

Cigna Health and Life Insurance Company (“Cigna”)

Individual Services
P. O. Box 30365
Tampa, FL 33630
1.800.Cigna24 (1.800.244.6224)

Cigna Dental Pediatric

POLICY FORM NUMBER: INDDENPEDI.IL.3

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Cigna Health and Life Insurance Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Coverage is provided by Cigna Health and Life Insurance Company (referred to herein as “Cigna”), an insurance company that provides Participating Provider benefits.

To **obtain additional information**, including Provider information write to the following address or call the toll-free number:

Cigna
Individual Services – Illinois
P. O. Box 30365
Tampa, FL 33630
1.800.Cigna24 (1.800.244.6224)

A **Participating Provider Plan** enables the Insured to incur lower dental costs by using Providers in the Cigna network.

A **Participating Provider - Cigna Dental Preferred Provider** is a Dentist or a professional corporation, professional association, partnership, or any other entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services at predetermined fees with regard to a particular Policy under which an Insured Person is covered. The Providers qualifying as Participating Providers may change from time to time.

Participating Providers

We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new Provider listing for any other reason, please call Cigna at 1.800.Cigna24 (1.800.244.6224) and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.

A **Non-Participating Provider** (Out of Network Provider) is a Provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. 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.

Insured’s Financial Responsibility

The Insured is responsible for paying the monthly premium on a timely basis. The Insured is also responsible to pay Providers for charges that are applied to the Deductibles, Coinsurance, Additional Deductibles, Penalties and any amounts charged by Non-Participating Providers in excess of the Contracted Fee. In addition, any charges for Dentally Necessary items that are excluded under the Policy are the responsibility of the Insured.

PLEASE READ THE FOLLOWING IMPORTANT NOTICES

This Dental Plan offers the full range of Essential Health Benefit Pediatric Oral Care and satisfies the requirements under the Affordable Care Act.

NOTE: The Cigna Dental Pediatric Benefits sections of this Policy are available to Insured Persons up to the age of 19.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a Non-Participating Provider for a covered service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional Providers and information on out-of-pocket expenses by calling 1.800.Cigna24 (1.800.244.6224).

Benefit Schedule

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.:

Benefit	Participating Providers	Non-Participating Providers
Calendar Year Maximum: Class I, II, III & IV	None	
Lifetime Maximum: Class IV	None	
Calendar Year Deductible: Class I	None	
Calendar Year Deductible: Class II, III & IV	\$150 per person	
	\$300 per family	
Separate Lifetime Deductible for Class IV	None	
Out of Pocket Maximum: Class I, II, III & IV	\$350 per person	
	\$700 per family	

Benefit	Percentage of Covered Expenses the Plan Pays	
	Participating Providers	Non-Participating Providers
Class I - Preventive/Diagnostic Services	100%	100%
Class II - Basic Restorative Services	50% after Deductible	50% after Deductible
Class III - Major Restorative Services	50% after Deductible	50% after Deductible
Class IV – Medically Necessary Orthodontia	50% after Deductible	50% after Deductible

Covered Services and Benefits

Benefits covered by your Dental Plan include Preventive & Diagnostic Care such as Oral Exams, Cleanings and X-Rays. Your Plan also includes Basic Restorative Care such as fillings and simple extractions. Major Restorative Care is covered under your plan and includes Crowns, Dentures and Bridges. Coverage for Orthodontia is also included under your plan. For a complete listing of covered services, please read your plan documents.

The frequency of certain Covered Services, like cleanings, are limited. Refer to your Policy for specific limitations on frequency under your plan.

Waiting Periods

There are no waiting periods for Class I, II, III or IV.

Predetermination of Benefits Program

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed \$500.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Exclusions And Limitations: What Is Not Covered By This Policy

Expenses Not Covered

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.
- 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.
- procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- 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. Except in cases where it is Dentally Necessary
- 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 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.
- 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:
 - 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.
- 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;
- 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.
- Procedures that are a covered expense under any other dental plan which provides dental benefits
- 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.
- 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.

Renewability, Eligibility, and Continuation

1. The Policy will renew except for the specific events stated in the Policy. Cigna may change the premiums of the Policy with 30 days written notice to the Insured. However, Cigna will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all insured's in the same class and covered under the same Policy as You.
2. The Individual Plan is designed for residents of Illinois who are not enrolled under or covered by any other group or individual health coverage. You must notify Cigna of all changes that may affect any Insured Person's eligibility under the Policy.
3. You or Your Insured Family Member(s) will become ineligible for coverage:
 - When premiums are not paid according to the due dates and grace periods described in the premium section.
 - With respect to Your spouse or domestic partner: when the spouse is no longer married to the Insured.
 - With respect to You and Your Family Member (s): when you no longer meet the requirements listed in the Conditions of Eligibility section;
 - The date the Policy terminates.
 - When the Insured no longer lives in the Service Area.
4. If an Insured Person's eligibility under this Plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. Any waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this Plan.

Premium

The monthly premium amount is listed on the Policy specification page which is sent with the Policy. This monthly premium amount applies to individuals who pay monthly.

You will be responsible for an additional \$45 charge for any check or electronic funds transfer that is returned to Us unpaid.

There is a grace period of 31 days for the receipt at Our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums.

Your premium may change from time to time due to (but not limited to):

- a. Deletion or addition of a new eligible Insured Person(s)
- b. A change in age of any member which results in a higher premium
- c. A change in residence

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium on 30 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.