Cigna Dental Benefit Summary
NOVANT HEALTH, INC.
Plan Effective Date: 01/01/2026

Administered By: Cigna Health and Life Insurance Company

Your plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.

Receiving regular dental care can not only catch minor problems before they become major and expensive to treat - it may even help improve your overall health. Gum disease is increasingly being linked to complications for pre-term birth, heart disease, stroke, diabetes, osteoporosis, and other health issues. That's why this dental plan includes Cigna Dental WellnessPlus℠, which is designed to encourage visits to your dentist for preventive care.

The maximum will:
- **Increase one level in the following benefit period when you or your family members receive Class 1 services in the prior benefit period.**

Please refer to your plan materials for additional information on this plan feature.

Plan Option Name: BASE DPPO PLAN

Network Options	TOTAL	Non-Network
Annual Deductible Individual/Family Includes: Implants	$50/$150	$50/$150
Annual Maximum Individual Includes: TMJ and Implants	Level 1: $1000 Level 2: $1100 Level 3: $1200 Level 4: $1300	Level 1: $900 Level 2: $1000 Level 3: $1100 Level 4: $1200
Reimbursement Level	Based on Contracted Fees	85th percentile of Maximum Reimbursable Charge
Summary of Benefits **For a complete listing of your benefits, please see your Certificate or Plan Document**		
Class 1		
Diagnostic services - No Deductible Applies. No Maximum Applies		
Oral Evaluations: Limited to 2 per Year	100%	100%
Radiographs (X-Rays): Limited to 2 per Year		
Non-Standard Radiographs (X-Rays): Limited to 1 per 60 Consecutive Months		
Preventive - No Deductible Applies. No Maximum Applies		
Prophylaxis (Cleaning): Limited to 2 per Year	100%	100%
Fluoride: Limited to 2 per Year, age 0 - 18		
Sealants: Age 0 - 18		
Space Maintainers		
Emergency Care - No Deductible Applies. No Maximum Applies		
Palliative Care	100%	100%
Class 2		
Basic Restoration - Annual Deductible Applies Unless Noted. Annual Maximum Applies Unless Noted		
Amalgam/Silver Restoration (Filling): Limited to 1 per 12 Consecutive Months	80%	80%
Composite/White Restoration (Filling): Limited to 1 per 12 Consecutive Months		
Crown Repair		
Denture Adjustment: Limited to 1 per 12 Consecutive Months		
Denture Reline: Limited to 1 per 12 Consecutive Months		
Anesthesia		

Endodontics - Annual Deductible Applies Unless Noted. Annual Maximum Applies Unless Noted		
Root Canal: Limited to 1 per tooth per Lifetime	80%	80%
Periodontics - Annual Deductible Applies Unless Noted. Annual Maximum Applies Unless Noted		
Periodontal Scaling and Root Planing: Limited to 1 per 24 Consecutive Months	80%	80%
Major/Surgical Periodontics: Limited to 1 per 36 Consecutive Months		
Oral Surgery - Annual Deductible Applies Unless Noted. Annual Maximum Applies Unless Noted		
Simple/Non-Surgical Extraction	80%	80%
Surgical Extraction		
Other Oral Surgery		
Class 3		
Major Restoration - Annual Deductible Applies Unless Noted. Annual Maximum Applies Unless Noted		
Cone Beam Radiographs (X-Rays): Limited to 1 per 36 Months	50%	50%
Inlay/Onlay		
Crown: Limited to 1 per 84 Consecutive Months		
Bridge/Pontic: Limited to 1 per 84 Consecutive Months		
Removable and Fixed Prosthetic: Limited to 1 per 84 Consecutive Months		
Prosthetic Over Implant: Limited to 1 per 84 Consecutive Months		
Bridge Repair		
Denture Repair: Limited to 1 per 12 Consecutive Months		
Class 5		
TMJ - No Deductible Applies. Annual Maximum Applies Unless Noted		
TMJ	80%	80%
Class 9		
Implants - Annual Deductible Applies Unless Noted. Annual Maximum Applies Unless Noted		
Implants: Limited to 1 per 84 Consecutive Months	50%	50%

Benefit Plan Provisions	
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.
Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit specific maximums may also apply.
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.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Reimbursement Level	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse according to a Fee Schedule or Discount Schedule. Cigna Dental will reimburse based on the Maximum Reimbursable Charge. For this plan, the MRC is calculated at the 85th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.
Timely Filing	Claims submitted to Cigna after a specified number of months from date of service could be denied. Please see your Certificate or Plan Document for detail.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed by the provider.
Oral Health Integration Program	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers we have identified as having 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.

Exclusions
What's Not Covered (not all-inclusive): Your plan provides for most dentally necessary services. The complete list of exclusions is provided in your Certificate or Plan Document. To the extent there may be differences, the terms of the Certificate or Plan Document will prevail. Examples of things your plan does not cover, unless required by law, include but are not limited to:
Procedures and services not included in the list of covered dental expenses;
Preventive Services: instructions for plaque control, oral hygiene and/or nutritional counseling;
Restorative: tooth colored materials such as composite/white restoration (fillings) on posterior teeth; 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 (back or posterior teeth);
Periodontics: bite registrations; splinting;
Prosthodontic: precision or semi-precision attachments;
Orthodontics: orthodontic treatment;
Procedures, appliances or restorations whose sole purpose is to change or preserve occlusion (teeth contact or bite) except for orthodontic services as covered by the plan; or to stabilize teeth affected by periodontal (gum) disease;
Procedures,appliances or restorations, except full dentures, whose main purpose is to diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ) EXCEPT for as noted in your plan booklet;
Athletic mouth guards : services performed primarily for cosmetic reasons; personalization; 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;
Important things to consider:
This document is an overview provided for your convenience and contains a general description of your dental benefit plan. This document is meant for you to use as a reference guide. A complete description of your dental benefit plan including plan exclusions and limitations is located in the group contract between your plan sponsor and Cigna Dental as well as your Certificate or Plan Document. Covered Expenses will not include, and no payment will be made for procedures and services not listed in the group contract. Benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan, any medical expense plan or prepaid treatment program sponsored or made available by your Employer. 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. In Texas, the insured dental product is referred to as Cigna Dental Choice and this plan uses the national Cigna DPPO network. Cigna Dental PPO plans are underwritten or administered by Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Arizona and Louisiana, the insured Dental PPO plan offered by CGLIC is known as the "CG Dental PPO". "Cigna," the "Tree of Life" logo and "Cigna Dental Care" are registered service marks of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries. **For questions regarding benefit coverage, plan limitations, plan exclusions, claims or any other information need, please visit our website at www.mycigna.com or call Cigna Customer Service 24/7 at 1.800.CIGNA24.**