Summary of Benefits
2027 Insurance Plan Information

Cigna Healthcare Dental Insurance

The Cigna Healthcare® Dental Pediatric Plan is available for purchase on the Health Insurance Marketplace in North Carolina for individuals up to age 19.

Dental Benefit	CIGNA HEALTHCARE DENTAL PEDIATRIC PLAN	
	Advantage Network	**Out-of-network*** Out-of-pocket expenses may be higher; these providers do not offer Cigna Healthcare 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	$450 per person/$900 per family	
Payment levels	Based on provider's contracted fees for covered services	Based on provider's actual billed charges and the contracted fee
Class I: Preventive/Diagnostic services		
Preventive/diagnostic services Routine cleanings, oral Exams, routine X-Rays, nonroutine X-Rays, sealants, fluoride treatment, space maintainers (non-orthodontic), emergency treatment	You pay $0.	You pay the difference between the provider's actual billed charges and 100% of the contracted fee.
Class II: Basic Restorative Services		
Basic restorative services Fillings, Routine Tooth Extraction, Wisdom Tooth Extraction	You pay 50% of the provider's contracted fee (after deductible).	You pay the difference between the provider's actual billed charges and 50% of the contracted fee (after deductible).
Class III: Major Restorative Services		
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 actual billed charges and 50% of the contracted fee (after deductible).
Class IV: Orthodontia		
Orthodontia (medically/dentally necessary)	You pay 50% of the provider's contracted fee if approved as medically necessary for cleft palate or cleft lip (after deductible).	You pay the difference between the provider's actual billed charges and 50% of the provider's contracted fee if approved as medically necessary for cleft palate or cleft lip (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 Healthcare reimburses for such services (contracted fee) and the amount charged by the dentist (actual billed charged), except for emergency services.[2] This is known as balance billing. See Cigna Healthcare Dental terms on the last page for actual billed charges, balance billing and contracted fee.

1. Pediatric coverage may continue through the end of the calendar year in which the individual turns 19.
2. Emergency services as defined by your plan.

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Procedure	CIGNA HEALTHCARE DENTAL PEDIATRIC PLAN Frequency/Limitation
	Class I: Preventive/Diagnostic services
Routine cleanings	I per consecutive 6-month period
Oral exams	I per consecutive 6-month period
Routine X-Rays	Bitewings: I set in any consecutive 6-month period
Nonroutine X-Rays	Full mouth or Panorex: I per consecutive 60-month period
Sealants	I treatment per tooth per consecutive 36-month period; payable on unrestored permanent molar teeth only
Fluoride treatment	2 per consecutive 12-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	I per consecutive 24-month period
Periodontal maintenance	No limitation
	Class III: Major Restorative Services
Root canal therapy	I per tooth per lifetime; applies to primary ("baby") teeth only
Crowns	I 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.

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2027 Plan Exclusions

Excluded Services

Covered Expenses do not include expenses incurred for:

- procedures and services which are not included in the list of "Covered Dental Expenses".
- 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.
- 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, including the correction of occlusion (malocclusion) caused by the congenital defect or birth anomaly. 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 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 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 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 or transportation costs.
- temporary, transitional or interim dental services.
- 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 (e.g., 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 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, including a Dentist, from any of the following:
  - o Yourself or Your employer;
  - o a person who lives in the Insured Person's home, or that person's employer;
  - o 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 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;
- for charges which the person is not legally required to pay;
- for charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule, except in the case of Emergency Services;
- 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 services covered under both a medical plan and this dental plan and reimbursed under the medical plan will not be reimbursed under this Plan.

– Yourself or your employer.

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Cigna Healthcare Dental terms

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

Actual billed charges: The fee that a provider charges a patient who does not have dental insurance for a service. If a patient has dental insurance and visits an Advantage provider, the provider charges the negotiated rate/contracted fee for covered services.

Balance billing: When an out-of-network provider bills you for the difference between the charges for a service and what Cigna Healthcare will pay for that service after coinsurance and the contracted fee have been applied. For example, an out-of-network provider may charge $100 to fill a cavity. If the contracted fee is $50 for that service and the coinsurance is 50%, assuming the calendar-year deductible has already been met, Cigna Healthcare 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 deductible: The dollar amount you must pay each year for eligible dental expenses before the insurance begins paying for basic and major and restorative care services and orthodontia, if covered by your plan.

Calendar-year out-of-pocket maximum: The most you will pay for covered services during a calendar year (12-month period beginning each January 1). 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.

Advantage network: A network made up of dentists who have contracted with Cigna Healthcare and agreed to accept a predetermined contracted fee for the services provided to Cigna Healthcare 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 Healthcare. If you have already met your annual deductible amount, Cigna Healthcare may pay 80% ($160) and you will pay a coinsurance of 20% ($40).

Contracted fee: The fee to be charged for a service that Cigna Healthcare has negotiated with a contracted provider on your behalf. The most Cigna Healthcare will pay a dentist for a covered service or procedure for out-of-network dental care is based on a basic Advantage fee schedule within a specified area. See example provided under balance billing.

Out-of-network providers: Providers who have not contracted with Cigna Healthcare to offer you savings. They charge their own standard fees, also referred to as actual billed charges.

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2027 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 45 days' prior notice in North Carolina.

Waiting periods do not apply.

Dental preferred provider insurance policy (NDDENPEDI.NC.05.2026) has exclusions, limitations, reduction of benefits and terms under which policies may be continued in force or discontinued. The policy may be cancelled by Cigna Healthcare due to failure to pay premium, fraud, or 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, and the cancellation will take effect 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 866.GET.Cigna (866.438.2446).

Health Insurance Marketplace

Product availability may vary by location and plan type and is subject to change. All dental insurance policies contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, or Cigna Dental Health Inc.

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