

# CIGNA Dental Benefit Summary for Employees of Denison University



## Summary of Benefits

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Benefits	CIGNA Dental Care	CIGNA Dental PPO			
		In-Network	Out-of-Network		
<b>Calendar Year Maximum</b> (Class I, II and III expenses)	No Dollar Maximum	\$1,000	\$1,000		
<b>Annual Deductible</b> Individual Family	None None	\$50 per person \$100 per family	\$50 per person \$100 per family		
<b>Reimbursement Levels**</b>	Reduced, fixed charges for covered services, with no waiting periods and no missing tooth limitations.	Based on Reduced Contracted Fees	80th percentile of Reasonable and Customary Allowances		
	<b>You Pay</b>	<b>Plan Pays</b>	<b>You Pay</b>	<b>Plan Pays</b>	<b>You Pay</b>
<b>Class I - Preventive &amp; Diagnostic Care</b> Oral Exams (Two per year) Routine Cleanings (Two per year) Full Mouth X-rays (One complete set every three years) Bitewing X-rays (Two per year) Panoramic X-ray (One every three years) Fluoride Application (One per year for persons under 19) Sealants (Limited to posterior teeth; one treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to Relieve Pain Histopathologic Exams	See the following pages for sample patient charges.	100%	No Charge	100%	No Charge
<b>Class II - Basic Restorative Care</b> Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Oral Surgery – Simple Extractions Oral Surgery – all except simple extractions Anesthetics Surgical Extractions of Impacted Teeth Repairs to Bridges, Crowns and Inlays	See the following pages for sample patient charges.	60%*	40%*	50%*	50%*
<b>Class III - Major Restorative Care</b> Crowns Dentures Bridges	See the following pages for sample patient charges.	40%*	60%*	Not covered	100% of your dentist's usual fees
<b>Class IV - Orthodontia</b>	See the following two pages for sample patient charges.	Not covered	100% of your dentist's usual fees	Not covered	100% of your dentist's usual fees

Pretreatment review is available on a voluntary basis when extensive dental work in excess of \$500 is proposed.

\* Subject to annual deductible

\*\*For services provided by a CIGNA Dental PPO network dentist, CIGNA Dental will reimburse the dentist according to a Contracted Fee Schedule. For services provided by an out-of-network dentist, CIGNA Dental will reimburse according to Reasonable and Customary Allowances but the dentist may balance bill up to their usual fees.

This *Overview* shows you a sampling of covered services and what you will pay with your CIGNA Dental Care Plan compared to what you would pay *without* coverage.

**The Importance of Good Oral Care**

Did you know that most preventive dental care has \$0 or low co-pay thus encouraging preventive care, which often catches minor problems before they become major and expensive to treat. And healthier gums may:

- Help reduce pre-term birth
- Lead to a healthier heart
- Help control blood sugar

**Key Highlights of the CIGNA Dental Care Plan**

This plan offers coverage for a wide range of services at a cost savings. Coverage includes:

- Preventive care (cleanings, x-rays, and more)
- Basic care (fillings, basic restorative work)
- Major services (bridges, crowns, root canals and more)

**Key Features of the CIGNA Dental Care Plan**

- NO waiting periods
- NO deductibles
- NO dollar maximums
- NO claim forms

See a *complete* list of covered services, descriptions, limitations and exclusions inside!

See *savings* below!

Code	Procedure Description	What You'll Pay	
		With CIGNA Dental Care	Without Dental Coverage*
D1110	Cleaning - Adult (Limit 1 Every 6 Months)	\$0.00	\$73.00
D0150	Comprehensive Oral Evaluation - New or Established Patient	\$0.00	\$59.00
D1203	Topical Fluoride Application - Child (Up to 19th Birthday) (Once in 6 Months)	\$0.00	\$27.00
D0210	X-Rays - Complete Series (including bitewings) (Limit 1 Every 3 Years)	\$0.00	\$100.00
D1351	Sealant - Per Tooth	\$15.00	\$43.00
D2150	Amalgam - Two Surfaces, Primary or Permanent	\$25.00	\$117.00
D2330	Resin-Based Composite - One Surface, Anterior	\$30.00	\$118.00
D2160	Amalgam - Three Surfaces, Primary or Permanent	\$30.00	\$142.00
D2391	Resin-Based Composite - One Surface, Posterior	\$40.00	\$128.00
D3310	Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$325.00	\$595.00
D3330	Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$515.00	\$868.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (Bandings)	\$425.00	\$1,104.00
D8660	Pre-Orthodontic Treatment Visit	\$55.00	\$85.00
D8670	Periodic Orthodontic Treatment Visit (As Part of Contract)	\$2,100.00	\$3,565.00
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	\$315.00	\$496.00
D8999	Unspecified Orthodontic Procedure, By Report (Orthodontic Treatment Plan and Records)	\$160.00	\$242.00
D4341	Periodontal Scaling and Root Planing, Four or More Teeth or Bounded Teeth Spaces Per Quadrant (Limit 4 Quadrants per Consecutive 12 Months)	\$125.00	\$184.00
D7210	Surgical Removal of Erupted Tooth - Removal of Bone and/or Section of Tooth	\$120.00	\$207.00
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	\$55.00	\$119.00
D7240	Removal of Impacted Tooth - Completely Bony	\$275.00	\$378.00
D7241	Removal of Impacted Tooth - Completely Bony, Unusual Complications	\$275.00	\$442.00
D5214	Lower Partial Denture - Metal (Including Clasps, Rests and Teeth)	\$720.00	\$1,197.00
D2750	Crown - Porcelain Fused to High Noble Metal	\$460.00	\$859.00
D6750	Crown - Porcelain Fused to High Noble Metal	\$460.00	\$844.00
D6240	Pontic - Porcelain Fused to High Noble Metal	\$460.00	\$835.00
<b>Grand Total</b>		<b>\$6,985.00</b>	<b>\$12,827.00</b>
<b>Total Savings with CIGNA Dental Care</b>		<b>\$5,842.00</b>	

\*Estimated costs without dental coverage are based on Connecticut General Life Insurance Company analysis on average charge for each dental procedure based on geographic distribution of CIGNA Dental Care membership and national claims analysis, prepared March 2006. Actual charges without dental coverage may differ from your area charges or local dentist's fees.

**G1-06****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 I.V. 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.
- 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.
- 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.

<b>CIGNA DENTAL CARE</b>	<b>PATIENT CHARGE SCHEDULE</b>	<b>G1-06</b>
<b>Code</b>	<b>Procedure Description</b>	<b>Patient Charge</b>
	<b>DIAGNOSTIC/PREVENTIVE</b>	
D9310	Consultation (Normally Not The Same Dentist Who Provides The Treatment)	\$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	\$0.00
D0140	Limited Oral Evaluation - Problem Focused	\$0.00
D0150	Comprehensive Oral Evaluation - New or Established Patient	\$0.00
D0170	Re-evaluation - Problem Focused (Not Post-Operative Visit)	\$0.00
D0210	X-Rays - Complete Series (including bitewings) (Limit 1 Every 3 Years)	\$0.00
D0220	X-Rays Intraoral Periapical, First Film	\$0.00
D0230	X-Rays Intraoral Periapical, Each Additional Film	\$0.00
D0240	X-Rays Intraoral - Occlusal Film	\$0.00
D0270	X-Rays (Bitewing) - Single Film	\$0.00
D0272	X-Rays (Bitewings) - Two Films	\$0.00
D0274	X-Rays (Bitewings) - Four Films	\$0.00
D0277	X-Rays (Bitewings, Vertical) - 7 to 8 Films	\$0.00
D0330	X-Rays (Panoramic Film) - (Limit 1 every 3 years)	\$0.00
D0431	Oral Cancer Screening Using a Special Light Source	\$50.00
D0460	Pulp Vitality Tests	\$10.00
D0470	Diagnostic Casts	\$0.00
D0472	Pathology Report - Gross Examination of Lesion	\$0.00
D0473	Pathology Report - Microscopic Examination of Lesion	\$0.00
D0474	Pathology Report - Microscopic Examination of Lesion and Area	\$0.00
D1110	Cleaning - Adult (Limit 1 Every 6 Months)	\$0.00
	(Additional Cleaning, In Addition to the One Allowed Every 6 Months)	\$45.00

<b>Code</b>	<b>Procedure Description</b>	<b>Patient Charge</b>
D1120	Cleaning - Child (Limit 1 Every 6 Months)	\$0.00
	(Additional Cleaning, In Addition to the One Allowed Every 6 Months)	\$30.00
D1203	Topical Fluoride Application - Child (Up to 19th Birthday) (Once in 6 Months)	\$0.00
D1330	Oral Hygiene Instructions	\$0.00
D1351	Sealant - Per Tooth	\$15.00
D1510	Space Maintainer - Fixed Unilateral	\$95.00
D1515	Space Maintainer - Fixed Bilateral	\$155.00
	<b>RESTORATIVE (Fillings)</b>	
D2140	Amalgam - One Surface, Primary or Permanent	\$20.00
D2150	Amalgam - Two Surfaces, Primary or Permanent	\$25.00
D2160	Amalgam - Three Surfaces, Primary or Permanent	\$30.00
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	\$35.00
D2330	Resin-Based Composite - One Surface, Anterior	\$30.00
D2331	Resin-Based Composite - Two Surfaces, Anterior	\$35.00
D2332	Resin-Based Composite - Three Surfaces, Anterior	\$40.00
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	\$75.00
D2390	Resin-Based Composite Crown, Anterior	\$120.00
D2391	Resin-Based Composite - One Surface, Posterior	\$40.00
D2392	Resin-Based Composite - Two Surfaces, Posterior	\$50.00
D2393	Resin-Based Composite - Three Surfaces, Posterior	\$70.00
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	\$95.00
	<b>CROWN AND BRIDGE</b> All charges for crown and bridge are per unit (each replacement or supporting tooth equals one unit) - Replacement limit 1 every 5 years.	
D2510	Inlay - Metallic - One Surface	\$405.00
D2520	Inlay - Metallic - Two Surfaces	\$405.00
D2530	Inlay - Metallic - Three or More Surfaces	\$405.00
D2542	Onlay - Metallic - Two Surfaces	\$475.00
D2543	Onlay - Metallic - Three Surfaces	\$475.00
D2544	Onlay - Metallic - Four or More Surfaces	\$475.00
D2740	Crown - Porcelain/Ceramic Substrate	\$500.00
D2750	Crown - Porcelain Fused to High Noble Metal	\$460.00
D2751	Crown - Porcelain Fused to Predominantly Base Metal	\$405.00
D2752	Crown - Porcelain Fused to Noble Metal	\$430.00
D2780	Crown - 3/4 Cast High Noble Metal	\$460.00
D2781	Crown - 3/4 Cast Predominantly Base Metal	\$405.00
D2782	Crown - 3/4 Cast Noble Metal	\$430.00
D2790	Crown - Full Cast High Noble Metal	\$460.00
D2791	Crown - Full Cast Predominantly Base Metal	\$405.00
D2792	Crown - Full Cast Noble Metal	\$430.00
D2794	Crown - Titanium	\$460.00
D2910	Recement Inlay, Onlay or Veneer	\$40.00
D2915	Recement Cast or Prefabricated Post and Core	\$40.00
D2920	Recement Crown	\$40.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	\$100.00
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	\$100.00
D2932	Prefabricated Resin Crown	\$120.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	\$140.00
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	\$140.00
D2940	Sedative Filling	\$20.00
D2950	Core Buildup, Including Any Pins	\$110.00
D2951	Pin Retention - Per Tooth, In Addition to Restoration	\$25.00
D2952	Cast Post and Core, In Addition to Crown	\$155.00

<b>Code</b>	<b>Procedure Description</b>	<b>Patient Charge</b>
D2954	Prefabricated Post and Core In Addition to Crown	\$125.00
D2960	Labial Veneer (Resin Laminate) - Chairside	\$110.00
D6210	Pontic - Cast High Noble Metal	\$460.00
D6211	Pontic - Cast Predominantly Base Metal	\$405.00
D6212	Pontic - Cast Noble Metal	\$430.00
D6214	Pontic Titanium	\$460.00
D6240	Pontic - Porcelain Fused to High Noble Metal	\$460.00
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	\$405.00
D6242	Pontic - Porcelain Fused to Noble Metal	\$430.00
D6245	Pontic - Porcelain/Ceramic	\$450.00
D6602	Inlay - Cast High Noble Metal, Two Surfaces	\$460.00
D6603	Inlay - Cast High Noble Metal, Three or More Surfaces	\$460.00
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	\$405.00
D6605	Inlay - Cast Predominantly Base Metal, Three or More Surfaces	\$405.00
D6606	Inlay - Cast Noble Metal, Two Surfaces	\$430.00
D6607	Inlay - Cast Noble Metal, Three or More Surfaces	\$430.00
D6610	Onlay - Cast High Noble Metal, Two Surfaces	\$460.00
D6611	Onlay - Cast High Noble Metal, Three or More Surfaces	\$460.00
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	\$405.00
D6613	Onlay - Cast Predominantly Base Metal, Three or More Surfaces	\$405.00
D6614	Onlay - Cast Noble Metal, Two Surfaces	\$430.00
D6615	Onlay - Cast Noble Metal, Three or More Surfaces	\$430.00
D6624	Inlay Titanium	\$460.00
D6634	Onlay Titanium	\$460.00
D6740	Crown - Porcelain/Ceramic	\$500.00
D6750	Crown - Porcelain Fused to High Noble Metal	\$460.00
D6751	Crown - Porcelain Fused to Predominantly Base Metal	\$405.00
D6752	Crown - Porcelain Fused to Noble Metal	\$430.00
D6780	Crown - 3/4 Cast High Noble Metal	\$460.00
D6781	Crown - 3/4 Cast Predominantly Base Metal	\$405.00
D6782	Crown - 3/4 Cast Noble Metal	\$430.00
D6790	Crown - Full Cast High Noble Metal	\$460.00
D6791	Crown - Full Cast Predominantly Base Metal	\$405.00
D6792	Crown - Full Cast Noble Metal	\$430.00
D6794	Crown Titanium	\$460.00
	Complex Rehabilitation - ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION (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)	\$125.00
D6930	Recement Fixed Partial Denture	\$60.00
	<b>ENDODONTICS</b> (Root Canal Treatment, Excluding Final Restorations)	
D3110	Pulp Cap - Direct (Excluding Final Restoration)	\$30.00
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	\$30.00
D3220	Pulpotomy - Removal of Pulp, Not Part of a Root Canal	\$85.00
D3221	Pulpal Debridement (Not to be used when root canal is done on the same day)	\$85.00
D3310	Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$325.00
D3320	Bicuspid Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$385.00
D3330	Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$515.00
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access	\$145.00
D3332	Incomplete Endodontic Therapy; Inoperable or Fractured Tooth	\$145.00
D3333	Internal Root Repair of Perforation Defects	\$145.00
D3346	Retreatment of Previous Root Canal Therapy Anterior	\$430.00
D3347	Retreatment of Previous Root Canal Therapy Bicuspid	\$490.00
D3348	Retreatment of Previous Root Canal Therapy Molar	\$620.00

<b>Code</b>	<b>Procedure Description</b>	<b>Patient Charge</b>
D3410	Apicoectomy/Periradicular Surgery Anterior	\$385.00
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$410.00
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	\$435.00
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$155.00
D3430	Retrograde Filling - Per Root	\$100.00
	<b>PERIODONTICS</b> (Treatment of Supporting Tissues [Gum and Bone] of the Teeth)	
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	\$70.00
D4210	Gingivectomy or Gingivoplasty - 4 or More Teeth, Per Quadrant	\$290.00
D4211	Gingivectomy or Gingivoplasty - 1 to 3 Teeth, Per Quadrant	\$145.00
D4240	Gingival Flap, Including Root Planing - 4 or More Teeth, Per Quadrant	\$335.00
D4241	Gingival Flap, Including Root Planing - 1 to 3 Teeth, Per Quadrant	\$175.00
D4245	Apically Positioned Flap	\$335.00
D4249	Clinical Crown Lengthening - Hard Tissue	\$370.00
D4260	Osseous Surgery - 4 or More Teeth or Bounded Spaces, Per Quadrant	\$585.00
D4261	Osseous Surgery - 1 to 3 Teeth, Per Quadrant	\$305.00
D4263	Bone Replacement Graft - First Site in Quadrant	\$260.00
D4264	Bone Replacement Graft - Each Additional Site in Quadrant	\$200.00
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	\$340.00
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	\$385.00
D4270	Pedicle Soft Tissue Graft Procedure	\$450.00
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	\$450.00
D4275	Soft Tissue Allograft	\$450.00
D4341	Periodontal Scaling and Root Planing, Four or More Teeth or Bounded Teeth Spaces Per Quadrant (Limit 4 Quadrants per Consecutive 12 Months)	\$125.00
D4342	Periodontal Scaling and Root Planing- One to Three Teeth, Per Quadrant (Limit 4 Quadrants per Consecutive 12 Months)	\$65.00
D4355	Full Mouth Debridement to Allow Evaluation and Diagnosis (1 Per Lifetime)	\$100.00
D4381	Localized Delivery of Chemotherapeutic Agents, Per Tooth, By Report	\$25.00
D4910	Periodontal Maintenance (Limit of 2 Within the First 12 Months After Active Therapy)	\$85.00
D9940	Occlusal Guard - By Report	\$330.00
D9951	Occlusal Adjustment Limited	\$65.00
D9952	Occlusal Adjustment Complete	\$300.00
	<b>PROSTHETICS</b> (Removable Tooth Replacement - Dentures) (Includes Up to 4 Adjustments Within First 6 Months After Insertion - Replacement Limit 1 Every 5 Years)	
D5110	Full Upper Denture	\$625.00
D5120	Full Lower Denture	\$625.00
D5130	Immediate Full Upper Denture	\$625.00
D5140	Immediate Full Lower Denture	\$625.00
D5211	Upper Partial Denture - Resin Base (Including Clasps, Rests and Teeth)	\$470.00
D5212	Lower Partial Denture - Resin Base (Including Clasps, Rests and Teeth)	\$470.00
D5213	Upper Partial Denture - Metal (Including Clasps, Rests and Teeth)	\$720.00
D5214	Lower Partial Denture - Metal (Including Clasps, Rests and Teeth)	\$720.00
D5225	Upper Partial Denture - Flexible (Including Clasps, Rests and Teeth)	\$470.00
D5226	Lower Partial Denture - Flexible (Including Clasps, Rests and Teeth)	\$470.00
D5410	Adjust Complete Denture Upper	\$40.00
D5411	Adjust Complete Denture Lower	\$40.00
D5421	Adjust Partial Denture Upper	\$40.00
D5422	Adjust Partial Denture Lower	\$40.00
	<b>REPAIRS TO PROSTHETICS</b>	
D5510	Repair Broken Complete Denture Base	\$75.00
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	\$75.00

<b>Code</b>	<b>Procedure Description</b>	<b>Patient Charge</b>
D5610	Repair Resin Denture Base	\$75.00
D5630	Repair or Replace Broken Clasp	\$100.00
D5640	Replace Broken Teeth - Per Tooth	\$75.00
D5650	Add Tooth to Existing Partial Denture	\$75.00
D5660	Add Clasp to Existing Partial Denture	\$100.00
	<b>DENTURE RELINING (Limit 1 Every 36 Months)</b>	
D5710	Rebase Complete Upper Denture	\$225.00
D5711	Rebase Complete Lower Denture	\$225.00
D5720	Rebase Upper Partial Denture	\$225.00
D5721	Rebase Lower Partial Denture	\$225.00
D5730	Reline Complete Upper Denture (Chairside)	\$125.00
D5731	Reline Complete Lower Denture (Chairside)	\$125.00
D5740	Reline Upper Partial Denture (Chairside)	\$125.00
D5741	Reline Lower Partial Denture (Chairside)	\$125.00
D5750	Reline Complete Upper Denture (Laboratory)	\$195.00
D5751	Reline Complete Lower Denture (Laboratory)	\$195.00
D5760	Reline Upper Partial Denture (Laboratory)	\$195.00
D5761	Reline Lower Partial Denture (Laboratory)	\$195.00
	<b>INTERIM DENTURES (Limit 1 Every 5 years)</b>	
D5810	Interim Complete Denture (Upper)	\$330.00
D5811	Interim Complete Denture (Lower)	\$330.00
D5820	Interim Partial Denture (Upper)	\$270.00
D5821	Interim Partial Denture (Lower)	\$270.00
	<b>ORAL SURGERY (Includes Routine Post-Operative Treatment) <i>Surgical Removal of Impacted Tooth - Not Covered for Ages Below 15 Unless Pathology (Disease) Exists.</i></b>	
D7111	Extraction of Coronal Remnants - Deciduous Tooth	\$55.00
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	\$55.00
D7210	Surgical Removal of Erupted Tooth - Removal of Bone and/or Section of Tooth	\$120.00
D7220	Removal of Impacted Tooth - Soft Tissue	\$130.00
D7230	Removal of Impacted Tooth - Partially Bony	\$185.00
D7240	Removal of Impacted Tooth - Completely Bony	\$275.00
D7241	Removal of Impacted Tooth - Completely Bony, Unusual Complications	\$275.00
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	\$120.00
D7260	Oroantral Fistula Closure	\$380.00
D7261	Primary Closure of a Sinus Perforation	\$380.00
D7270	Tooth Stabilization of Accidentally Evulsed or Displaced Tooth	\$170.00
D7280	Surgical Access of an Unerupted Tooth (Excluding Wisdom Teeth)	\$215.00
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	\$55.00
D7285	Biopsy of Oral Tissue - Hard (Bone, Tooth) (Tooth Related - Not allowed when in conjunction with another surgical procedure)	\$180.00
D7286	Biopsy of Oral Tissue - Soft (All Others) (Tooth Related - Not allowed when in conjunction with another surgical procedure)	\$150.00
D7288	Brush Biopsy - Transepithelial Sample Collection	\$60.00
D7310	Alveoloplasty with Extractions - Per Quadrant	\$110.00
D7311	Alveoloplasty with Extractions - Localized, Per Quadrant	\$55.00
D7320	Alveoloplasty not in Conjunction with Extractions - Per Quadrant	\$130.00
D7321	Alveoloplasty not in Conjunction with Extractions - Localized, Per Quadrant	\$65.00
D7450	Removal of Benign Odontogenic Cyst or Tumor - Up to 1.25cm	\$205.00
D7451	Removal of Benign Odontogenic Cyst or Tumor - Greater Than 1.25cm	\$205.00
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	\$220.00
D7472	Removal of Torus Palatinus	\$220.00
D7473	Removal of Torus Mandibularis	\$220.00

Code	Procedure Description	Patient Charge
D7485	Surgical Reduction of Osseous Tuberosity	\$130.00
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	\$85.00
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue Complicated	\$130.00
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate procedure	\$140.00
D7963	Frenuloplasty	\$175.00
	<b>ORTHODONTICS (Tooth Movement)</b> Orthodontic Treatment (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.)	
D8050	Interceptive Orthodontic Treatment of the Primary Dentition (Banding)	\$395.00
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition (Banding)	\$395.00
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition (Banding)	\$425.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (Banding)	\$425.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition (Banding)	\$425.00
D8660	Pre-Orthodontic Treatment Visit	\$55.00
D8670	Periodic Orthodontic Treatment Visit (As Part of Contract)	
	Children (Up to 19 <sup>th</sup> Birthday): 24 Month Treatment Fee	\$2100.00
	Charge Per Month for 24 Months	\$87.50
	Adults: 24 Month Treatment Fee	\$2900.00
	Charge Per Month for 24 Months	\$120.83
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	\$315.00
D8999	Unspecified Orthodontic Procedure, By Report (Orthodontic Treatment Plan and Records)	\$160.00
	<b>GENERAL ANESTHESIA/IV SEDATION</b> - 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 one hour per appointment.	
D9220	General Anesthesia - First 30 Minutes	\$145.00
D9221	General Anesthesia - Additional 15 Minutes	\$65.00
D9241	I.V. Conscious Sedation - First 30 Minutes	\$145.00
D9242	I.V. Conscious Sedation - Additional 15 Minutes	\$65.00
	<b>EMERGENCY SERVICES</b>	
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	\$65.00
D9440	Office Visit - After Regularly Scheduled Hours	\$70.00

**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:

- On-line provider directory at [www.cigna.com](http://www.cigna.com)
- On-line provider directory on [myCIGNA.com](http://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 groups 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 groups plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

This may contain CDT Codes and/or portions of, or excerpts from the Nomenclature contained within the Current Dental Terminology, 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.

“\*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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## ***CIGNA Dental Care Exclusions and Limitations***

*This Fee Overview highlights some of the benefits available under your plan. A complete description regarding the terms of coverage, exclusions and limitation, including benefits will be provided in your insurance certificate or plan description. In case of discrepancy between this Fee Overview and your plan documents, the plan documents will prevail.*

### **Exclusions and Limitations**

Listed below are limitations on services covered by your Dental Plan:

1. **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
2. **Specialty Care** - Except for Pediatric Dentistry and Endodontics, payment authorization is required for coverage of services performed by a Network Specialty Dentist.
3. **Pediatric Dentistry** - 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 after your child's 7th birthday.
4. **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.

### **Exclusions**

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

1. Services not listed on the Patient Charge Schedule.
2. Services provided by a non-Network Dentist without CIGNA Dental's prior approval (except emergencies, as described in your plan documents).
3. Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
6. Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule.
7. General anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.)
8. Prescription drugs.
9. Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or, if your Patient Charge Schedule ends in "-04" or higher, c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction. (California residents: The word "attrition" is modified as follows: except for medically necessary treatment where functionality of teeth has been impaired.)
10. Replacement of fixed and/or removable appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
11. Services associated with the placement or prosthodontic restoration of a dental implant.
12. Services considered to be unnecessary or experimental in nature. (California and Maryland residents: This exclusion should read "Services considered to be unnecessary." Pennsylvania residents: This exclusion should read "Services considered experimental in nature".)
13. Procedures or appliances for minor tooth guidance or to control harmful habits.
14. Hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
15. Services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)
16. The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage. (Texas residents: Pre-existing conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule.)

In addition to the above, if your Patient Charge Schedule number ends in "-04" or a higher number, there is no coverage for the following:

17. Crowns and bridges used solely for splinting.
18. Resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

**For information on this plan, call Customer Service at 1.800.CIGNA24 (1.800.244.6224).**

**You can locate a participating provider by visiting [www.cigna.com](http://www.cigna.com).**

## ***CIGNA Dental PPO Exclusions and Limitations Exclusions and Limitations***

### ***Exclusions***

Covered expenses will not include, and no payment will be made for, expenses incurred for:

- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second or third molars;
- Bite registrations; precision or semi-precision attachments; or splinting;
- A 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;
- Services for which benefits are not payable according to the “General Limitations” section.

In addition, these 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 and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

### ***General Limitations***

No payment will be made for expenses incurred for you or any one of your Dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military service connected condition;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- To the extent that they are more than either the applicable Contracted Fee, applicable Reasonable or Customary Charges or applicable Scheduled Amount;
- 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; or
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

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. Connecticut General Life Insurance Company will take into account any adjustment option chosen under such part by you or any one of your Dependents.

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