

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Cigna Dental Health of California, Inc.
Type of Product Line: DHMO
Effective Date: Beginning on or after 01/01/2024

Name of Product: T4IV9
Plan Phone #: 1-800-Cigna24
Plan 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 PLAN WEBSITE 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 | None | None |
| Orthodontia | None | None |

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan 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 plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

| Maximums | In-Network | Out-of-Network |
|--|-------------------|-----------------------|
| Annual Maximum | Not applicable | Not applicable |
| Lifetime or Annual Maximum for Orthodontia | Not applicable | Not applicable |

- **Annual maximum** is the maximum dollar amount your plan 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 plan 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 or services for all or certain dental treatments. **Your dental benefit package has no waiting periods for covered services, once you are enrolled.**

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 Patient Charge Schedule and your Plan Booklet. |
|---------------------------------|-------------------------|-------------------|-----------------------|--|
| <i>Oral Exam</i> | Preventive & Diagnostic | \$0 | Not Covered | Oral evaluations are limited to a combined total of 4 comprehensive or periodic evaluations during a 12 consecutive month period. |
| <i>Bitewing X-ray</i> | Preventive & Diagnostic | \$0 | Not Covered | Not applicable |

| | | | | |
|--|-------------------------|--------|-------------|---|
| <i>Cleaning</i> | Preventive & Diagnostic | \$0 | Not Covered | Limited to 2 per year; 2 additional cleanings per year are available at the co-pay listed on your Patient Charge Schedule. |
| <i>Filling</i> | Basic | \$25 | Not Covered | Not applicable |
| <i>Extraction, Erupted Tooth or Exposed Root</i> | Basic | \$15 | Not Covered | Not applicable |
| <i>Root Canal</i> | Basic | \$125 | Not Covered | Not applicable |
| <i>Scaling and Root Planing</i> | Basic | \$45 | Not Covered | Limited to 4 quadrants per consecutive 12 months |
| <i>Ceramic Crown</i> | Major | \$265 | Not Covered | Not applicable |
| <i>Removable Partial Denture</i> | Major | \$350 | Not Covered | Not applicable |
| <i>Extraction, Erupted Tooth with Bone Removal</i> | Basic | \$55 | Not Covered | Not applicable |
| <i>Orthodontia</i> | Orthodontia | \$3360 | Not Covered | Co-pay reflects twenty-four (24) months of active child comprehensive treatment. Cases beyond 24 months require an additional payment by the patient. |

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 product to other dental products 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 (full-mouth x-ray) 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 Covered | Deductible | In-network: Not applicable Out-of-network: Not Covered | Deductible | In-network: Not applicable Out-of-network: Not Covered |
| Annual Maximum (Plan Will Pay) | In-network: Not applicable Out-of-network: Not applicable | Annual Maximum (Plan Will Pay) | In-network: Not applicable Out-of-network: Not applicable | Annual Maximum (Plan Will Pay) | In-network: Not applicable Out-of-network: Not applicable |

| Dana's Visit | Dana's Cost | Sam's Visit | Sam's Cost | Maria's Visit | Maria's Cost |
|---|--|--|---|--|--|
| Patient Cost (copayment or coinsurance) | In-network: \$0 Out-of-network: \$550 | Patient Cost (copayment or coinsurance) | In-network: \$40 Out-of-network: \$200 | Patient Cost (copayment or coinsurance) | In-network: \$265 Out-of-network: \$1,750 |
| In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable): | In-network: \$0 Out-of-network: \$550 | In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable): | In-network: \$40 Out-of-network: \$200 | In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable): | In-network: \$265 Out-of-network: \$1,750 |

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|---|--|---|-----------------------|---|-----------------------|
| <p>Summary of what is not covered or subject to a limitation:</p> | <p>Oral evaluations are limited to a combined total of 4 comprehensive or periodic evaluations during a 12 consecutive month period. A complete series of full mouth X-rays are limited to 1 every 3 years. Cleanings are limited to 2 per year; 2 additional cleanings per year are available at the co-pay listed on your Patient Charge Schedule.</p> | <p>Summary of what is not covered or subject to a limitation:</p> | <p>Not Applicable</p> | <p>Summary of what is not covered or subject to a limitation:</p> | <p>Not Applicable</p> |
|---|--|---|-----------------------|---|-----------------------|