Cigna Dental Benefit Summary
EP Cares – DPPO
Plan Renewal Date: 01/01/2024

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Benefit Plan Features	***Total Cigna DPPO Network***		***Non-Network***
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: Class I, II & III expenses	$2,000	$1,500	$1,500
Calendar Year Deductible Individual Family	 $50 $150	 $50 $150	 $50 $150
Benefit Highlights	***Plan Pays***	***Plan Pays***	***Plan Pays***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain (Note: This service is administrated at the in network coinsurance level.)	100% No Deductible	80% No Deductible	80% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation	80% After Deductible	60% After Deductible	60% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments	50% After Deductible	40% After Deductible	40% After Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.

Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program®	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.

Benefit Exclusions:

Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Orthodontics: orthodontic treatment;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Reimbursable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

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

A copy of the NH Dental Outline of Coverage is available and can be downloaded at Health Insurance & Medical Forms for Customers | Cigna under Dental Forms.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Cigna Health and Life Insurance Company
Policy Type: DPPO
Effective Date: Beginning on or after 01/01/2024
Plan Name: 3339171 & DPPO
Insurer Phone #: 1-800-Cigna24
Insurer 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 INSURER WEBSITE AT 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	Per individual - $50 / Per family - $150	Per individual - $50 / Per family - $150
Orthodontia	Not Covered	Not Covered

- **The deductible applies to all services except preventive/diagnostic services.**
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer 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 insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	$2,000	$1,500
Lifetime Maximum for Orthodontia	Not Covered	Not Covered

- **Annual maximum** is the maximum dollar amount your policy 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 policy 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 for all or certain dental treatments. **There is no waiting period.**

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 Plan Certificate.
Oral Exam	Preventive & Diagnostic	0%, deductible does not apply	20%, deductible does not apply	Limited to two oral exams per year.
Bitewing X-ray	Preventive & Diagnostic	0%, deductible does not apply	20%, deductible does not apply	Limited to 2 sets per year.
Cleaning	Preventive & Diagnostic	0%, deductible does not apply	20%, deductible does not apply	Limited to 2 per year.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions For complete coverage details, exclusions and limitations, please see your Plan Certificate.
Filling	Basic	20%	40%	Not applicable
Extraction, Erupted Tooth or Exposed Root	Basic	20%	40%	Not applicable
Root Canal	Basic	20%	40%	Not applicable
Scaling and Root Planing	Basic	20%	40%	Not applicable
Ceramic Crown	Major	50%	60%	Replacement is limited to 1 per tooth, per 60 consecutive months.
Removable Partial Denture	Major	50%	60%	Replacement is limited to 1 partial denture per arch per 60 consecutive months.
Extraction, Erupted Tooth with Bone Removal	Basic	20%	40%	Not applicable
Orthodontia	Orthodontia	Not Covered	Not Covered	Not applicable

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 policy to other dental policies 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 (FMX) 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 Applicable	Deductible	In-network: $50 Out-of-network: $50	Deductible	In-network: $50 Out-of-network: $50
Annual Maximum (Plan Will Pay)	In-network: $2,000 Out-of-network: $1,500	Annual Maximum (Plan Will Pay)	In-network: $2,000 Out-of-network: $1,500	Annual Maximum (Plan Will Pay)	In-network: $2,000 Out-of-network: $1,500
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 40%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 60%
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0* **Out-of-network:** $182.00*	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $70.00* **Out-of-network:** $110.00*	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $675.00* **Out-of-network:** $1,136.40*

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Summary of what is not covered or subject to a limitation:	Oral exams and cleanings are limited to 2 per year. A complete series of full mouth X-rays are limited to a combined total of 1 per 36 months. *These Coverage Examples are based on a standard plan which may not reflect your coverages as described in Sections I – V. Please see the applicable Plan Certificate for details. For out-of-network benefits, you may be charged the difference between the amount Cigna reimburses for such services under your specific plan and the amount charged by the dentist.	Summary of what is not covered or subject to a limitation:	The following may apply: if more than one covered service will treat a dental condition, payment is limited to the least costly service. *These Coverage Examples are based on a standard plan which may not reflect your coverages as described in Sections I – V. Please see the applicable Plan Certificate for details. For out-of-network benefits, you may be charged the difference between the amount Cigna reimburses for such services under your specific plan and the amount charged by the dentist.	Summary of what is not covered or subject to a limitation:	Crowns are limited to 1 per tooth, per 60 consecutive months. The following may apply: if more than one covered service will treat a dental condition, payment is limited to the least costly service. *These Coverage Examples are based on a standard plan which may not reflect your coverages as described in Sections I – V. Please see the applicable Plan Certificate for details. For out-of-network benefits, you may be charged the difference between the amount Cigna reimburses for such services under your specific plan and the

Dana’s Visit	Dana’s Cost	Sam’s Visit	Sam’s Cost	Maria’s Visit	Maria’s Cost
					amount charged by the dentist.