# *Cigna Dental Benefit Summary*
# *Exelixis, Inc. - Core Plan*
# *Effective Date: 01/01/2027*

**Administered 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.

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[SM]** features. When you or your family members receive any preventive care service in one plan year, the annual dollar maximum will increase in the following plan year. When you or your family members remain enrolled in the plan and continue to receive preventive care, the annual dollar maximum will increase in the following plan year, until it reaches the level specified below. Please refer to your plan materials for additional information on this plan feature. **Your plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

| ***DPPO*** | | | | |
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| ***Network Options*** | ***In-Network:*** **Total Network** | | ***Out-of-Network:*** ***See Out-of-Network Reimbursement*** | |
| ***Reimbursement Levels*** | Based on Contracted Fees | | Maximum Reimbursable Charge | |
| ***WellnessPlus[SM] Progressive Maximum Benefit:*** When you or your family members receive any preventive care service during one plan year, the annual dollar maximum will increase in the following plan year; until it reaches the highest level specified below. Please refer to your plan materials for additional information on this plan feature. | | | | |
| ***Calendar Year Benefits Maximum*** Applies to: Class I, II, III & IX expenses | Level 1: $1,750<br>Level 2: $1,900<br>Level 3: $2,050<br>Level 4 & Beyond: $2,200 | | Level 1: $1,750<br>Level 2: $1,900<br>Level 3: $2,050<br>Level 4 & Beyond: $2,200 | |
| ***Calendar Year Deductible*** Individual<br>Family | $50<br>$150 | | $50<br>$150 | |
| ***Benefit Highlights*** | **Plan Pays** | **You Pay** | **Plan Pays** | **You Pay** |
| ***Class I: Diagnostic & Preventive***<br>Oral Evaluations<br>Prophylaxis: routine cleanings<br>X-rays: routine<br>X-rays: non-routine<br>Fluoride Application<br>Sealants: per tooth<br>Space Maintainers: non-orthodontic<br>Emergency Care to Relieve Pain (Note: This service is administered at the in-network coinsurance level.) | 100%<br>No Deductible | No Charge | 100%<br>No Deductible | No Charge |
| ***Class II: Basic Restorative***<br>Restorative: fillings<br>Endodontics: minor and major<br>Periodontics: minor and major<br>Oral Surgery: minor and major<br>Anesthesia: general and IV sedation<br>Crowns: prefabricated stainless steel / resin | 90%<br>After Deductible | 10%<br>After Deductible | 90%<br>After Deductible | 10%<br>After Deductible |
| ***Class III: Major Restorative***<br>Inlays and Onlays<br>Prosthesis Over Implant<br>Crowns: permanent cast and porcelain<br>Bridges and Dentures<br>Repairs: bridges, crowns and inlays<br>Repairs: dentures<br>Denture Relines, Rebases and Adjustments | 60%<br>After Deductible | 40%<br>After Deductible | 60%<br>After Deductible | 40%<br>After Deductible |
| ***Class IX: Implants*** | 60%<br>After Deductible | 40%<br>After Deductible | 60%<br>After Deductible | 40%<br>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. | | | |

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| ***Out-of-Network Reimbursement*** | For services provided by an out-of-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th 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. |
| ***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 HealthCare 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 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.<br>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:*** | |
| Oral Evaluations/Exams | 2 per calendar year. |
| X-rays (routine) | Bitewings: 1 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 | 2 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 16. |
| Space Maintainers | Limited to non-orthodontic treatment for children under age 16. |
| 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 and Rebases | Covered if more than 6 months after installation. After that, allowed 1 per 36 consecutive months. |
| Denture Adjustments | Covered if more than 6 months after installation. |
| Prosthesis Over Implant | 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. |

***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: 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;
- 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.

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