

## CIGNA DENTAL CARE PLAN® 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 as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested that you check with your Network Dentist in advance of receiving services.
- ▶ This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made by your Network General Dentist to a Network Specialty Endodontist, Periodontist or Oral Surgeon. A referral is not required for Specialty Care at a Network Specialty Pediatric Dentist or Orthodontist. You may select a Network Pediatric Dentist for your child under the age of 13 by calling Customer Service 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 13th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 13th birthday.
- ▶ Procedures not listed on this Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.
- ▶ Infection control and/or sterilization are considered to be incidental to and part of the charges for services provided and not separately chargeable.
- ▶ This Patient Charge Schedule is subject to *annual change* in accordance with the terms of the group agreement.



## CIGNA DENTAL CARE PLAN PATIENT CHARGE SCHEDULE (SCI09)

### Important Highlights (Continued)

- 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 correspond to the Patient Charge Schedule in effect on the date the *procedure is initiated*.
- Current Dental Terminology ("CDT") codes are established by the American Dental Association (ADA) Council on Dental Benefit Programs in accordance with authority granted by the federal government under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) as the national terminology for reporting dental services, and are recognized as the industry standard. The ADA publishes CDT as part of a reference manual and may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures. The language in *italics* is intended to clarify the members' benefit.

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code                                                                                                                                                                                                                                                                                                                                      | Procedure Description                                                                                                                                                             | Patient Charge |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| Office visit fee (per patient, per office visit in addition to any other applicable patient charges)                                                                                                                                                                                                                                      |                                                                                                                                                                                   |                |
|                                                                                                                                                                                                                                                                                                                                           | Office visit fee                                                                                                                                                                  | \$0.00         |
| Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180) and oral evaluations for patients under 3 years of age (D0145). |                                                                                                                                                                                   |                |
| D9310                                                                                                                                                                                                                                                                                                                                     | Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)                                                                     | \$0.00         |
| D9311                                                                                                                                                                                                                                                                                                                                     | Consultation with a medical health care professional                                                                                                                              | \$0.00         |
| D9430                                                                                                                                                                                                                                                                                                                                     | Office visit for observation – No other services performed                                                                                                                        | \$0.00         |
| D9450                                                                                                                                                                                                                                                                                                                                     | Case presentation, subsequent to detailed and extensive treatment planning                                                                                                        | \$0.00         |
| D0120                                                                                                                                                                                                                                                                                                                                     | Periodic oral evaluation – Established patient                                                                                                                                    | \$0.00         |
| D0140                                                                                                                                                                                                                                                                                                                                     | Limited oral evaluation – Problem focused                                                                                                                                         | \$0.00         |
| D0145                                                                                                                                                                                                                                                                                                                                     | Oral evaluation for a patient under 3 years of age and counseling with primary caregiver                                                                                          | \$0.00         |
| D0150                                                                                                                                                                                                                                                                                                                                     | Comprehensive oral evaluation – New or established patient                                                                                                                        | \$0.00         |
| D0160                                                                                                                                                                                                                                                                                                                                     | Detailed and extensive oral evaluation - problem focused, by report <i>(limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)</i> | \$0.00         |
| D0170                                                                                                                                                                                                                                                                                                                                     | Re-evaluation – Limited, problem focused (established patient; not post-operative visit)                                                                                          | \$0.00         |
| D0171                                                                                                                                                                                                                                                                                                                                     | Reevaluation – Post-operative office visit                                                                                                                                        | \$0.00         |
| D0180                                                                                                                                                                                                                                                                                                                                     | Comprehensive periodontal evaluation – New or established patient                                                                                                                 | \$45.00        |
| D0210                                                                                                                                                                                                                                                                                                                                     | X-rays intraoral – Comprehensive series of radiographic images <i>(limited to 1 D0210 or D0709 every 3 years)</i>                                                                 | \$0.00         |
| D0220                                                                                                                                                                                                                                                                                                                                     | X-rays intraoral – Periapical – First radiographic image                                                                                                                          | \$0.00         |

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| Code  | Procedure Description                                                                                                                                                                                                                                                                | Patient Charge |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D0230 | X-rays intraoral – Periapical – Each additional radiographic image                                                                                                                                                                                                                   | \$0.00         |
| D0240 | X-rays intraoral – Occlusal radiographic image                                                                                                                                                                                                                                       | \$0.00         |
| D0251 | X-rays extra-oral posterior dental radiographic image ( <i>limit 1 D0251 or D0705 per calendar year</i> )                                                                                                                                                                            | \$0.00         |
| D0270 | X-rays (bitewing) – Single radiographic image                                                                                                                                                                                                                                        | \$0.00         |
| D0272 | X-rays (bitewings) – 2 radiographic images                                                                                                                                                                                                                                           | \$0.00         |
| D0273 | X-rays (bitewings) – 3 radiographic images                                                                                                                                                                                                                                           | \$0.00         |
| D0274 | X-rays (bitewings) – 4 radiographic images                                                                                                                                                                                                                                           | \$0.00         |
| D0277 | X-rays (bitewings, vertical) – 7 to 8 radiographic images                                                                                                                                                                                                                            | \$0.00         |
| D0330 | X-rays (panoramic radiographic image) – ( <i>limited to 1 D0330 or D0701 every 3 years</i> ) ( <i>when utilized for orthodontic services, see D8999</i> )                                                                                                                            | \$0.00         |
| D0364 | Cone beam CT capture and interpretation with limited field of view – less than one whole jaw ( <i>only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year</i> )                          | \$200.00       |
| D0365 | Cone beam CT capture and interpretation with field of view of one full dental arch – mandible ( <i>only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year</i> )                         | \$220.00       |
| D0366 | Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium ( <i>only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year</i> ) | \$220.00       |
| D0367 | Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium ( <i>only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year</i> )                      | \$240.00       |
| D0368 | Cone beam CT capture and interpretation for TMJ series including two or more exposures ( <i>limit 1 per calendar year; only</i>                                                                                                                                                      | \$240.00       |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code  | Procedure Description                                                                                                                                             | Patient Charge |
|-------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
|       | <i>covered in conjunction with Temporomandibular Joint (TMJ) evaluation)</i>                                                                                      |                |
| D0431 | Oral cancer screening using a special light source                                                                                                                | \$50.00        |
| D0460 | Pulp vitality tests                                                                                                                                               | \$14.00        |
| D0470 | Diagnostic casts <i>(when utilized for orthodontic services, see D8999)</i>                                                                                       | \$0.00         |
| D0472 | Pathology report – Gross examination of lesion (only when tooth related)                                                                                          | \$0.00         |
| D0473 | Pathology report – Microscopic examination of lesion (only when tooth related)                                                                                    | \$0.00         |
| D0474 | Pathology report – Microscopic examination of lesion and area (only when tooth related)                                                                           | \$0.00         |
| D0600 | Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum                            | \$0.00         |
| D0701 | X-rays (panoramic radiographic image) – Image capture only <i>(limited to 1 D0330 or D0701 every 3 years) (when utilized for orthodontic services, see D8999)</i> | \$0.00         |
| D0705 | X-rays extra-oral posterior dental radiographic image – Image capture only <i>(limited to 1 D0251 or D0705 per calendar year)</i>                                 | \$0.00         |
| D0706 | X-rays intraoral – Occlusal radiographic image – Image capture only                                                                                               | \$0.00         |
| D0707 | X-rays intraoral – Periapical radiographic image – Image capture only                                                                                             | \$0.00         |
| D0708 | X-rays intraoral – Bitewing radiographic image – Image capture only                                                                                               | \$0.00         |
| D0709 | X-rays intraoral – Comprehensive series of radiographic images – Image capture only <i>(limit 1 D0210 or D0709 every 3 years)</i>                                 | \$0.00         |
| D1110 | Prophylaxis (cleaning) – Adult <i>(limit 2 per calendar year)</i>                                                                                                 | \$0.00         |
|       | Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year                                                        | \$45.00        |

## CIGNA DENTAL CARE PLAN

### PATIENT CHARGE SCHEDULE (SCIO9)

| Code  | Procedure Description                                                                                                                                                                                                                              | Patient Charge |
|-------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D1120 | Prophylaxis (cleaning) – Child <i>(limit 2 per calendar year)</i>                                                                                                                                                                                  | \$0.00         |
|       | Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year                                                                                                                                         | \$30.00        |
| D1206 | Topical application of fluoride varnish – <i>(limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.</i>                                                                                    | \$0.00         |
|       | Additional topical application of fluoride varnish in addition to any combination of two (2) D1206s (topical application of fluoride varnish) and/or D1208s (topical application of fluoride - excluding varnish) per calendar year.               | \$15.00        |
| D1208 | Topical application of fluoride - excluding varnish <i>(limit 2 per calendar year) There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.</i>                                                                           | \$0.00         |
|       | Additional topical application of fluoride - excluding varnish - In addition to any combination of two (2) D1206s (topical applications of fluoride varnish) and/or D1208s (topical application of fluoride - excluding varnish) per calendar year | \$15.00        |
| D1310 | Nutritional counseling for control of dental disease                                                                                                                                                                                               | \$0.00         |
| D1330 | Oral hygiene instructions                                                                                                                                                                                                                          | \$0.00         |
| D1351 | Sealant – Per tooth                                                                                                                                                                                                                                | \$0.00         |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth                                                                                                                                                           | \$0.00         |
| D1353 | Sealant repair – Per tooth                                                                                                                                                                                                                         | \$11.00        |
| D1354 | Application of caries arresting medicament - Per tooth                                                                                                                                                                                             | \$0.00         |
| D1355 | Caries preventive medicament application – Per tooth                                                                                                                                                                                               | \$0.00         |
| D1510 | Space maintainer – Fixed – Unilateral                                                                                                                                                                                                              | \$110.00       |
| D1516 | Space maintainer – Fixed – Bilateral, Maxillary                                                                                                                                                                                                    | \$170.00       |
| D1517 | Space maintainer – Fixed – Bilateral, Mandibular                                                                                                                                                                                                   | \$170.00       |
| D1551 | Re-cement or re-bond bilateral space maintainer – Upper                                                                                                                                                                                            | \$0.00         |

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## PATIENT CHARGE SCHEDULE (SCI09)

| Code                                                                     | Procedure Description                                                           | Patient Charge |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------|
| D1552                                                                    | Re-cement or re-bond bilateral space maintainer – Lower                         | \$0.00         |
| D1553                                                                    | Re-cement or re-bond unilateral space maintainer – Per quadrant                 | \$0.00         |
| D1556                                                                    | Removal of fixed unilateral space maintainer – Per quadrant                     | \$0.00         |
| D1557                                                                    | Removal of fixed bilateral space maintainer – Upper                             | \$0.00         |
| D1558                                                                    | Removal of fixed bilateral space maintainer – Lower                             | \$0.00         |
| D1575                                                                    | Distal shoe space maintainer – Fixed, Unilateral - Per quadrant                 | \$121.00       |
| Restorative (fillings - primary or permanent teeth, including polishing) |                                                                                 |                |
| D2140                                                                    | Amalgam – 1 surface, primary or permanent                                       | \$6.00         |
| D2150                                                                    | Amalgam – 2 surfaces, primary or permanent                                      | \$6.00         |
| D2160                                                                    | Amalgam – 3 surfaces, primary or permanent                                      | \$12.00        |
| D2161                                                                    | Amalgam – 4 or more surfaces, primary or permanent                              | \$18.00        |
| D2330                                                                    | Resin-based composite – 1 surface, anterior                                     | \$6.00         |
| D2331                                                                    | Resin-based composite – 2 surfaces, anterior                                    | \$13.00        |
| D2332                                                                    | Resin-based composite – 3 surfaces, anterior                                    | \$18.00        |
| D2335                                                                    | Resin-based composite – 4 or more surfaces or involving incisal angle, anterior | \$60.00        |
| D2390                                                                    | Resin-based composite crown, anterior                                           | \$88.00        |
| D2391                                                                    | Resin-based composite – 1 surface, posterior                                    | \$35.00        |
| D2392                                                                    | Resin-based composite – 2 surfaces, posterior                                   | \$45.00        |
| D2393                                                                    | Resin-based composite – 3 surfaces, posterior                                   | \$60.00        |
| D2394                                                                    | Resin-based composite – 4 or more surfaces, posterior                           | \$85.00        |

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## PATIENT CHARGE SCHEDULE (SCIO9)

| Code                                                                                                                                                                                                                        | Procedure Description                                                                                                                                                                                                                                                                                                                                      | Patient Charge |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| Crown and bridge – All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals 1 unit).Coverage for replacement of crowns and bridges is limited to 1 every 5 years. |                                                                                                                                                                                                                                                                                                                                                            |                |
|                                                                                                                                                                                                                             | Additional charge per tooth/unit for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) Services. Same day in-office CAD/CAM (ceramic) Services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine. | \$150.00       |
| D2510                                                                                                                                                                                                                       | Inlay – Metallic – 1 surface                                                                                                                                                                                                                                                                                                                               | \$380.00       |
| D2520                                                                                                                                                                                                                       | Inlay – Metallic – 2 surfaces                                                                                                                                                                                                                                                                                                                              | \$380.00       |
| D2530                                                                                                                                                                                                                       | Inlay – Metallic – 3 or more surfaces                                                                                                                                                                                                                                                                                                                      | \$380.00       |
| D2542                                                                                                                                                                                                                       | Onlay – Metallic – 2 surfaces                                                                                                                                                                                                                                                                                                                              | \$380.00       |
| D2543                                                                                                                                                                                                                       | Onlay – Metallic – 3 surfaces                                                                                                                                                                                                                                                                                                                              | \$380.00       |
| D2544                                                                                                                                                                                                                       | Onlay – Metallic – 4 or more surfaces                                                                                                                                                                                                                                                                                                                      | \$380.00       |
| D2740                                                                                                                                                                                                                       | Crown – Porcelain/ceramic                                                                                                                                                                                                                                                                                                                                  | \$400.00       |
| D2750                                                                                                                                                                                                                       | Crown – Porcelain fused to high noble metal                                                                                                                                                                                                                                                                                                                | \$380.00       |
| D2751                                                                                                                                                                                                                       | Crown – Porcelain fused to predominantly base metal                                                                                                                                                                                                                                                                                                        | \$335.00       |
| D2752                                                                                                                                                                                                                       | Crown – Porcelain fused to noble metal                                                                                                                                                                                                                                                                                                                     | \$360.00       |
| D2780                                                                                                                                                                                                                       | Crown – 3/4 cast high noble metal                                                                                                                                                                                                                                                                                                                          | \$400.00       |
| D2781                                                                                                                                                                                                                       | Crown – 3/4 cast predominantly base metal                                                                                                                                                                                                                                                                                                                  | \$380.00       |
| D2782                                                                                                                                                                                                                       | Crown – 3/4 cast noble metal                                                                                                                                                                                                                                                                                                                               | \$335.00       |
| D2790                                                                                                                                                                                                                       | Crown – Full cast high noble metal                                                                                                                                                                                                                                                                                                                         | \$400.00       |
| D2791                                                                                                                                                                                                                       | Crown – Full cast predominantly base metal                                                                                                                                                                                                                                                                                                                 | \$380.00       |
| D2792                                                                                                                                                                                                                       | Crown – Full cast noble metal                                                                                                                                                                                                                                                                                                                              | \$335.00       |
| D2794                                                                                                                                                                                                                       | Crown – Titanium and titanium alloys                                                                                                                                                                                                                                                                                                                       | \$430.00       |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code  | Procedure Description                                                          | Patient Charge |
|-------|--------------------------------------------------------------------------------|----------------|
| D2910 | Re•cement or re•bond inlay, onlay, veneer or partial coverage restoration      | \$12.00        |
| D2915 | Re•cement or re•bond cast indirectly fabricated or prefabricated post and core | \$12.00        |
| D2920 | Re•cement or re•bond crown                                                     | \$12.00        |
| D2929 | Prefabricated porcelain/ceramic crown - Primary tooth                          | \$145.00       |
| D2930 | Prefabricated stainless steel crown – Primary tooth                            | \$92.00        |
| D2931 | Prefabricated stainless steel crown – Permanent tooth                          | \$92.00        |
| D2932 | Prefabricated resin crown                                                      | \$120.00       |
| D2933 | Prefabricated stainless steel crown with resin window                          | \$145.00       |
| D2934 | Prefabricated esthetic coated stainless steel crown – Primary tooth            | \$145.00       |
| D2940 | Protective restoration                                                         | \$13.00        |
| D2941 | Interim therapeutic restoration - Primary dentition                            | \$13.00        |
| D2950 | Core buildup – Including any pins when required                                | \$97.00        |
| D2951 | Pin retention – Per tooth – In addition to restoration                         | \$18.00        |
| D2952 | Post and core – In addition to crown, indirectly fabricated                    | \$150.00       |
| D2954 | Prefabricated post and core – In addition to crown                             | \$125.00       |
| D2960 | Labial veneer (resin laminate) – Direct                                        | \$105.00       |
| D6210 | Pontic – Cast high noble metal                                                 | \$420.00       |
| D6211 | Pontic – Cast predominantly base metal                                         | \$380.00       |
| D6212 | Pontic – Cast noble metal                                                      | \$410.00       |
| D6214 | Pontic – Titanium and titanium alloys                                          | \$430.00       |
| D6240 | Pontic – Porcelain fused to high noble metal                                   | \$420.00       |
| D6241 | Pontic – Porcelain fused to predominantly base metal                           | \$380.00       |

CIGNA DENTAL CARE PLAN

PATIENT CHARGE SCHEDULE (SCIO9)

| Code  | Procedure Description                                              | Patient Charge |
|-------|--------------------------------------------------------------------|----------------|
| D6242 | Pontic – Porcelain fused to noble metal                            | \$410.00       |
| D6245 | Pontic – Porcelain/ceramic                                         | \$425.00       |
| D6602 | Retainer inlay – Cast high noble metal, 2 surfaces                 | \$420.00       |
| D6603 | Retainer inlay – Cast high noble metal, 3 or more surfaces         | \$430.00       |
| D6604 | Retainer inlay – Cast predominantly base metal, 2 surfaces         | \$370.00       |
| D6605 | Retainer inlay – Cast predominantly base metal, 3 or more surfaces | \$370.00       |
| D6606 | Retainer inlay – Cast noble metal, 2 surfaces                      | \$390.00       |
| D6607 | Retainer inlay – Cast noble metal, 3 or more surfaces              | \$400.00       |
| D6610 | Retainer onlay – Cast high noble metal, 2 surfaces                 | \$430.00       |
| D6611 | Retainer onlay – Cast high noble metal, 3 or more surfaces         | \$430.00       |
| D6612 | Retainer onlay – Cast predominantly base metal, 2 surfaces         | \$370.00       |
| D6613 | Retainer onlay – Cast predominantly base metal, 3 or more surfaces | \$370.00       |
| D6614 | Retainer onlay – Cast noble metal, 2 surfaces                      | \$390.00       |
| D6615 | Retainer onlay – Cast noble metal, 3 or more surfaces              | \$410.00       |
| D6624 | Retainer inlay – Titanium                                          | \$420.00       |
| D6634 | Retainer onlay – Titanium                                          | \$420.00       |
| D6740 | Retainer crown – Porcelain/ceramic                                 | \$470.00       |
| D6750 | Retainer crown – Porcelain fused to high noble metal               | \$430.00       |
| D6751 | Retainer crown – Porcelain fused to predominantly base metal       | \$380.00       |
| D6752 | Retainer crown – Porcelain fused to noble metal                    | \$410.00       |
| D6780 | Retainer crown – 3/4 cast high noble metal                         | \$430.00       |
| D6781 | Retainer crown – 3/4 cast predominantly base metal                 | \$380.00       |
| D6782 | Retainer crown – 3/4 cast noble metal                              | \$410.00       |

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## PATIENT CHARGE SCHEDULE (SCI09)

| Code                                                             | Procedure Description                                                                                                                                                                                                                                            | Patient Charge |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D6790                                                            | Retainer crown – Full cast high noble metal                                                                                                                                                                                                                      | \$430.00       |
| D6791                                                            | Retainer crown – Full cast predominantly base metal                                                                                                                                                                                                              | \$380.00       |
| D6792                                                            | Retainer crown – Full cast noble metal                                                                                                                                                                                                                           | \$410.00       |
| D6794                                                            | Retainer crown – Titanium and titanium alloys                                                                                                                                                                                                                    | \$430.00       |
|                                                                  | Complex rehabilitation – Additional charge per unit for multiple crown units/complex rehabilitation ( <i>6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines</i> ) | \$135.00       |
| D6930                                                            | Re-cement or re-bond fixed partial denture                                                                                                                                                                                                                       | \$12.00        |
| Endodontics (root canal treatment, excluding final restorations) |                                                                                                                                                                                                                                                                  |                |
| D3110                                                            | Pulp cap – Direct (excluding final restoration)                                                                                                                                                                                                                  | \$14.00        |
| D3120                                                            | Pulp cap – Indirect (excluding final restoration)                                                                                                                                                                                                                | \$14.00        |
| D3220                                                            | Pulpotomy – Removal of pulp, not part of a root canal                                                                                                                                                                                                            | \$89.00        |
| D3221                                                            | Pulpal debridement, primary and permanent ( <i>not to be used when root canal is done on the same day</i> )                                                                                                                                                      | \$83.00        |
| D3222                                                            | Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development                                                                                                                                                                            | \$89.00        |
| D3310                                                            | Anterior root canal – Permanent tooth (excluding final restoration)                                                                                                                                                                                              | \$200.00       |
| D3320                                                            | Premolar root canal – Permanent tooth (excluding final restoration)                                                                                                                                                                                              | \$235.00       |
| D3330                                                            | Molar root canal – Permanent tooth (excluding final restoration)                                                                                                                                                                                                 | \$320.00       |
| D3331                                                            | Treatment of root canal obstruction – Nonsurgical access                                                                                                                                                                                                         | \$130.00       |
| D3332                                                            | Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth                                                                                                                                                                                      | \$130.00       |
| D3333                                                            | Internal root repair of perforation defects                                                                                                                                                                                                                      | \$130.00       |
| D3346                                                            | Retreatment of previous root canal therapy – Anterior                                                                                                                                                                                                            | \$395.00       |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCIO9)

| Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Procedure Description                                                                           | Patient Charge |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------|
| D3347                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Retreatment of previous root canal therapy – Premolar                                           | \$445.00       |
| D3348                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Retreatment of previous root canal therapy – Molar                                              | \$565.00       |
| D3410                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Apicoectomy/periradicular surgery – Anterior                                                    | \$360.00       |
| D3421                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Apicoectomy/periradicular surgery – Premolar (first root)                                       | \$385.00       |
| D3425                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Apicoectomy/periradicular surgery – Molar (first root)                                          | \$420.00       |
| D3426                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Apicoectomy/periradicular surgery (each additional root)                                        | \$150.00       |
| D3430                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Retrograde filling per root                                                                     | \$89.00        |
| D3471                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Surgical repair of root resorption – Anterior                                                   | \$360.00       |
| D3472                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Surgical repair of root resorption – Premolar                                                   | \$360.00       |
| D3473                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Surgical repair of root resorption – Molar                                                      | \$360.00       |
| D3501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Surgical exposure of root surface without apicoectomy or repair of root resorption – Anterior   | \$360.00       |
| D3502                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Surgical exposure of root surface without apicoectomy or repair of root resorption – Premolar   | \$360.00       |
| D3503                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Surgical exposure of root surface without apicoectomy or repair of root resorption – Molar      | \$360.00       |
| D3911                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Intraorifice barrier                                                                            | \$0.00         |
| D3921                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Decoronation or submergence of an erupted tooth                                                 | \$0.00         |
| <b>Periodontics (treatment of supporting tissues (gum and bone) of the teeth) periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the patient charge schedule. The relevant procedure codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 teeth (or 8 sites, if applicable) per 12 consecutive months when covered on the patient charge schedule. The use of any tools or equipment, including but not limited to handpieces, lasers, scalers, etc., is considered inclusive to the overall covered procedure listed on the Patient Charge Schedule, and cannot be separately charged.</b> |                                                                                                 |                |
| D4210                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Gingivectomy or gingivoplasty – 4 or more contiguous teeth or tooth bounded spaces per quadrant | \$240.00       |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code  | Procedure Description                                                                                                                            | Patient Charge |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D4211 | Gingivectomy or gingivoplasty – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant                                                     | \$65.00        |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth                                                               | \$65.00        |
| D4240 | Gingival flap (including root planing) – 4 or more contiguous teeth or tooth bounded spaces per quadrant                                         | \$305.00       |
| D4241 | Gingival flap (including root planing) – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant                                            | \$165.00       |
| D4245 | Apically positioned flap                                                                                                                         | \$280.00       |
| D4249 | Clinical crown lengthening – Hard tissue                                                                                                         | \$205.00       |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) – 4 or more contiguous teeth or tooth bounded spaces per quadrant     | \$280.00       |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant        | \$240.00       |
| D4263 | Bone replacement graft – Retained natural tooth - First site in quadrant                                                                         | \$110.00       |
| D4264 | Bone replacement graft – Retained natural tooth - Each additional site in quadrant                                                               | \$80.00        |
| D4266 | Guided tissue regeneration, natural teeth – Resorbable barrier per site                                                                          | \$105.00       |
| D4267 | Guided tissue regeneration, natural teeth – Nonresorbable barrier per site (includes membrane removal)                                           | \$110.00       |
| D4270 | Pedicle soft tissue graft procedure                                                                                                              | \$225.00       |
| D4275 | Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft | \$225.00       |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCIO9)

| Code                                                                                                                                                                | Procedure Description                                                                                                                                                                                | Patient Charge |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D4277                                                                                                                                                               | Free soft tissue graft procedure (including recipient donor surgical sites), first tooth implant or edentulous ( <i>missing</i> ) tooth position in graft                                            | \$225.00       |
| D4278                                                                                                                                                               | Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous ( <i>missing</i> ) tooth position in same graft site        | \$105.00       |
| D4285                                                                                                                                                               | Non-autogenous connective tissue graft procedure (including recipient surgical site and donor materials) – Each additional contiguous tooth, implant or edentulous tooth position in same graft site | \$208.00       |
| D4286                                                                                                                                                               | Removal of non-resorbable barrier                                                                                                                                                                    | \$22.00        |
| D4341                                                                                                                                                               | Periodontal scaling and root planing – 4 or more teeth per quadrant ( <i>limited to once per quadrant per consecutive 12 months</i> )                                                                | \$60.00        |
| D4342                                                                                                                                                               | Periodontal scaling and root planing – 1 to 3 teeth per quadrant ( <i>limited to once per quadrant per consecutive 12 months</i> )                                                                   | \$45.00        |
| D4346                                                                                                                                                               | Scaling in presence of generalized moderate or severe gingival inflammation – Full mouth, after oral evaluation ( <i>limit 1 per calendar year</i> )                                                 | \$0.00         |
|                                                                                                                                                                     | Additional scaling in presence of generalized moderate or severe gingival inflammation – Full mouth, after oral evaluation ( <i>limit 2 per calendar year</i> )                                      | \$45.00        |
| D4355                                                                                                                                                               | Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit ( <i>1 per lifetime, unless medically necessary</i> )                                    | \$84.00        |
| D4381                                                                                                                                                               | Localized delivery of antimicrobial agents per tooth                                                                                                                                                 | \$15.00        |
| D4910                                                                                                                                                               | Periodontal maintenance ( <i>only covered after active periodontal therapy</i> )                                                                                                                     | \$0.00         |
| <b>Prosthetics (removable tooth replacement – dentures) includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years.</b> |                                                                                                                                                                                                      |                |
| D5110                                                                                                                                                               | Full upper denture                                                                                                                                                                                   | \$535.00       |
| D5120                                                                                                                                                               | Full lower denture                                                                                                                                                                                   | \$535.00       |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code  | Procedure Description                                                                                                                     | Patient Charge |
|-------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D5130 | Immediate full upper denture                                                                                                              | \$575.00       |
| D5140 | Immediate full lower denture                                                                                                              | \$575.00       |
| D5211 | Upper partial denture – Resin base (including retentive/clasping materials, rests and teeth)                                              | \$400.00       |
| D5212 | Lower partial denture – Resin base (including retentive/clasping materials, rests and teeth)                                              | \$400.00       |
| D5213 | Upper partial denture – Cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)           | \$625.00       |
| D5214 | Lower partial denture – Cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)           | \$625.00       |
| D5221 | Immediate upper partial denture – Resin base (including retentive/clasping materials, rests and teeth)                                    | \$400.00       |
| D5222 | Immediate lower partial denture – Resin base (including retentive/clasping materials, rests and teeth)                                    | \$400.00       |
| D5223 | Immediate upper partial denture – Cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$625.00       |
| D5224 | Immediate lower partial denture – Cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | \$625.00       |
| D5225 | Upper partial denture – Flexible base (including retentive/clasping materials, rests and teeth)                                           | \$430.00       |
| D5226 | Lower partial denture – Flexible base (including retentive/clasping materials, rests and teeth)                                           | \$430.00       |
| D5410 | Adjust complete denture – Upper                                                                                                           | \$38.00        |
| D5411 | Adjust complete denture – Lower                                                                                                           | \$38.00        |
| D5421 | Adjust partial denture – Upper                                                                                                            | \$38.00        |
| D5422 | Adjust partial denture – Lower                                                                                                            | \$38.00        |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCIO9)

| Code                                       | Procedure Description                                             | Patient Charge |
|--------------------------------------------|-------------------------------------------------------------------|----------------|
| Repairs to prosthetics                     |                                                                   |                |
| D5511                                      | Repair broken complete denture base - Lower                       | \$71.00        |
| D5512                                      | Repair broken complete denture base - Upper                       | \$71.00        |
| D5520                                      | Replace missing or broken teeth – Complete denture (each tooth)   | \$71.00        |
| D5611                                      | Repair resin partial denture base - Lower                         | \$71.00        |
| D5612                                      | Repair resin partial denture base - Upper                         | \$71.00        |
| D5630                                      | Repair or replace broken retentive/clasping materials - Per tooth | \$88.00        |
| D5640                                      | Replace broken teeth – Per tooth                                  | \$71.00        |
| D5650                                      | Add tooth to existing partial denture                             | \$71.00        |
| D5660                                      | Add clasp to existing partial denture - Per tooth                 | \$88.00        |
| Denture relining (limit 1 every 36 months) |                                                                   |                |
| D5710                                      | Rebase complete upper denture                                     | \$210.00       |
| D5711                                      | Rebase complete lower denture                                     | \$210.00       |
| D5720                                      | Rebase upper partial denture                                      | \$210.00       |
| D5721                                      | Rebase lower partial denture                                      | \$210.00       |
| D5730                                      | Reline complete upper denture – Direct                            | \$120.00       |
| D5731                                      | Reline complete lower denture –Direct                             | \$120.00       |
| D5740                                      | Reline upper partial denture – Direct                             | \$120.00       |
| D5741                                      | Reline lower partial denture – Direct                             | \$120.00       |
| D5750                                      | Reline complete upper denture – Indirect                          | \$185.00       |
| D5751                                      | Reline complete lower denture – Indirect                          | \$185.00       |
| D5760                                      | Reline upper partial denture – Indirect                           | \$185.00       |
| D5761                                      | Reline lower partial denture – Indirect                           | \$185.00       |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code                                                                                                                                                                       | Procedure Description                                                                                                                                            | Patient Charge |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| Interim dentures (limit 1 every 5 years)                                                                                                                                   |                                                                                                                                                                  |                |
| D5810                                                                                                                                                                      | Interim complete denture – Upper                                                                                                                                 | \$305.00       |
| D5811                                                                                                                                                                      | Interim complete denture – Lower                                                                                                                                 | \$305.00       |
| D5820                                                                                                                                                                      | Interim partial denture (including retentive/clasping materials, rests and teeth), upper                                                                         | \$255.00       |
| D5821                                                                                                                                                                      | Interim partial denture (including retentive/clasping materials, rests and teeth), lower                                                                         | \$255.00       |
| D5876                                                                                                                                                                      | Add metal substructure to acrylic full denture (per arch)                                                                                                        | \$205.00       |
| Implant Services - Surgical Placement of Implants (D6010, D6012, D6013, D6040, and D6050) have a limit of 1 implant per calendar year with a replacement of 1 per 10 years |                                                                                                                                                                  |                |
| D6010                                                                                                                                                                      | Surgical placement of implant body: Endosteal implant                                                                                                            | \$1,025.00     |
| D6011                                                                                                                                                                      | Surgical access to an implant body (second stage implant surgery)                                                                                                | \$255.00       |
| D6012                                                                                                                                                                      | Surgical placement of interim implant body for transitional prosthesis: Endosteal implant                                                                        | \$390.00       |
| D6013                                                                                                                                                                      | Surgical placement of mini implant                                                                                                                               | \$340.00       |
| D6040                                                                                                                                                                      | Surgical placement: Eposteal implant                                                                                                                             | \$940.00       |
| D6050                                                                                                                                                                      | Surgical placement: Transosteal implant                                                                                                                          | \$920.00       |
| D6055                                                                                                                                                                      | Connecting bar - Implant supported or abutment supported (limit 1 per calendar year)                                                                             | \$1,170.00     |
| D6056                                                                                                                                                                      | Prefabricated abutment - Includes modification and placement (limit 1 per calendar year)                                                                         | \$340.00       |
| D6057                                                                                                                                                                      | Custom fabricated abutment - Includes placement (limit 1 per calendar year)                                                                                      | \$450.00       |
| D6080                                                                                                                                                                      | Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (limit 1 per calendar year) | \$65.00        |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCIO9)

| Code                                                                                                                                                                                                                                                                                            | Procedure Description                                                                                                                                                                                                       | Patient Charge |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D6081                                                                                                                                                                                                                                                                                           | Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure <i>(limit 2 per implant, per calendar year)</i>        | \$12.00        |
| D6090                                                                                                                                                                                                                                                                                           | Repair implant supported prosthesis, by report <i>(limit 1 per calendar year)</i>                                                                                                                                           | \$130.00       |
| D6091                                                                                                                                                                                                                                                                                           | Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment <i>(limit 1 per calendar year)</i>                            | \$60.00        |
| D6095                                                                                                                                                                                                                                                                                           | Repair implant abutment, by report <i>(limit 1 per calendar year)</i>                                                                                                                                                       | \$245.00       |
| D6096                                                                                                                                                                                                                                                                                           | Remove broken implant retaining screw                                                                                                                                                                                       | \$51.00        |
| D6100                                                                                                                                                                                                                                                                                           | Implant removal, by report <i>(limit 1 per calendar year)</i>                                                                                                                                                               | \$245.00       |
| D6101                                                                                                                                                                                                                                                                                           | Debridement of a periimplant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure <i>(limit 1 per calendar year)</i>                      | \$125.00       |
| D6102                                                                                                                                                                                                                                                                                           | Debridement and osseous contouring of a periimplant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, flap entry and closure <i>(limit 1 per calendar year)</i> | \$240.00       |
| D6103                                                                                                                                                                                                                                                                                           | Bone graft for repair of periimplant defect - does not include flap entry and closure <i>(limit 1 per calendar year)</i>                                                                                                    | \$290.00       |
| D6104                                                                                                                                                                                                                                                                                           | Bone graft at time of implant placement <i>(limit 1 per calendar year)</i>                                                                                                                                                  | \$290.00       |
| D6190                                                                                                                                                                                                                                                                                           | Radiographic/surgical implant index, by report <i>(limit 1 per calendar year)</i>                                                                                                                                           | \$165.00       |
| <b>Implant/abutment supported prosthetics – All charges for crown and bridge (fixed partial denture) are per unit (each replacement on a supporting implant(s) equals 1 unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to 1 every 5 years.</b> |                                                                                                                                                                                                                             |                |
|                                                                                                                                                                                                                                                                                                 | Additional charge per tooth/unit for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) Services. Same day in-office CAD/CAM                                     | \$150.00       |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code  | Procedure Description                                                                                                                                              | Patient Charge |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
|       | (ceramic) Services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine. |                |
| D6058 | Abutment supported porcelain/ceramic crown                                                                                                                         | \$525.00       |
| D6059 | Abutment supported porcelain fused to metal crown (high noble metal)                                                                                               | \$500.00       |
| D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal)                                                                                       | \$465.00       |
| D6061 | Abutment supported porcelain fused to metal crown (noble metal)                                                                                                    | \$485.00       |
| D6062 | Abutment supported cast metal crown (high noble metal)                                                                                                             | \$500.00       |
| D6063 | Abutment supported cast metal crown (predominantly base metal)                                                                                                     | \$465.00       |
| D6064 | Abutment supported cast metal crown (noble metal)                                                                                                                  | \$485.00       |
| D6065 | Implant supported porcelain/ceramic crown                                                                                                                          | \$525.00       |
| D6066 | Implant supported crown - Porcelain fused to high noble alloys                                                                                                     | \$500.00       |
| D6067 | Implant supported crown High noble alloys                                                                                                                          | \$500.00       |
| D6068 | Abutment supported retainer for porcelain/ceramic fixed partial denture                                                                                            | \$525.00       |
| D6069 | Abutment supported retainer for porcelain fused to metal fixed partial denture (high noble metal)                                                                  | \$500.00       |
| D6070 | Abutment supported retainer for porcelain fused to metal fixed partial denture (predominantly base metal)                                                          | \$465.00       |
| D6071 | Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal)                                                                       | \$485.00       |
| D6072 | Abutment supported retainer for cast metal fixed partial denture (high noble metal)                                                                                | \$500.00       |
| D6073 | Abutment supported retainer for cast metal fixed partial denture (predominantly base metal)                                                                        | \$465.00       |

CIGNA DENTAL CARE PLAN

PATIENT CHARGE SCHEDULE (SCIO9)

| Code  | Procedure Description                                                                       | Patient Charge |
|-------|---------------------------------------------------------------------------------------------|----------------|
| D6074 | Abutment supported retainer for cast metal fixed partial denture (noble metal)              | \$485.00       |
| D6075 | Implant supported retainer for ceramic fixed partial denture                                | \$525.00       |
| D6076 | Implant supported retainer for fixed partial denture - Porcelain fused to high noble alloys | \$500.00       |
| D6077 | Implant supported retainer for metal fixed partial denture - High noble alloys              | \$500.00       |
| D6092 | Re-cement or re-bond implant/abutment supported crown                                       | \$51.00        |
| D6093 | Re-cement or re-bond implant/abutment supported fixed partial denture                       | \$51.00        |
| D6094 | Abutment supported crown - Titanium and titanium alloys                                     | \$500.00       |
| D6110 | Implant /abutment supported removable denture for edentulous arch – Upper                   | \$835.00       |
| D6111 | Implant /abutment supported removable denture for edentulous arch – Lower                   | \$835.00       |
| D6112 | Implant /abutment supported removable denture for partially edentulous arch – Upper         | \$925.00       |
| D6113 | Implant /abutment supported removable denture for partially edentulous arch – Lower         | \$925.00       |
| D6114 | Implant /abutment supported fixed denture for edentulous arch – Upper                       | \$835.00       |
| D6115 | Implant /abutment supported fixed denture for edentulous arch – Lower                       | \$835.00       |
| D6116 | Implant /abutment supported fixed denture for partially edentulous arch – Upper             | \$925.00       |
| D6117 | Implant /abutment supported fixed denture for partially edentulous arch – Lower             | \$925.00       |
| D6118 | Implant/abutment supported interim fixed denture for edentulous arch – Lower                | \$500.00       |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code                                                                                                                                                               | Procedure Description                                                                                                                                                                                                                                                                                                 | Patient Charge |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D6119                                                                                                                                                              | Implant/abutment supported interim fixed denture for edentulous arch – Upper                                                                                                                                                                                                                                          | \$500.00       |
| D6194                                                                                                                                                              | Abutment supported retainer crown for fixed partial denture - Titanium and titanium alloys                                                                                                                                                                                                                            | \$720.00       |
| D6198                                                                                                                                                              | Remove interim implant component                                                                                                                                                                                                                                                                                      | \$0.00         |
|                                                                                                                                                                    | Complex rehabilitation on implant/abutment supported prosthetic procedures – Additional charge per unit for multiple crown units/complex rehabilitation ( <i>6 or more units of crown and/ or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines</i> ) | \$135.00       |
| <b>Oral surgery (includes routine postoperative treatment)</b><br><b>Surgical removal of impacted teeth are covered for ages below 15 when medically necessary</b> |                                                                                                                                                                                                                                                                                                                       |                |
| D7111                                                                                                                                                              | Extraction of coronal remnants – Primary tooth                                                                                                                                                                                                                                                                        | \$12.00        |
| D7140                                                                                                                                                              | Extraction, erupted tooth or exposed root – Elevation and/or forceps removal                                                                                                                                                                                                                                          | \$12.00        |
| D7210                                                                                                                                                              | Extraction, erupted tooth – Removal of bone and/or section of tooth                                                                                                                                                                                                                                                   | \$71.00        |
| D7220                                                                                                                                                              | Removal of impacted tooth – Soft tissue                                                                                                                                                                                                                                                                               | \$71.00        |
| D7230                                                                                                                                                              | Removal of impacted tooth – Partially bony                                                                                                                                                                                                                                                                            | \$100.00       |
| D7240                                                                                                                                                              | Removal of impacted tooth – Completely bony                                                                                                                                                                                                                                                                           | \$120.00       |
| D7241                                                                                                                                                              | Removal of impacted tooth – Completely bony, unusual complications (narrative required)                                                                                                                                                                                                                               | \$150.00       |
| D7250                                                                                                                                                              | Removal of residual tooth roots – Cutting procedure                                                                                                                                                                                                                                                                   | \$71.00        |
| D7251                                                                                                                                                              | Coronectomy – Intentional partial tooth removal                                                                                                                                                                                                                                                                       | \$145.00       |
| D7260                                                                                                                                                              | Oroantral fistula closure                                                                                                                                                                                                                                                                                             | \$200.00       |
| D7261                                                                                                                                                              | Primary closure of a sinus perforation                                                                                                                                                                                                                                                                                | \$200.00       |
| D7270                                                                                                                                                              | Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth                                                                                                                                                                                                                                 | \$14.00        |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCIO9)

| Code  | Procedure Description                                                                                                                          | Patient Charge |
|-------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D7280 | Exposure of an unerupted tooth <i>(excluding wisdom teeth)</i>                                                                                 | \$14.00        |
| D7283 | Placement of device to facilitate eruption of impacted tooth                                                                                   | \$8.00         |
| D7285 | Incisional biopsy of oral tissue - Hard (bone, tooth) <i>(tooth related - not allowed when in conjunction with another surgical procedure)</i> | \$145.00       |
| D7286 | Incisional biopsy of oral tissue - Soft (all others) <i>(tooth related - not allowed when in conjunction with another surgical procedure)</i>  | \$110.00       |
| D7287 | Exfoliative cytological sample collection                                                                                                      | \$78.00        |
| D7288 | Brush biopsy – Transepithelial sample collection                                                                                               | \$78.00        |
| D7310 | Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant                                                   | \$89.00        |
| D7311 | Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant                                                      | \$45.00        |
| D7320 | Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant                                               | \$120.00       |
| D7321 | Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant                                                  | \$64.00        |
| D7450 | Removal of benign odontogenic cyst or tumor – Up to 1.25 cm                                                                                    | \$14.00        |
| D7451 | Removal of benign odontogenic cyst or tumor – Greater than 1.25 cm                                                                             | \$14.00        |
| D7471 | Removal of lateral exostosis – Maxilla or mandible                                                                                             | \$14.00        |
| D7472 | Removal of torus palatinus                                                                                                                     | \$14.00        |
| D7473 | Removal of torus mandibularis                                                                                                                  | \$14.00        |
| D7485 | Reduction of osseous tuberosity                                                                                                                | \$120.00       |
| D7510 | Incision and drainage of abscess – Intraoral soft tissue                                                                                       | \$14.00        |
| D7511 | Incision and drainage of abscess – Intraoral soft tissue – Complicated                                                                         | \$20.00        |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code                                                                                                                                                                                                                                                                                                                                                                                        | Procedure Description                                                                                                                          | Patient Charge |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D7880                                                                                                                                                                                                                                                                                                                                                                                       | Occlusal orthotic device, by report - <i>(limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)</i> | \$425.00       |
| D7881                                                                                                                                                                                                                                                                                                                                                                                       | Occlusal orthotic device adjustment                                                                                                            | \$38.00        |
| D7922                                                                                                                                                                                                                                                                                                                                                                                       | Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site                                             | \$0.00         |
| D7951                                                                                                                                                                                                                                                                                                                                                                                       | Sinus augmentation with bone or bone substitutes via a lateral open approach <i>(limit 1 per calendar year)</i>                                | \$850.00       |
| D7952                                                                                                                                                                                                                                                                                                                                                                                       | Sinus augmentation via a vertical approach <i>(limit 1 per calendar year)</i>                                                                  | \$640.00       |
| D7953                                                                                                                                                                                                                                                                                                                                                                                       | Bone replacement graft for ridge preservation - Per site <i>(limit 1 per calendar year)</i>                                                    | \$100.00       |
| D7961                                                                                                                                                                                                                                                                                                                                                                                       | Buccal/labial frenectomy (frenulectomy)                                                                                                        | \$14.00        |
| D7963                                                                                                                                                                                                                                                                                                                                                                                       | Frenuloplasty                                                                                                                                  | \$20.00        |
| <b>Orthodontics (tooth movement) - The Patient Charge for your entire orthodontic case, including retention, will be based upon the applicable charge in effect on the date your orthodontic treatment begins (banding/appliance insertion). Coverage is provided for twenty-four (24) months of active treatment. Cases beyond 24 months require an additional payment by the patient.</b> |                                                                                                                                                |                |
| D8010                                                                                                                                                                                                                                                                                                                                                                                       | Limited orthodontic treatment of the primary dentition - Banding                                                                               | \$330.00       |
| D8020                                                                                                                                                                                                                                                                                                                                                                                       | Limited orthodontic treatment of the transitional dentition – Banding                                                                          | \$330.00       |
| D8070                                                                                                                                                                                                                                                                                                                                                                                       | Comprehensive orthodontic treatment of the transitional dentition – Banding                                                                    | \$500.00       |
| D8080                                                                                                                                                                                                                                                                                                                                                                                       | Comprehensive orthodontic treatment of the adolescent dentition – Banding                                                                      | \$515.00       |
| D8090                                                                                                                                                                                                                                                                                                                                                                                       | Comprehensive orthodontic treatment of the adult dentition – Banding                                                                           | \$515.00       |
| D8660                                                                                                                                                                                                                                                                                                                                                                                       | Pre-orthodontic treatment examination to monitor growth and development                                                                        | \$67.00        |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCIO9)

| Code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Procedure Description                                                                                                                                                                                                              | Patient Charge                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| D8670                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Periodic orthodontic treatment visit<br><br>Children – Up to 19th birthday:<br><br>24-month treatment fee<br><br>Charge per month for 24 months<br><br>Adults:<br><br>24-month treatment fee<br><br>Charge per month for 24 months | <br><br><br><br>\$2,112.00<br><br>\$88.00<br><br><br><br>\$2,520.00<br><br>\$105.00 |
| D8680                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Orthodontic retention – Removal of appliances, construction and placement of retainer(s)                                                                                                                                           | \$335.00                                                                            |
| D8681                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Removable orthodontic retainer adjustment                                                                                                                                                                                          | \$0.00                                                                              |
| D8695                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Removal of fixed orthodontic appliances for reasons other than completion of treatment                                                                                                                                             | \$175.00                                                                            |
| D8999                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Unspecified orthodontic procedure – By report ( <i>orthodontic treatment plan and records including all necessary images</i> )                                                                                                     | \$170.00                                                                            |
| <p><b>General anesthesia/IV sedation – General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the patient charge schedule. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the patient charge schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or IV sedation when used for the purpose of anxiety control or patient management.</b></p> |                                                                                                                                                                                                                                    |                                                                                     |
| D9222                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Deep sedation/general anesthesia – First 15 minutes                                                                                                                                                                                | \$50.00                                                                             |
| D9223                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Deep sedation/general anesthesia – Each subsequent 15 minute increment                                                                                                                                                             | \$50.00                                                                             |
| D9239                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Intravenous moderate (conscious) sedation/anesthesia – First 15 minutes                                                                                                                                                            | \$50.00                                                                             |
| D9243                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Intravenous moderate (conscious) sedation/analgesia - Each subsequent 15 minute increment                                                                                                                                          | \$50.00                                                                             |

# CIGNA DENTAL CARE PLAN

## PATIENT CHARGE SCHEDULE (SCI09)

| Code                                                                                                                                                                          | Procedure Description                                                                                                                                         | Patient Charge |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| D9911                                                                                                                                                                         | Application of desensitizing resin for cervical and/or root surface, per tooth                                                                                | \$0.00         |
| Emergency services                                                                                                                                                            |                                                                                                                                                               |                |
| D9110                                                                                                                                                                         | Palliative treatment of dental pain – Per visit                                                                                                               | \$0.00         |
| D9440                                                                                                                                                                         | Office visit – After regularly scheduled hours                                                                                                                | \$66.00        |
| D9613                                                                                                                                                                         | Infiltration of sustained release therapeutic drug – Single or multiple sites                                                                                 | \$50.00        |
| Miscellaneous services                                                                                                                                                        |                                                                                                                                                               |                |
| D9912                                                                                                                                                                         | Pre-visit patient screening                                                                                                                                   | \$0.00         |
| D9941                                                                                                                                                                         | Fabrication of athletic mouthguard - <i>(limit 1 per 12 months)</i>                                                                                           | \$110.00       |
| D9943                                                                                                                                                                         | Occlusal guard adjustment                                                                                                                                     | \$0.00         |
| D9944                                                                                                                                                                         | Occlusal guard – Hard appliance, full arch <i>(limit 1 per 24 months)</i>                                                                                     | \$185.00       |
| D9945                                                                                                                                                                         | Occlusal guard – Soft appliance, full arch <i>(limit 1 per 24 months)</i>                                                                                     | \$94.00        |
| D9946                                                                                                                                                                         | Occlusal guard – Hard appliance, partial arch <i>(limit 1 per 24 months)</i>                                                                                  | \$110.00       |
| D9951                                                                                                                                                                         | Occlusal adjustment – Limited                                                                                                                                 | \$58.00        |
| D9952                                                                                                                                                                         | Occlusal adjustment – Complete                                                                                                                                | \$255.00       |
| D9961                                                                                                                                                                         | Duplicate/copy patient's records                                                                                                                              | \$0.00         |
| D9975                                                                                                                                                                         | External bleaching for home application, per arch; includes materials and fabrication of custom trays <i>(all other methods of bleaching are not covered)</i> | \$165.00       |
| D9990                                                                                                                                                                         | Certified translation or sign language services, per visit                                                                                                    | \$0.00         |
| D9995                                                                                                                                                                         | Teledentistry – Synchronous; real-time encounter                                                                                                              | \$0.00         |
| D9996                                                                                                                                                                         | Teledentistry – Asynchronous; information stored and forwarded to dentist for subsequent review                                                               | \$0.00         |
| This may contain CDT Codes and/or portions of, or excerpts from the Code on Dental Procedures and Nomenclature (CDT Code) contained within the current version of the "Dental |                                                                                                                                                               |                |

CIGNA DENTAL CARE PLAN  
PATIENT CHARGE SCHEDULE (SCI09)

| Code                                                                                                                                                                                                    | Procedure Description | Patient Charge |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------|
| Procedure Codes”, 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.” |                       |                |

## 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 the toll free number listed on your ID card or plan materials.

Multiple ways to locate a Network General Dentist:

- On-line provider directory at **Cigna.com**<sup>®</sup>
- On-line provider directory on **myCigna.com**<sup>®</sup>
- 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 dental office, dental clinic, or other comparable facility. 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.



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