SUMMARY OF BENEFITS 2022 PLAN INFORMATION

Cigna Dental Insurance

The Cigna Pediatric plan is available for purchase on the Health Insurance Marketplace in Arizona, Florida, and Tennessee for individuals up to age 20.[1]

The plan is included with the purchase of a medical plan off Marketplace and covers individuals up to age 19.[2]

DENTAL BENEFIT	Cigna Dental Pediatric Plan	
	CIGNA DPPO ADVANTAGE NETWORK Offers the most savings, 39%[3] national average.	**OUT-OF-NETWORK** Providers charge standard fees Out-of-pocket expenses may be higher; these providers do not offer Cigna customers our contracted or discounted fees.
Individual Calendar Year Deductible	$150 per person	
Family Calendar Year Deductible	$300 per family	
Calendar Year Out-of-Pocket Maximum	$375 per person/$750 per family	
Payment levels	Based on provider's **contracted fees**	Based on provider's **standard fees and MAC** (Maximum Allowable Charge)
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES	
Preventive/Diagnostic Services Waiting Period	Not applicable	
Preventive/Diagnostic Services Routine Cleanings, Oral Exam, Routine X-Rays, Nonroutine X-Rays, Sealants, Fluoride Treatment, Space Maintainers (non-orthodontic), Emergency Treatment	You pay $0	You pay the difference between the provier's **standard fee** and **100% / in NC 95%, of the MAC**[4]
	CLASS II: BASIC RESTORATIVE SERVICES	
Basic Restorative Services Waiting Period	Not applicable	
Basic Restorative Services Fillings, Routine Tooth Extraction, Wisdom Tooth Extraction, Periodontal (Deep Cleaning), Periodontal Maintenance	You pay 50% of the provider's **contracted fee** (after deductible)	You pay the difference between the provider's **standard fee** and **50% / in NC 45%, of the MAC**[4] (after deductible)
	CLASS III: MAJOR RESTORATIVE SERVICES	
Major Restorative Services Waiting Period	Not applicable	
Major Restorative Services Root Canal Therapy, Crowns	You pay 50% of the provider's **contracted fee** (after deductible)	You pay the difference between the provider's **standard fee** and **50% / in NC 45%, of the MAC**[4] (after deductible)
	CLASS IV: ORTHODONTIA	
Orthodontia Waiting Period	Not applicable	
Orthodontia (Medically/dentally necessary)	You pay 50% of the provider's **contracted fee** (after deductible)	You pay the difference between the provider's **standard fee** and **50% / in NC 45%, of the MAC**[4] (after deductible)

This summary contains highlights only.
If you choose to visit a dentist out-of-network, you will pay the out-of-network benefit and the difference in the amount that Cigna reimburses for such services and the amount charged by the dentist, except for emergency services.[5] This is known as balance billing.

1. Pediatric coverage may continue through the end of the calendar year in which the individual turns age 21.
2. Pediatric coverage may continue through the end of the calendar year in which the individual turns age 19.
3. Based upon 1/1/2018–12/31/2018 National Average Charges projected by Cigna Dental to 7/1/2019. Fees vary by region
4. In North Carolina, Out of Network coverage is 95% of the MAC for Class I and 45% of the MAC for Classes II, III and IV.
5. Emergency services as defined by your plan

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Cigna Dental Plans

PROCEDURE	Cigna Dental Pediatric FREQUENCY/LIMITATION
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES
Routine Cleanings	1 per consecutive 6 month period
Oral Exams	1 per consecutive 6 month period
Routine X-Rays	Bitewings: 1 set in any consecutive 6 month period
Nonroutine X-Rays	Full mouth or Panorex: 1 per consecutive 60 month period
Sealants	1 treatment per tooth per consecutive 36 month period. Payable on unrestored permanent molar teeth only
Fluoride Treatment	2 per 12 consecutive month period.
Space Maintainers (non-orthodontic)	Limited to non-orthodontic treatment for prematurely removed or missing teeth
Emergency Treatment	Paid as a separate benefit only if no other service, except x-rays, is rendered during the visit
	CLASS II: BASIC RESTORATIVE SERVICES
Fillings	No limitation
Routine Tooth Extraction	Includes an allowance for local anesthesia and routine postoperative care
Wisdom Tooth Extraction	Includes an allowance for local anesthesia and routine postoperative care
Periodontal Deep Cleaning	1 per consecutive 24 month period
Periodontal Maintenance	No limitation
	CLASS III: MAJOR RESTORATIVE SERVICES
Root Canal Therapy	1 per tooth per lifetime; applies to primary ("baby") teeth only
Crowns	1 per tooth per consecutive 60 month period. Replacement must be indicated by inability to restore by an amalgam or composite filling due to major decay or a fracture
	CLASS IV: ORTHODONTIA
Orthodontia (Medically/dentally necessary)	No limitation

This summary contains highlights only.

Cigna Dental Pediatric Plan

2022 PLAN EXCLUSIONS AND LIMITATIONS

What Is Not Covered By This Plan
Excluded Services

Covered expenses do not include expenses incurred for:

- Procedures and services which are not included in the list of "Covered Dental Expenses" 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.
- 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.
  NC Only: 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. the initial placement of an implant unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify an implant for benefit under this provision. Except in cases where it is Dentally Necessary.
- 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.
- 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.
- Orthodontic treatment, except in cases where it is medically/dentally necessary.
- 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 or professional advice given on the phone.
- 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 3 years, as determined by Cigna.
- Any charge for any treatment performed outside of the United States other than for emergency treatment.
- Oral hygiene and diet instruction, broken appointments, completion of claim forms, personal supplies (water pick, toothbrush, floss holder, etc.), 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 or supplies that are not medically/dentally necessary.
- For services received before the effective 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, except a licensed 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 (not applicable in AZ).
- 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.
  NC Only: 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 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 (not applicable in FL).
- 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 is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Any service under both a medical plan and this dental plan and reimbursed under the medical plan will not be reimbursed under this Plan.
- Procedures that are a covered expense under any other dental plan which provides dental benefits (not applicable in AZ).
- 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. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

Cigna Dental Plans

CIGNA DENTAL TERMS

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

Cigna DPPO Advantage Network: Dentists that 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.

Out-of-Network: Providers who have not contracted with Cigna to offer you savings. They charge their own standard fees.

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 MAC have been applied. For example, an out-of-network provider may charge $100 to fill a cavity. If Maximum Allowable Charge is $50 for that service and the coinsurance is 50%, assuming the calendar year deductible has already been met, 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 could be $75. Balance billing charges are separate from any applicable deductible and coinsurance.

Calendar Year Out-of-Pocket Maximum: The most you will pay for covered services during a calendar year (12-month period beginning each January 1st). You will no longer have to pay any Coinsurance for covered dental services for the remainder of that year once you reach your calendar year out-of-pocket maximum.

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).

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

Maximum Allowable Charge (MAC): 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.

Standard Fee: The fee that a provider charges to a patient for a service who does not have dental insurance. If a patient has dental insurance and visits a Cigna DPPO Advantage provider, the provider charges the negotiated rate/contracted fee for covered services.

Contracted Fee: The fee to be charged for a service that Cigna has negotiated with a contracted provider on your behalf.

2022 IMPORTANT PLAN DISCLOSURES

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, number of enrolled dependents, geographic location (residential zip code), and plan design.

Rates are subject to change upon 30 days prior notice in Arizona, Missouri, and Tennessee, and 45 days prior notice in Florida. In NC, dental rates are guaranteed for a 12-month period.

Waiting periods do not apply.

Dental preferred provider insurance policies (INDDENPEDI.AZ.2, INDDENPEDI.FL.2, INDDENPEDI.NC.2, INDDENPEDI.MO.2, INDDENPEDI.TN.2) have exclusions, limitations, reduction of benefits and terms under which policies may be continued in force or discontinued. The policy may be cancelled by Cigna due to failure to pay premium, 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 the state, in accordance with applicable law. You may cancel the policy, on the first of the month following our receipt of your written notice. We reserve the right to modify the policy, including policy provisions, benefits and coverages, consistent with state or federal law. The policy renews on a calendar year basis.

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

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).

Health Insurance Marketplace

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