

# 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.
- 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.



# Cigna Dental Care®

## Patient Charge Schedule (B1-06)

| Code                         | Procedure Description                                                           | Patient Charge |
|------------------------------|---------------------------------------------------------------------------------|----------------|
| <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) ( <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         |
| 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) – ( <i>Limit 1 Every 3 Years</i> )                      | \$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         |

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## Patient Charge Schedule (B1-06)

| Code                          | Procedure Description                                                                           | Patient Charge |
|-------------------------------|-------------------------------------------------------------------------------------------------|----------------|
| D0474                         | Pathology Report – Microscopic Examination of Lesion and Area                                   | \$0.00         |
| D1110                         | Cleaning – Adult ( <i>Limit 1 Every 6 Months</i> )                                              | \$0.00         |
|                               | (Additional Cleaning, In Addition to the One Allowed Every 6 Months)                            | \$45.00        |
| D1120                         | Cleaning – Child ( <i>Limit 1 Every 6 Months</i> )                                              | \$0.00         |
|                               | (Additional Cleaning, In Addition to the One Allowed Every 6 Months)                            | \$30.00        |
| D1203                         | Topical Fluoride Application – Child ( <i>Up to 19th Birthday</i> ) ( <i>Once in 6 Months</i> ) | \$0.00         |
| D1330                         | Oral Hygiene Instructions                                                                       | \$0.00         |
| D1351                         | Sealant – Per Tooth                                                                             | \$0.00         |
| D1510                         | Space Maintainer – Fixed Unilateral                                                             | \$0.00         |
| D1515                         | Space Maintainer – Fixed Bilateral                                                              | \$0.00         |
| <b>Restorative (Fillings)</b> |                                                                                                 |                |
| D2140                         | Amalgam – One Surface, Primary or Permanent                                                     | \$0.00         |
| D2150                         | Amalgam – Two Surfaces, Primary or Permanent                                                    | \$0.00         |
| D2160                         | Amalgam – Three Surfaces, Primary or Permanent                                                  | \$0.00         |
| D2161                         | Amalgam – Four or More Surfaces, Primary or Permanent                                           | \$0.00         |
| D2330                         | Resin-Based Composite – One Surface, Anterior                                                   | \$0.00         |
| D2331                         | Resin-Based Composite – Two Surfaces, Anterior                                                  | \$0.00         |
| D2332                         | Resin-Based Composite – Three Surfaces, Anterior                                                | \$0.00         |
| D2335                         | Resin-Based Composite – Four or More Surfaces or Involving Incisal Angle (Anterior)             | \$75.00        |
| D2390                         | Resin-Based Composite Crown, Anterior                                                           | \$30.00        |
| 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        |

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## Patient Charge Schedule (B1-06)

| Code                                                                                                                                                              | Procedure Description                                    | Patient Charge |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------|
| 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                           | \$230.00       |
| D2520                                                                                                                                                             | Inlay – Metallic – Two Surfaces                          | \$230.00       |
| D2530                                                                                                                                                             | Inlay – Metallic – Three or More Surfaces                | \$230.00       |
| D2542                                                                                                                                                             | Onlay – Metallic – Two Surfaces                          | \$200.00       |
| D2543                                                                                                                                                             | Onlay – Metallic – Three Surfaces                        | \$200.00       |
| D2544                                                                                                                                                             | Onlay – Metallic – Four or More Surfaces                 | \$200.00       |
| D2740                                                                                                                                                             | Crown – Porcelain/Ceramic Substrate                      | \$230.00       |
| D2750                                                                                                                                                             | Crown – Porcelain Fused to High Noble Metal              | \$220.00       |
| D2751                                                                                                                                                             | Crown – Porcelain Fused to Predominantly Base Metal      | \$175.00       |
| D2752                                                                                                                                                             | Crown – Porcelain Fused to Noble Metal                   | \$210.00       |
| D2780                                                                                                                                                             | Crown – 3/4 Cast High Noble Metal                        | \$220.00       |
| D2781                                                                                                                                                             | Crown – 3/4 Cast Predominantly Base Metal                | \$175.00       |
| D2782                                                                                                                                                             | Crown – 3/4 Cast Noble Metal                             | \$210.00       |
| D2790                                                                                                                                                             | Crown – Full Cast High Noble Metal                       | \$220.00       |
| D2791                                                                                                                                                             | Crown – Full Cast Predominantly Base Metal               | \$175.00       |
| D2792                                                                                                                                                             | Crown – Full Cast Noble Metal                            | \$210.00       |
| D2794                                                                                                                                                             | Crown – Titanium                                         | \$220.00       |
| D2910                                                                                                                                                             | Recement Inlay, Onlay or Veneer                          | \$10.00        |
| D2915                                                                                                                                                             | Recement Cast or Prefabricated Post and Core             | \$10.00        |
| D2920                                                                                                                                                             | Recement Crown                                           | \$10.00        |
| D2930                                                                                                                                                             | Prefabricated Stainless Steel Crown – Primary Tooth      | \$10.00        |

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## Patient Charge Schedule (B1-06)

| Code  | Procedure Description                                               | Patient Charge |
|-------|---------------------------------------------------------------------|----------------|
| D2931 | Prefabricated Stainless Steel Crown – Permanent Tooth               | \$10.00        |
| D2932 | Prefabricated Resin Crown                                           | \$50.00        |
| D2933 | Prefabricated Stainless Steel Crown with Resin Window               | \$70.00        |
| D2934 | Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth | \$70.00        |
| D2940 | Sedative Filling                                                    | \$10.00        |
| D2950 | Core Buildup, Including Any Pins                                    | \$40.00        |
| D2951 | Pin Retention – Per Tooth, In Addition to Restoration               | \$10.00        |
| D2952 | Cast Post and Core, In Addition to Crown                            | \$65.00        |
| D2954 | Prefabricated Post and Core In Addition to Crown                    | \$55.00        |
| D2960 | Labial Veneer (Resin Laminate) – Chairside                          | \$90.00        |
| D6210 | Pontic – Cast High Noble Metal                                      | \$220.00       |
| D6211 | Pontic – Cast Predominantly Base Metal                              | \$175.00       |
| D6212 | Pontic – Cast Noble Metal                                           | \$210.00       |
| D6214 | Pontic Titanium                                                     | \$220.00       |
| D6240 | Pontic – Porcelain Fused to High Noble Metal                        | \$220.00       |
| D6241 | Pontic – Porcelain Fused to Predominantly Base Metal                | \$175.00       |
| D6242 | Pontic – Porcelain Fused to Noble Metal                             | \$210.00       |
| D6245 | Pontic – Porcelain/Ceramic                                          | \$195.00       |
| D6602 | Inlay – Cast High Noble Metal, Two Surfaces                         | \$220.00       |
| D6603 | Inlay – Cast High Noble Metal, Three or More Surfaces               | \$220.00       |
| D6604 | Inlay – Cast Predominantly Base Metal, Two Surfaces                 | \$175.00       |
| D6605 | Inlay – Cast Predominantly Base Metal, Three or More Surfaces       | \$175.00       |
| D6606 | Inlay – Cast Noble Metal, Two Surfaces                              | \$210.00       |
| D6607 | Inlay – Cast Noble Metal, Three or More Surfaces                    | \$210.00       |

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## Patient Charge Schedule (B1-06)

| Code  | Procedure Description                                                                                                                                                                                                                                             | Patient Charge |
|-------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D6610 | Onlay – Cast High Noble Metal, Two Surfaces                                                                                                                                                                                                                       | \$220.00       |
| D6611 | Onlay – Cast High Noble Metal, Three or More Surfaces                                                                                                                                                                                                             | \$220.00       |
| D6612 | Onlay – Cast Predominantly Base Metal, Two Surfaces                                                                                                                                                                                                               | \$175.00       |
| D6613 | Onlay – Cast Predominantly Base Metal, Three or More Surfaces                                                                                                                                                                                                     | \$175.00       |
| D6614 | Onlay – Cast Noble Metal, Two Surfaces                                                                                                                                                                                                                            | \$210.00       |
| D6615 | Onlay – Cast Noble Metal, Three or More Surfaces                                                                                                                                                                                                                  | \$210.00       |
| D6624 | Inlay Titanium                                                                                                                                                                                                                                                    | \$220.00       |
| D6634 | Onlay Titanium                                                                                                                                                                                                                                                    | \$220.00       |
| D6740 | Crown – Porcelain/Ceramic                                                                                                                                                                                                                                         | \$230.00       |
| D6750 | Crown – Porcelain Fused to High Noble Metal                                                                                                                                                                                                                       | \$220.00       |
| D6751 | Crown – Porcelain Fused to Predominantly Base Metal                                                                                                                                                                                                               | \$175.00       |
| D6752 | Crown – Porcelain Fused to Noble Metal                                                                                                                                                                                                                            | \$210.00       |
| D6780 | Crown – 3/4 Cast High Noble Metal                                                                                                                                                                                                                                 | \$220.00       |
| D6781 | Crown – 3/4 Cast Predominantly Base Metal                                                                                                                                                                                                                         | \$175.00       |
| D6782 | Crown – 3/4 Cast Noble Metal                                                                                                                                                                                                                                      | \$210.00       |
| D6790 | Crown – Full Cast High Noble Metal                                                                                                                                                                                                                                | \$220.00       |
| D6791 | Crown – Full Cast Predominantly Base Metal                                                                                                                                                                                                                        | \$175.00       |
| D6792 | Crown – Full Cast Noble Metal                                                                                                                                                                                                                                     | \$210.00       |
| D6794 | Crown Titanium                                                                                                                                                                                                                                                    | \$220.00       |
|       | Complex Rehabilitation – ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION<br><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> | \$125.00       |
| D6930 | Recement Fixed Partial Denture                                                                                                                                                                                                                                    | \$10.00        |

# Cigna Dental Care®

## Patient Charge Schedule (B1-06)

| Code                                                                              | Procedure Description                                                                | Patient Charge |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------|
| <b>Endodontics</b> (Root Canal Treatment, Excluding Final Restorations)           |                                                                                      |                |
| D3110                                                                             | Pulp Cap – Direct (Excluding Final Restoration)                                      | \$10.00        |
| D3120                                                                             | Pulp Cap – Indirect (Excluding Final Restoration)                                    | \$10.00        |
| D3220                                                                             | Pulpotomy – Removal of Pulp, Not Part of a Root Canal                                | \$15.00        |
| D3221                                                                             | Pulpal Debridement ( <i>Not to be used when root canal is done on the same day</i> ) | \$15.00        |
| D3310                                                                             | Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)                  | \$10.00        |
| D3320                                                                             | Bicuspid Root Canal (Permanent Tooth) (Excluding Final Restoration)                  | \$25.00        |
| D3330                                                                             | Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)                     | \$150.00       |
| D3331                                                                             | Treatment of Root Canal Obstruction; Non-Surgical Access                             | \$10.00        |
| D3332                                                                             | Incomplete Endodontic Therapy; Inoperable or Fractured Tooth                         | \$10.00        |
| D3333                                                                             | Internal Root Repair of Perforation Defects                                          | \$10.00        |
| D3346                                                                             | Retreatment of Previous Root Canal Therapy Anterior                                  | \$10.00        |
| D3347                                                                             | Retreatment of Previous Root Canal Therapy Bicuspid                                  | \$25.00        |
| D3348                                                                             | Retreatment of Previous Root Canal Therapy Molar                                     | \$185.00       |
| D3410                                                                             | Apicoectomy/Periradicular Surgery Anterior                                           | \$10.00        |
| D3421                                                                             | Apicoectomy/Periradicular Surgery – Bicuspid (First Root)                            | \$35.00        |
| D3425                                                                             | Apicoectomy/Periradicular Surgery – Molar (First Root)                               | \$60.00        |
| D3426                                                                             | Apicoectomy/Periradicular Surgery (Each Additional Root)                             | \$10.00        |
| D3430                                                                             | Retrograde Filling – Per Root                                                        | \$10.00        |
| <b>Periodontics</b> (Treatment of Supporting Tissues [Gum and Bone] of the Teeth) |                                                                                      |                |
| D0180                                                                             | Comprehensive Periodontal Evaluation – New or Established Patient                    | \$15.00        |

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## Patient Charge Schedule (B1-06)

| Code  | Procedure Description                                                                                                                                | Patient Charge |
|-------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D4210 | Gingivectomy or Gingivoplasty – 4 or More Teeth, Per Quadrant                                                                                        | \$85.00        |
| D4211 | Gingivectomy or Gingivoplasty – 1 to 3 Teeth, Per Quadrant                                                                                           | \$45.00        |
| D4240 | Gingival Flap, Including Root Planing – 4 or More Teeth, Per Quadrant                                                                                | \$100.00       |
| D4241 | Gingival Flap, Including Root Planing – 1 to 3 Teeth, Per Quadrant                                                                                   | \$55.00        |
| D4245 | Apically Positioned Flap                                                                                                                             | \$100.00       |
| D4249 | Clinical Crown Lengthening – Hard Tissue                                                                                                             | \$75.00        |
| D4260 | Osseous Surgery – 4 or More Teeth or Bounded Spaces, Per Quadrant                                                                                    | \$150.00       |
| D4261 | Osseous Surgery – 1 to 3 Teeth, Per Quadrant                                                                                                         | \$80.00        |
| 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                                                                                                                  | \$80.00        |
| D4271 | Free Soft Tissue Graft Procedure (Including Donor Site Surgery)                                                                                      | \$80.00        |
| D4275 | Soft Tissue Allograft                                                                                                                                | \$80.00        |
| D4341 | Periodontal Scaling and Root Planing, Four or More Teeth or Bounded Teeth Spaces Per Quadrant ( <i>Limit 4 Quadrants per Consecutive 12 Months</i> ) | \$35.00        |
| D4342 | Periodontal Scaling and Root Planing – One to Three Teeth, Per Quadrant ( <i>Limit 4 Quadrants per Consecutive 12 Months</i> )                       | \$20.00        |
| D4355 | Full Mouth Debridement to Allow Evaluation and Diagnosis ( <i>1 Per Lifetime</i> )                                                                   | \$35.00        |

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## Patient Charge Schedule (B1-06)

| Code                                                                                                                                                                 | Procedure Description                                                                         | Patient Charge |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------|
| D4381                                                                                                                                                                | Localized Delivery of Chemotherapeutic Agents, Per Tooth, By Report                           | \$25.00        |
| D4910                                                                                                                                                                | Periodontal Maintenance ( <i>Limit of 2 Within the First 12 Months After Active Therapy</i> ) | \$25.00        |
| D9940                                                                                                                                                                | Occlusal Guard – By Report                                                                    | \$80.00        |
| D9951                                                                                                                                                                | Occlusal Adjustment Limited                                                                   | \$25.00        |
| D9952                                                                                                                                                                | Occlusal Adjustment Complete                                                                  | \$65.00        |
| <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                                                                            | \$310.00       |
| D5120                                                                                                                                                                | Full Lower Denture                                                                            | \$310.00       |
| D5130                                                                                                                                                                | Immediate Full Upper Denture                                                                  | \$310.00       |
| D5140                                                                                                                                                                | Immediate Full Lower Denture                                                                  | \$310.00       |
| D5211                                                                                                                                                                | Upper Partial Denture – Resin Base (Including Clasps, Rests and Teeth)                        | \$230.00       |
| D5212                                                                                                                                                                | Lower Partial Denture – Resin Base (Including Clasps, Rests and Teeth)                        | \$230.00       |
| D5213                                                                                                                                                                | Upper Partial Denture – Metal (Including Clasps, Rests and Teeth)                             | \$360.00       |
| D5214                                                                                                                                                                | Lower Partial Denture – Metal (Including Clasps, Rests and Teeth)                             | \$360.00       |
| D5225                                                                                                                                                                | Upper Partial Denture – Flexible (Including Clasps, Rests and Teeth)                          | \$230.00       |
| D5226                                                                                                                                                                | Lower Partial Denture – Flexible (Including Clasps, Rests and Teeth)                          | \$230.00       |
| D5410                                                                                                                                                                | Adjust Complete Denture Upper                                                                 | \$20.00        |
| D5411                                                                                                                                                                | Adjust Complete Denture Lower                                                                 | \$20.00        |
| D5421                                                                                                                                                                | Adjust Partial Denture Upper                                                                  | \$20.00        |
| D5422                                                                                                                                                                | Adjust Partial Denture Lower                                                                  | \$20.00        |

# Cigna Dental Care®

## Patient Charge Schedule (B1-06)

| Code                                              | Procedure Description                                           | Patient Charge |
|---------------------------------------------------|-----------------------------------------------------------------|----------------|
| <b>Repairs To Prosthetics</b>                     |                                                                 |                |
| D5510                                             | Repair Broken Complete Denture Base                             | \$40.00        |
| D5520                                             | Replace Missing or Broken Teeth – Complete Denture (Each Tooth) | \$40.00        |
| D5610                                             | Repair Resin Denture Base                                       | \$40.00        |
| D5630                                             | Repair or Replace Broken Clasp                                  | \$50.00        |
| D5640                                             | Replace Broken Teeth – Per Tooth                                | \$40.00        |
| D5650                                             | Add Tooth to Existing Partial Denture                           | \$40.00        |
| D5660                                             | Add Clasp to Existing Partial Denture                           | \$50.00        |
| <b>Denture Relining (Limit 1 Every 36 Months)</b> |                                                                 |                |
| D5710                                             | Rebase Complete Upper Denture                                   | \$110.00       |
| D5711                                             | Rebase Complete Lower Denture                                   | \$110.00       |
| D5720                                             | Rebase Upper Partial Denture                                    | \$110.00       |
| D5721                                             | Rebase Lower Partial Denture                                    | \$110.00       |
| D5730                                             | Reline Complete Upper Denture (Chairside)                       | \$10.00        |
| D5731                                             | Reline Complete Lower Denture (Chairside)                       | \$10.00        |
| D5740                                             | Reline Upper Partial Denture (Chairside)                        | \$10.00        |
| D5741                                             | Reline Lower Partial Denture (Chairside)                        | \$10.00        |
| D5750                                             | Reline Complete Upper Denture (Laboratory)                      | \$95.00        |
| D5751                                             | Reline Complete Lower Denture (Laboratory)                      | \$95.00        |
| D5760                                             | Reline Upper Partial Denture (Laboratory)                       | \$95.00        |
| D5761                                             | Reline Lower Partial Denture (Laboratory)                       | \$95.00        |
| <b>Interim Dentures (Limit 1 Every 5 years)</b>   |                                                                 |                |
| D5810                                             | Interim Complete Denture (Upper)                                | \$165.00       |
| D5811                                             | Interim Complete Denture (Lower)                                | \$165.00       |

# Cigna Dental Care®

## Patient Charge Schedule (B1-06)

| Code                                                                                                                                                                   | Procedure Description                                                                                                        | Patient Charge |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------|
| D5820                                                                                                                                                                  | Interim Partial Denture (Upper)                                                                                              | \$130.00       |
| D5821                                                                                                                                                                  | Interim Partial Denture (Lower)                                                                                              | \$130.00       |
| <b>Oral Surgery</b> (Includes Routine Post-Operative Treatment) – Surgical Removal of Impacted Tooth – Not Covered for Ages Below 15 Unless Pathology (Disease) Exists |                                                                                                                              |                |
| D7111                                                                                                                                                                  | Extraction of Coronal Remnants – Deciduous Tooth                                                                             | \$10.00        |
| D7140                                                                                                                                                                  | Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)                                                 | \$10.00        |
| D7210                                                                                                                                                                  | Surgical Removal of Erupted Tooth – Removal of Bone and/or Section of Tooth                                                  | \$15.00        |
| D7220                                                                                                                                                                  | Removal of Impacted Tooth – Soft Tissue                                                                                      | \$15.00        |
| D7230                                                                                                                                                                  | Removal of Impacted Tooth – Partially Bony                                                                                   | \$25.00        |
| D7240                                                                                                                                                                  | Removal of Impacted Tooth – Completely Bony                                                                                  | \$50.00        |
| D7241                                                                                                                                                                  | Removal of Impacted Tooth – Completely Bony, Unusual Complications                                                           | \$50.00        |
| D7250                                                                                                                                                                  | Surgical Removal of Residual Tooth Roots (Cutting Procedure)                                                                 | \$15.00        |
| D7260                                                                                                                                                                  | Oroantral Fistula Closure                                                                                                    | \$50.00        |
| D7261                                                                                                                                                                  | Primary Closure of a Sinus Perforation                                                                                       | \$50.00        |
| D7270                                                                                                                                                                  | Tooth Stabilization of Accidentally Evulsed or Displaced Tooth                                                               | \$10.00        |
| D7280                                                                                                                                                                  | Surgical Access of an Unerupted Tooth (Excluding Wisdom Teeth)                                                               | \$10.00        |
| D7283                                                                                                                                                                  | Placement of Device to Facilitate Eruption of Impacted Tooth                                                                 | \$5.00         |
| D7285                                                                                                                                                                  | Biopsy of Oral Tissue – Hard (Bone, Tooth) (Tooth Related – Not allowed when in conjunction with another surgical procedure) | \$45.00        |
| D7286                                                                                                                                                                  | Biopsy of Oral Tissue – Soft (All Others) (Tooth Related – Not allowed when in conjunction with another surgical procedure)  | \$35.00        |
| D7288                                                                                                                                                                  | Brush Biopsy – Transepithelial Sample Collection                                                                             | \$60.00        |

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## Patient Charge Schedule (B1-06)

| Code                                                                                                                                                                                                                               | Procedure Description                                                       | Patient Charge |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------|
| D7310                                                                                                                                                                                                                              | Alveoloplasty with Extractions – Per Quadrant                               | \$10.00        |
| D7311                                                                                                                                                                                                                              | Alveoloplasty with Extractions – Localized, Per Quadrant                    | \$5.00         |
| D7320                                                                                                                                                                                                                              | Alveoloplasty not in Conjunction with Extractions – Per Quadrant            | \$10.00        |
| D7321                                                                                                                                                                                                                              | Alveoloplasty not in Conjunction with Extractions – Localized, Per Quadrant | \$5.00         |
| D7450                                                                                                                                                                                                                              | Removal of Benign Odontogenic Cyst or Tumor – Up to 1.25cm                  | \$10.00        |
| D7451                                                                                                                                                                                                                              | Removal of Benign Odontogenic Cyst or Tumor – Greater than 1.25cm           | \$10.00        |
| D7471                                                                                                                                                                                                                              | Removal of Lateral Exostosis (Maxilla or Mandible)                          | \$10.00        |
| D7472                                                                                                                                                                                                                              | Removal of Torus Palatinus                                                  | \$10.00        |
| D7473                                                                                                                                                                                                                              | Removal of Torus Mandibularis                                               | \$10.00        |
| D7485                                                                                                                                                                                                                              | Surgical Reduction of Osseous Tuberosity                                    | \$10.00        |
| D7510                                                                                                                                                                                                                              | Incision and Drainage of Abscess – Intraoral Soft Tissue                    | \$10.00        |
| D7511                                                                                                                                                                                                                              | Incision and Drainage of Abscess – Intraoral Soft Tissue Complicated        | \$15.00        |
| D7960                                                                                                                                                                                                                              | Frenulectomy (Frenectomy or Frenotomy) – Separate procedure                 | \$10.00        |
| D7963                                                                                                                                                                                                                              | Frenuloplasty                                                               | \$15.00        |
| <b>Orthodontics (Tooth Movement) – 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.)</b> |                                                                             |                |
| 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       |

# Cigna Dental Care®

## Patient Charge Schedule (B1-06)

| Code                                                                                                                                                                                                                                                                                                                                                                                                                        | Procedure Description                                                                    | Patient Charge |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------|
| D8090                                                                                                                                                                                                                                                                                                                                                                                                                       | Comprehensive Orthodontic Treatment of the Adult Dentition (Banding)                     | \$425.00       |
| D8660                                                                                                                                                                                                                                                                                                                                                                                                                       | Pre-Orthodontic Treatment Visit                                                          | \$40.00        |
| D8670                                                                                                                                                                                                                                                                                                                                                                                                                       | Periodic Orthodontic Treatment Visit (As Part of Contract)                               |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                             | Children (Up to 19th Birthday):                                                          |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                             | 24 Month Treatment Fee                                                                   | \$1,300.00     |
|                                                                                                                                                                                                                                                                                                                                                                                                                             | Charge Per Month for 24 Months                                                           | \$54.17        |
|                                                                                                                                                                                                                                                                                                                                                                                                                             | Adults:                                                                                  |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                             | 24 Month Treatment Fee                                                                   | \$1,900.00     |
|                                                                                                                                                                                                                                                                                                                                                                                                                             | Charge Per Month for 24 Months                                                           | \$79.17        |
| 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                                                                                                                                                                                                                                                                                                                                                                                                                       | IV Conscious Sedation – First 30 Minutes                                                 | \$145.00       |
| D9242                                                                                                                                                                                                                                                                                                                                                                                                                       | IV Conscious Sedation – Additional 15 Minutes                                            | \$65.00        |
| <b>Emergency Services</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                          |                |
| D9110                                                                                                                                                                                                                                                                                                                                                                                                                       | Palliative (Emergency) Treatment of Dental Pain – Minor Procedure                        | \$0.00         |
| D9440                                                                                                                                                                                                                                                                                                                                                                                                                       | Office Visit – After Regularly Scheduled Hours                                           | \$60.00        |

### 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:

- Online provider directory at **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.

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.





\* 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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