpose of splinting.
- Athletic mouth guards.
- Myofunctional therapy.
- Precision or semi-precision attachments.
- Denture duplication.
- Separate charges for acid etch.
- Labial veneers (laminate).
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old.
- Treatment of jaw fractures and orthognathic surgery.
- Orthodontic treatment. Exclusion does not apply if the plan otherwise covers services for orthodontic treatment.

Cigna Dental Plans

PLAN EXCLUSIONS AND LIMITATIONS

- Charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- Charges for travel time; transportation costs.
- Temporary, transitional or interim dental services.
- Any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least three years, as determined by Cigna.
- Diagnostic casts, diagnostic models or study models.
- Any charge for any treatment performed outside of the United States other than for emergency treatment (any benefits for emergency treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period).
- Oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (water pick, toothbrush, floss holder); duplication of x-rays and exams required by a third party.
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- Services that are deemed to be medical services.
- Services for which benefits are not payable according to the "General Limitations" section.

General Limitations

No payment will be made for expenses incurred for you or any one of your dependents:

- For services not specifically listed as covered services in the policy.
- For services or supplies that are not dentally necessary.
- For services received before the start date of coverage.
- For services received after coverage under this policy ends.
- For services for which you have no legal obligation to pay or for which no charge would be made if you did not have dental insurance coverage.
- For professional services or supplies received or purchased directly or on your behalf by anyone, including a dentist from any of the following.
  - Yourself or your employer.
  - A person who lives in the insured person's home, or that person's employer.
  - A person who is related to the insured person by blood, marriage or adoption, or that person's employer.
- Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- For or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.
- For or in connection with a sickness which is covered under any workers' compensation or similar law.
- For charges made by a hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected condition.
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- To the extent that billed charges exceed the rate of reimbursement as described in the schedule.
- For charges for unnecessary care, treatment or surgery.
- To the extent that you or any of your dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- Charges for or in connection with experimental procedures or treatment methods. In determining whether services are experimental, Cigna in consultation with a dental consultant, will consider if such services: (a) are approved by the American Dental Association or the appropriate dental specialty society; (b) are in general use in the medical/dental field in the state of Washington (WA residents only); (c) are under continued scientific testing and research; (d) have shown a demonstrable benefit for a particular dental condition or disease; and (e) are proven to be safe and effective.
- 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 will take into account any adjustment option chosen under such part by you or any one of your dependents.

Individual and Family Plans
Insured by Cigna Health and Life Insurance Company

All States – except MD & NY.
For MD & NY see state specific versions.

Cigna Dental Plans

PLAN IMPORTANT DISCLOSURES

Cigna Dental insurance coverage shall be only for the classes of service referred to in The Schedule of a purchased plan.

Dental plans are insured by Cigna Health and Life Insurance Company with network management services provided by Cigna Dental Health, Inc. Rates may vary based on age, family size, geographic location (residential zip code) and plan design.

Rates are subject to change upon 30 days' prior notice in AK, AL, AR, AZ, CO, CT, DC, DE, HI, IA, ID, IL, IN, KS, KY, MA, ME, MI, MN, MO, MT, ND, NE, NH, NJ, NM, OH, OK, OR, PA, RI, SD, TN, UT, VT, WI and WY, 31 days' prior notice in SC, 45 days' prior notice in FL, 75 days' prior notice in MS, and 60 days' prior notice in CA, GA, NV, TX, VA and WV. In LA rates are guaranteed for the initial 12-months of coverage, except if due to addition of a newly covered person, a change in age or geographic location, or a change in policy coverage. Thereafter, rates are subject to change upon 45 days' prior notice. In NC, dental rates are guaranteed for a 12-month period. **Dental plans apply waiting periods to covered basic (6-months), major (12-months) and orthodontic (12-months) dental care services.** In ME, waiting periods are waived for Class II and Class III if under the age of 19. Waiting periods may vary by state. Refer to the policy or outline of coverage for details. Class IV Orthodontia waiting period cannot be waived. **Dental plans do not apply waiting periods to covered preventive/diagnostic services and temporomandibular joint services in AR, NM, NV, MN and VT.** Some covered services are determined by age: topical application of fluoride or sealant, space maintainers, and materials for crowns and bridges. **If the plan covers replacement of teeth, there is no payment for replacement of teeth that are missing prior to coverage.** In FL, LA, OH, VA and VT, payment limitation no longer applies after 12 months of continuous coverage. In NM, payment limitation no longer applies after 6 months of continuous coverage.

Notice to Buyer: This policy provides dental coverage only. Review your policy carefully.

Dental preferred provider insurance policies (AL, CO, CT, DE, HI, IA, IL, MI, ND, PA, WV and WY: HC-NOT11 et al., AK: HC-NOT53, et al., AR: HC-NOT36 et al., AZ: INDDENTPOLAZ032017, CA: INDDENTPOLCA0713 et al., DC: HC-NOT42, et al., FL: HC-NOT15 et al., GA: INDDENPOLGA0317, ID: HC-NOT51 et al., IN: HC-NOT23, et al., KS: HC-NOT49 et al., KY: HC-NOT44, et al., LA: INDDENTPOLLA0713, HC-NOT32 et al., MA: HC-NOT11 et al. ME: HC-NOT58, et al., MI: INDENTPOLAMI042021.1500, MO: INDDENTPOLMO0713, MN: INDDENTPOLMN0713, MS: HC-NOT48 et al., MT: INDDENTPOLMT0713, NC: HC-NOT18, et al., NE HC-NOT47 et al., NH: INDDENTPOLNH.1500, NJ: HC-NOT46, et al., NM: INDDENPOLNM0317, NV: HC-NOT39 et al., OH: INDDENTPOLOH0317, OK: HC-NOT26 et al., OR: INDDENTPOLOR0713, RI HC-NOT35 et al., SC: HC-NOT19 et al., SD HC-NOT59 et al., TN: HC-NOT20 et al., TX: HC-NOT21 et al., UT: HC-NOT50 et al., VA: INDDENTPOLVA0317, VT HC-NOT56 et al., WA: INDDENTPOLWA0317, WI HC-NOT54 et al.) have exclusions, limitations, reduction of benefits and terms under which a policy may be continued in force or discontinued.

The policy may be cancelled by Cigna due to failure to pay premium, fraud (in VA, any act, practice or omission that constitutes fraud), ineligibility, when the insured no longer lives in the service area, or if we cease to offer policies of this type or any individual dental plans in this state, in accordance with applicable law. You may cancel the policy on the first of the month following our receipt of your written notice. In VA, you may cancel the policy on the date or our receipt of your written cancelation notice, unless otherwise stated. We reserve the right to modify this policy, including policy provisions, benefits and coverages, consistent with state or federal law. This individual plan is renewable monthly or quarterly.

For costs, and additional details about coverage, contact Cigna Health and Life Insurance Company at 900 Cottage Grove Rd, Hartford, CT 06152 or call **866.GET.Cigna (866.438.2446)**.

Please contact your insurance carrier, agent/producer, or the Health Insurance Marketplace if you wish to purchase PPACA-compliant pediatric dental coverage.

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