

CIGNA Dental Care® (*DHMO) Patient Charge Schedule

This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by CIGNA Dental as described in your plan documents.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialty Periodontist, Orthodontist or Oral Surgeon. You must verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by CIGNA Dental. Prior authorization is not required for specialty referrals for Pediatric and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 7 by calling Member Services at 1.800.CIGNA24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 7th birthday.
- Procedures **NOT** listed on this Patient Charge Schedule are **NOT** covered and are the patient's responsibility at the dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or Nitrous Oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- CIGNA Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.
- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.



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Patient Charge Schedule (K1-V7)

Important Highlights *(continued)*

- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

Code	Procedure Description	Patient Charge
Office Visit Fee <i>(Per patient, per office visit in addition to any other applicable patient charges)</i>		
	Office Visit Fee	\$5.00
Diagnostic/Preventive – <i>Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic Oral Evaluations (D0120), Comprehensive Oral Evaluations (D0150), Comprehensive Periodontal Evaluations (D0180), and Oral Evaluations for Patients Under 3 Years of Age (D0145).</i>		
D9310	Consultation (Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician)	\$0.00
D9430	Office Visit for Observation – No Other Services Performed	\$0.00
D9450	Case Presentation – Detailed and Extensive Treatment Planning	\$0.00
D0120	Periodic Oral Evaluation – Established Patient	\$0.00
D0140	Limited Oral Evaluation – Problem Focused	\$0.00
D0145	Oral Evaluation for a Patient Under 3 Years of Age and Counseling with Primary Caregiver	\$0.00
D0150	Comprehensive Oral Evaluation – New or Established Patient	\$0.00
D0170	Re-evaluation – Problem Focused (Not Postoperative Visit)	\$0.00
D0210	X-Rays Intraoral – Complete Series (Including Bitewings) <i>(Limit 1 Every 3 Years)</i>	\$0.00
D0220	X-Rays Intraoral – Periapical – First Film	\$0.00
D0230	X-Rays Intraoral – Periapical – Each Additional Film	\$0.00

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Patient Charge Schedule (K1-V7)

Code	Procedure Description	Patient Charge
D0240	X-Rays Intraoral – Occlusal Film	\$0.00
D0270	X-Rays (Bitewing) – Single Film	\$0.00
D0272	X-Rays (Bitewings) – 2 Films	\$0.00
D0273	X-Rays (Bitewings) – 3 Films	\$0.00
D0274	X-Rays (Bitewings) – 4 Films	\$0.00
D0277	X-Rays (Bitewings, Vertical) – 7 to 8 Films	\$0.00
D0330	X-Rays (Panoramic Film) – <i>(Limit 1 Every 3 Years)</i>	\$0.00
D0431	Oral Cancer Screening Using a Special Light Source	\$50.00
D0460	Pulp Vitality Tests	\$11.00
D0470	Diagnostic Casts	\$0.00
D0472	Pathology Report – Gross Examination of Lesion (Only When Tooth Related)	\$0.00
D0473	Pathology Report – Microscopic Examination of Lesion (Only When Tooth Related)	\$0.00
D0474	Pathology Report – Microscopic Examination of Lesion and Area (Only When Tooth Related)	\$0.00
D1110	Cleaning (Prophylaxis) – Adult <i>(Limit 2 per Calendar Year)</i>	\$0.00
	Additional Cleaning (Prophylaxis) – In Addition to the 2 Cleanings (Prophylaxes) Allowed per Calendar Year	\$45.00
D1120	Cleaning (Prophylaxis) – Child <i>(Limit 2 per Calendar Year)</i>	\$0.00
	Additional Cleaning (Prophylaxis) – In Addition to the 2 Cleanings (Prophylaxes) Allowed per Calendar Year	\$30.00
D1203	Topical Fluoride Application – Child <i>(Up to 19th Birthday)</i> <i>(Limited to 2 per Calendar Year). There is a Combined Limit of a Total of 2 D1203s and/or D1206s per Calendar Year.</i>	\$0.00
D1206	Topical Fluoride Varnish – Therapeutic Application for Moderate to High Caries Risk Patients – Child <i>(Up to 19th Birthday) (Limited to 2 per Calendar Year). There is a Combined Limit of a Total of 2 D1203s and/or D1206s per Calendar Year.</i>	\$0.00
D1330	Oral Hygiene Instructions	\$0.00
D1351	Sealant – Per Tooth	\$10.00

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Patient Charge Schedule (K1-V7)

Code	Procedure Description	Patient Charge
D1510	Space Maintainer – Fixed – Unilateral	\$95.00
D1515	Space Maintainer – Fixed – Bilateral	\$155.00
D1555	Removal of Fixed Space Maintainer	\$0.00
Restorative (Fillings)		
D2140	Amalgam – 1 Surface, Primary or Permanent	\$0.00
D2150	Amalgam – 2 Surfaces, Primary or Permanent	\$0.00
D2160	Amalgam – 3 Surfaces, Primary or Permanent	\$0.00
D2161	Amalgam – 4 or More Surfaces, Primary or Permanent	\$0.00
D2330	Resin-Based Composite – 1 Surface, Anterior	\$0.00
D2331	Resin-Based Composite – 2 Surfaces, Anterior	\$0.00
D2332	Resin-Based Composite – 3 Surfaces, Anterior	\$0.00
D2335	Resin-Based Composite – 4 or More Surfaces or Involving Incisal Angle, Anterior	\$80.00
D2390	Resin-Based Composite Crown, Anterior	\$80.00
D2391	Resin-Based Composite – 1 Surface, Posterior	\$42.00
D2392	Resin-Based Composite – 2 Surfaces, Posterior	\$53.00
D2393	Resin-Based Composite – 3 Surfaces, Posterior	\$74.00
D2394	Resin-Based Composite – 4 or More Surfaces, Posterior	\$100.00
Crown and Bridge <i>All charges for crown and bridge are per unit (each replacement or supporting tooth equals 1 unit) – Replacement limit 1 every 5 years.</i>		
D2510	Inlay – Metallic – 1 Surface	\$390.00
D2520	Inlay – Metallic – 2 Surfaces	\$390.00
D2530	Inlay – Metallic – 3 or More Surfaces	\$390.00
D2542	Onlay – Metallic – 2 Surfaces	\$450.00
D2543	Onlay – Metallic – 3 Surfaces	\$450.00
D2544	Onlay – Metallic – 4 or More Surfaces	\$450.00

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Patient Charge Schedule (K1-V7)

Code	Procedure Description	Patient Charge
D2740	Crown – Porcelain/Ceramic Substrate	\$480.00
D2750	Crown – Porcelain Fused to High Noble Metal	\$440.00
D2751	Crown – Porcelain Fused to Predominantly Base Metal	\$390.00
D2752	Crown – Porcelain Fused to Noble Metal	\$415.00
D2780	Crown – 3/4 Cast High Noble Metal	\$440.00
D2781	Crown – 3/4 Cast Predominantly Base Metal	\$390.00
D2782	Crown – 3/4 Cast Noble Metal	\$415.00
D2790	Crown – Full Cast High Noble Metal	\$440.00
D2791	Crown – Full Cast Predominantly Base Metal	\$390.00
D2792	Crown – Full Cast Noble Metal	\$415.00
D2794	Crown – Titanium	\$440.00
D2910	Recement Inlay – Onlay or Veneer	\$41.00
D2915	Recement Cast or Prefabricated Post and Core	\$41.00
D2920	Recement Crown	\$41.00
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	\$98.00
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	\$98.00
D2932	Prefabricated Resin Crown	\$125.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	\$155.00
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	\$155.00
D2940	Sedative Filling	\$11.00
D2950	Core Buildup – Including Any Pins	\$125.00
D2951	Pin Retention – Per Tooth – In Addition to Restoration	\$11.00
D2952	Cast Post and Core – In Addition to Crown	\$155.00
D2954	Prefabricated Post and Core – In Addition to Crown	\$125.00
D2960	Labial Veneer (Resin Laminate) – Chairside	\$85.00

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Patient Charge Schedule (K1-V7)

Code	Procedure Description	Patient Charge
D6210	Pontic – Cast High Noble Metal	\$440.00
D6211	Pontic – Cast Predominantly Base Metal	\$390.00
D6212	Pontic – Cast Noble Metal	\$415.00
D6214	Pontic – Titanium	\$440.00
D6240	Pontic – Porcelain Fused to High Noble Metal	\$440.00
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	\$390.00
D6242	Pontic – Porcelain Fused to Noble Metal	\$415.00
D6245	Pontic – Porcelain/Ceramic	\$435.00
D6602	Inlay – Cast High Noble Metal, 2 Surfaces	\$440.00
D6603	Inlay – Cast High Noble Metal, 3 or More Surfaces	\$440.00
D6604	Inlay – Cast Predominantly Base Metal, 2 Surfaces	\$390.00
D6605	Inlay – Cast Predominantly Base Metal, 3 or More Surfaces	\$390.00
D6606	Inlay – Cast Noble Metal, 2 Surfaces	\$415.00
D6607	Inlay – Cast Noble Metal, 3 or More Surfaces	\$415.00
D6610	Onlay – Cast High Noble Metal, 2 Surfaces	\$440.00
D6611	Onlay – Cast High Noble Metal, 3 or More Surfaces	\$440.00
D6612	Onlay – Cast Predominantly Base Metal, 2 Surfaces	\$390.00
D6613	Onlay – Cast Predominantly Base Metal, 3 or More Surfaces	\$390.00
D6614	Onlay – Cast Noble Metal, 2 Surfaces	\$415.00
D6615	Onlay – Cast Noble Metal, 3 or More Surfaces	\$415.00
D6624	Inlay – Titanium	\$440.00
D6634	Onlay – Titanium	\$440.00
D6740	Crown – Porcelain/Ceramic	\$480.00
D6750	Crown – Porcelain Fused to High Noble Metal	\$440.00
D6751	Crown – Porcelain Fused to Predominantly Base Metal	\$390.00
D6752	Crown – Porcelain Fused to Noble Metal	\$415.00

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Code	Procedure Description	Patient Charge
D6780	Crown – 3/4 Cast High Noble Metal	\$440.00
D6781	Crown – 3/4 Cast Predominantly Base Metal	\$390.00
D6782	Crown – 3/4 Cast Noble Metal	\$415.00
D6790	Crown – Full Cast High Noble Metal	\$440.00
D6791	Crown – Full Cast Predominantly Base Metal	\$390.00
D6792	Crown – Full Cast Noble Metal	\$415.00
D6794	Crown – Titanium	\$440.00
	Complex Rehabilitation – ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION <i>(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)</i>	\$130.00
D6930	Recent Fixed Partial Denture	\$57.00
Endodontics <i>(Root Canal Treatment, Excluding Final Restorations)</i>		
D3110	Pulp Cap – Direct (Excluding Final Restoration)	\$111.00
D3120	Pulp Cap – Indirect (Excluding Final Restoration)	\$111.00
D3220	Pulpotomy – Removal of Pulp, Not Part of a Root Canal	\$62.00
D3221	Pulpal Debridement (Not to be used when root canal is done on the same day)	\$62.00
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development	\$62.00
D3310	Anterior Root Canal – Permanent Tooth (Excluding Final Restoration)	\$195.00
D3320	Bicuspid Root Canal – Permanent Tooth (Excluding Final Restoration)	\$230.00
D3330	Molar Root Canal – Permanent Tooth (Excluding Final Restoration)	\$315.00
D3331	Treatment of Root Canal Obstruction – Nonsurgical Access	\$84.00
D3332	Incomplete Endodontic Therapy – Inoperable or Fractured Tooth	\$84.00

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Patient Charge Schedule (K1-V7)

Code	Procedure Description	Patient Charge
D3333	Internal Root Repair of Perforation Defects	\$84.00
D3346	Retreatment of Previous Root Canal Therapy – Anterior	\$260.00
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	\$295.00
D3348	Retreatment of Previous Root Canal Therapy – Molar	\$375.00
D3410	Apicoectomy/Periradicular Surgery – Anterior	\$235.00
D3421	Apicoectomy/Periradicular Surgery – Bicuspid (First Root)	\$265.00
D3425	Apicoectomy/Periradicular Surgery – Molar (First Root)	\$290.00
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$95.00
D3430	Retrograde Filling per Root	\$62.00

Periodontics (*Treatment of Supporting Tissues [Gum and Bone] of the Teeth*)
Periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. The Relevant Procedure Codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 Teeth (or 8 sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

D0180	Comprehensive Periodontal Evaluation – New or Established Patient	\$30.00
D4210	Gingivectomy or Gingivoplasty – 4 or More Teeth per Quadrant	\$155.00
D4211	Gingivectomy or Gingivoplasty – 1 to 3 Teeth per Quadrant	\$78.00
D4240	Gingival Flap (Including Root Planing) – 4 or More Teeth per Quadrant	\$200.00
D4241	Gingival Flap (Including Root Planing) – 1 to 3 Teeth per Quadrant	\$105.00
D4245	Apically Positioned Flap	\$200.00
D4249	Clinical Crown Lengthening – Hard Tissue	\$220.00
D4260	Osseous Surgery – 4 or More Teeth per Quadrant	\$375.00
D4261	Osseous Surgery – 1 to 3 Teeth per Quadrant	\$205.00
D4263	Bone Replacement Graft – First Site in Quadrant	\$290.00
D4264	Bone Replacement Graft – Each Additional Site in Quadrant	\$225.00

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Code	Procedure Description	Patient Charge
D4266	Guided Tissue Regeneration – Resorbable Barrier per Site	\$380.00
D4267	Guided Tissue Regeneration – Nonresorbable Barrier per Site (Includes Membrane Removal)	\$430.00
D4270	Pedicle Soft Tissue Graft Procedure	\$260.00
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	\$270.00
D4275	Soft Tissue Allograft	\$270.00
D4341	Periodontal Scaling and Root Planing – 4 or More Teeth per Quadrant (<i>Limit 4 Quadrants per Consecutive 12 Months</i>)	\$78.00
D4342	Periodontal Scaling and Root Planing – 1 to 3 Teeth – per Quadrant (<i>Limit 4 Quadrants per Consecutive 12 Months</i>)	\$39.00
D4355	Full Mouth Debridement to Allow Evaluation and Diagnosis (<i>1 per Lifetime</i>)	\$56.00
D4381	Localized Delivery of Chemotherapeutic Agents per Tooth – By Report	\$45.00
D4910	Periodontal Maintenance (<i>Limited to 2 per Calendar Year (Only Covered after Active Therapy)</i>)	\$45.00
D9940	Occlusal Guard – By Report (<i>Limit 1 per 24 Months</i>)	\$175.00
D9951	Occlusal Adjustment Limited	\$34.00
D9952	Occlusal Adjustment Complete	\$180.00
<p>Prosthetics (<i>Removable Tooth Replacement – Dentures</i>) Includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years.</p>		
D5110	Full Upper Denture	\$590.00
D5120	Full Lower Denture	\$590.00
D5130	Immediate Full Upper Denture	\$590.00
D5140	Immediate Full Lower Denture	\$590.00
D5211	Upper Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	\$525.00

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Code	Procedure Description	Patient Charge
D5212	Lower Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	\$525.00
D5213	Upper Partial Denture – Metal (Including Clasps, Rests and Teeth)	\$675.00
D5214	Lower Partial Denture – Metal (Including Clasps, Rests and Teeth)	\$675.00
D5225	Upper Partial Denture – Flexible (Including Clasps, Rests and Teeth)	\$525.00
D5226	Lower Partial Denture – Flexible (Including Clasps, Rests and Teeth)	\$525.00
D5410	Adjust Complete Denture – Upper	\$39.00
D5411	Adjust Complete Denture – Lower	\$39.00
D5421	Adjust Partial Denture – Upper	\$39.00
D5422	Adjust Partial Denture – Lower	\$39.00
Repairs to Prosthetics		
D5510	Repair Broken Complete Denture Base	\$77.00
D5520	Replace Missing or Broken Teeth – Complete Denture (Each Tooth)	\$72.00
D5610	Repair Resin Denture Base	\$77.00
D5630	Repair or Replace Broken Clasp	\$94.00
D5640	Replace Broken Teeth – Per Tooth	\$77.00
D5650	Add Tooth to Existing Partial Denture	\$77.00
D5660	Add Clasp to Existing Partial Denture	\$94.00
Denture Relining (<i>Limit 1 Every 36 Months</i>)		
D5710	Rebase Complete Upper Denture	\$215.00
D5711	Rebase Complete Lower Denture	\$215.00
D5720	Rebase Upper Partial Denture	\$215.00
D5721	Rebase Lower Partial Denture	\$215.00

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Code	Procedure Description	Patient Charge
D5730	Reline Complete Upper Denture – Chairside	\$120.00
D5731	Reline Complete Lower Denture – Chairside	\$120.00
D5740	Reline Upper Partial Denture – Chairside	\$120.00
D5741	Reline Lower Partial Denture – Chairside	\$120.00
D5750	Reline Complete Upper Denture – Laboratory	\$180.00
D5751	Reline Complete Lower Denture – Laboratory	\$180.00
D5760	Reline Upper Partial Denture – Laboratory	\$180.00
D5761	Reline Lower Partial Denture – Laboratory	\$180.00
Interim Dentures (<i>Limit 1 Every 5 Years</i>)		
D5810	Interim Complete Denture – Upper	\$275.00
D5811	Interim Complete Denture – Lower	\$275.00
D5820	Interim Partial Denture – Upper	\$240.00
D5821	Interim Partial Denture – Lower	\$240.00
Oral Surgery (<i>Includes Routine Postoperative Treatment</i>) <i>Surgical Removal of Impacted Tooth – Not covered for ages below 15 unless pathology (disease) exists.</i>		
D7111	Extraction of Coronal Remnants – Deciduous Tooth	\$11.00
D7140	Extraction, Erupted Tooth or Exposed Root – Elevation and/or Forceps Removal	\$11.00
D7210	Surgical Removal of Erupted Tooth – Removal of Bone and/or Section of Tooth	\$45.00
D7220	Removal of Impacted Tooth – Soft Tissue	\$39.00
D7230	Removal of Impacted Tooth – Partially Bony	\$78.00
D7240	Removal of Impacted Tooth – Completely Bony	\$105.00
D7241	Removal of Impacted Tooth – Completely Bony, Unusual Complications (Narrative Required)	\$105.00
D7250	Surgical Removal of Residual Tooth Roots – Cutting Procedure	\$45.00

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Patient Charge Schedule (K1-V7)

Code	Procedure Description	Patient Charge
D7260	Oroantral Fistula Closure	\$105.00
D7261	Primary Closure of a Sinus Perforation	\$105.00
D7270	Tooth Stabilization of Accidentally Evulsed or Displaced Tooth	\$11.00
D7280	Surgical Access of an Unerupted Tooth <i>(Excluding Wisdom Teeth)</i>	\$11.00
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	\$6.00
D7285	Biopsy of Oral Tissue – Hard (Bone, Tooth) <i>(Tooth Related – Not allowed when in conjunction with another surgical procedure)</i>	\$67.00
D7286	Biopsy of Oral Tissue – Soft (All Others) <i>(Tooth Related – Not allowed when in conjunction with another surgical procedure)</i>	\$56.00
D7287	Exfoliative Cytological Sample Collection	\$67.00
D7288	Brush Biopsy – Transepithelial Sample Collection	\$67.00
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces per Quadrant	\$50.00
D7311	Alveoloplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces per Quadrant	\$28.00
D7320	Alveoloplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces per Quadrant	\$67.00
D7321	Alveoloplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces per Quadrant	\$34.00
D7450	Removal of Benign Odontogenic Cyst or Tumor – Up to 1.25 cm	\$11.00
D7451	Removal of Benign Odontogenic Cyst or Tumor – Greater than 1.25 cm	\$11.00
D7471	Removal of Lateral Exostosis – Maxilla or Mandible	\$11.00
D7472	Removal of Torus Palatinus	\$11.00
D7473	Removal of Torus Mandibularis	\$11.00
D7485	Surgical Reduction of Osseous Tuberosity	\$67.00
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	\$11.00
D7511	Incision and Drainage of Abscess – Intraoral Soft Tissue Complicated	\$17.00

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Code	Procedure Description	Patient Charge
D7960	Frenulectomy (Frenectomy or Frenotomy) – Separate Procedure	\$11.00
D7963	Frenuloplasty	\$17.00
<p>Orthodontics (<i>Tooth Movement</i>) Orthodontic Treatment (<i>Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.</i>)</p>		
D8050	Interceptive Orthodontic Treatment of the Primary Dentition – Banding	\$435.00
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition – Banding	\$435.00
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition – Banding	\$470.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition – Banding	\$470.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition – Banding	\$470.00
D8660	Pre-Orthodontic Treatment Visit	\$61.00
D8670	Periodic Orthodontic Treatment Visit – As Part of Contract	
	Children – Up to 19th Birthday:	
	24-Month Treatment Fee	\$1,872.00
	Charge per Month for 24 Months	\$78.00
	Adults:	
	24-Month Treatment Fee	\$2,184.00
	Charge per Month for 24 Months	\$91.00
D8680	Orthodontic Retention – Removal of Appliances, Construction and Placement of Retainer(s)	\$345.00
D8999	Unspecified Orthodontic Procedure – By Report (<i>Orthodontic Treatment Plan and Records</i>)	\$175.00

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Patient Charge Schedule (K1-V7)

Code	Procedure Description	Patient Charge
<p>General Anesthesia/IV Sedation – <i>General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or intravenous sedation when used for the purpose of anxiety control or patient management.</i></p>		
D9220	General Anesthesia – First 30 Minutes	\$160.00
D9221	General Anesthesia – Additional 15 Minutes	\$73.00
D9241	IV Conscious Sedation – First 30 Minutes	\$160.00
D9242	IV Conscious Sedation – Additional 15 Minutes	\$73.00
<p>Emergency Services</p>		
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	\$0.00
D9440	Office Visit – After Regularly Scheduled Hours	\$50.00
<p>Miscellaneous Services – <i>External Bleaching (D9972) is limited to the use of take-home bleaching trays. All other bleaching methods are not covered.</i></p>		
D9972	External Bleaching per Arch	\$175.00
<p>This may contain CDT codes and/or portions of, or excerpts from the Nomenclature contained within the <i>Current Dental Terminology</i>, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.</p>		

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling CIGNA Dental at the toll-free number listed on your ID card or plan materials. Multiple ways to locate a *DHMO Network General Dentist:

- Online provider directory at www.cigna.com
- Online provider directory on myCIGNA.com
- Call the number located on your ID card to:
 - Use the Dental Office Locator via Speech Recognition
 - Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

*The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

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The Hamister Group of Companies

CIGNA Dental PPO Benefit Summary Effective 9/1/2009



This is a summary of benefits for your PPO plan. All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

CIGNA Core Network Benefits	CIGNA Dental PPO	
	In-Network	Out-of-Network
Calendar Year Maximum (Class I, II, and III Expenses)	\$750	\$750
Calendar Year Deductible		
Per Individual	\$50	\$50
Per Family	\$150	\$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams	100%, No Deductible	100%, No Deductible
Cleanings		
Routine X-Rays		
Fluoride Application		
Sealants		
Space Maintainers (limited to non-orthodontic treatment)		
Class II Expenses - Basic Restorative Care		
Fillings	80%, After Deductible	80%, After Deductible
Non-routine X-Rays		
Emergency Care to Relieve Pain		
Oral Surgery, Simple Extractions		
Class III Expenses - Major Restorative Care		
Crowns / Inlays / Onlays	50%, After Deductible	25%, After Deductible
Minor Periodontics		
Dentures		
Root Canal Therapy / Endodontics		
Major Periodontics		
Bridges		
Anesthetics		
Oral Surgery, All Except Simple Extractions		
Surgical Extraction of Impacted Teeth		
Relines, Rebases, and Adjustments		
Repairs - Bridges Crowns, and Inlays		
Repairs - Dentures		
Class IV Expenses - Orthodontia		
Coverage for eligible children only	50%, After Deductible	50%, After Deductible
Lifetime Maximum	\$1,500	\$1,500
Missing Tooth Provision	No Limitation (teeth missing prior to the effective date of coverage are covered)	
Pretreatment Review	Available on a voluntary basis when extensive work in excess of \$500 is proposed.	
Out-of-Network Reimbursement	Based on Contracted Fee Schedule (for location of service rendered); dentist may balance bill up to usual fees.	
Student Age	23	

CIGNA Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Late Entrants Limit	No coverage until your groups next open enrollment period.
Exams	1 per 6-month consecutive period.
Prophylaxis (Cleanings)	1 routine prophylaxis or perio maintenance procedure per 6-month consecutive period (routine prophylaxis is Class I; perio prophylaxis is Class III).
Fluoride Treatments	1 per consecutive 12 months for participants younger than age 14.
X-rays (routine)	Bitewings: 1 set in any consecutive 12 month period. Limited to a maximum of 4 films per set.
X-rays (non-routine)	Full mouth or Panorex: 1 per 60 consecutive months.
Periapical x-rays:	4 in 12 consecutive months if not performed in conjunction with an operative procedure.
Intraoral occlusal x-rays:	2 in 12 consecutive months.
Models	Not covered.
Fillings	1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only). No white-colored fillings on bicuspid or molar teeth.
Sealants	1 treatment per tooth per lifetime. Payable on unrestored permanent bicuspid or molar teeth only up to age 14.
Minor Perio (non-surgical)	Root planing-1 per quadrant per 36 consecutive months.
Perio Surgery	1 per 36 consecutive months per area of the mouth (same service).
Crowns and Inlays	Replacement limited to 1 per 84 consecutive months. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. Replacement must be indicated by major decay. Participants younger than age 16; Benefits limited to resin or stainless steel.
Bridges	Replacement limited to 1 per 84 consecutive 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.
Dentures and Partials	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired.
Relines, Rebases	Covered if more than 12 months after installation; 1 per 36 consecutive months.
Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months.
Repairs - Bridges	Covered if more than 12 months after installation.
Repairs - Dentures	Covered if more than 12 months after installation.
Endodontics	Root canal re-treatment 1 per 24 consecutive months, if necessity demonstrated.
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, CG will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Prosthesis Over Implant	1 per 84 consecutive 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.
Stainless Steel and Resin Crowns	1 per 36 consecutive months for participants younger than age 16.

Benefit Exclusions:

- * Services performed primarily for cosmetic reasons; Replacement of a lost or stolen appliance;
- * Initial placement of a full or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan; removal of only a permanent third molar will not qualify for an initial or replacement denture or bridge;
- * Overdentures, personalization, precision or semi-precision attachments;
- * Replacement of a bridge, denture or crown within 84 months following its initial date of insertion;
- * Replacement of a bridge, denture or crown which can be made useable according to dental standards;
- * Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion, the restoration of teeth which have been damaged by erosion, attrition or abrasion; bite registration; or bite analysis;
- * Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- * Core buildup, labial veneers; Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- * Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type;
- * Instruction for plaque control, oral hygiene and diet;
- * Dental services that do not meet common dental standards; Services that are deemed to be medical services;
- * Services and supplies received from a hospital;
- * Procedures for which a charge would not have been made in the absence of coverage, for which the person is not legally required to pay;
- * Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- * Experimental or investigational procedures and treatments; Procedures which are not necessary and which do not have uniform professional endorsement;
- * Any injury resulting from, or in the course of, any employment for wage or profit; Any sickness covered under any workers' compensation or similar law;
- * Charges in excess of the reasonable and customary allowances;
- * IV sedation or general anesthesia, except when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- * Fees charged for broken appointments, claim form submission or sterilization;
- * Services not included in the list of covered dental expenses, unless Connecticut General agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- * Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture; Replacement of teeth beyond the normal complement of 32;
- * Prescription drugs; Athletic mouth guards; Myofunctional therapy;
- * Charges for travel time; transportation costs; or professional advice given on the phone;
- * Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- * Any procedure, service, or supply which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least three years, as determined by CG; Temporary, transitional or interim dental services; Diagnostic casts, diagnostic models, or study models;
- * Any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of (\$100.00-\$200.00) per 12 consecutive month period);
- * Procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- * Any charges, including ancillary charges, made by hospital, ambulatory surgical center or similar facility;
- * To the extent that payment is unlawful where the person resides when the expenses are incurred;

- * For charges which would not have been made if the person had no insurance; 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;
- * Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- * No payment will be made for expenses incurred by you or any one of your Dependents 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.