CIGNA DENTAL OPEN ENROLLMENT BROCHURE

State of Connecticut Employees

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Cigna HealthCare of Connecticut, Inc., or their affiliates.

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You and your family have the opportunity to receive dental care through one of the following State of Connecticut dental plans:

- Basic Plan
- Enhanced Plan
- Cigna Dental Care Dental HMO (DHMO)[1]

Learn more. Choose well.

Make sure that you don't miss your opportunity to enroll for this important benefit. Review your plan materials and consider your family's needs. Access your dental benefit information at **Cigna.com/StateofCT** – the website developed by Cigna just for State of Connecticut employees.

We're there for you – when and how you need us.

Call us: 800.Cigna24

Customer service hours include weekdays, Saturdays, Sundays and holidays. Call us at **800.Cigna24** any time you need us – we'll be there. We're on the clock for you 24 hours a day, 7 days a week, 365 days a year. We are here to help answer questions like:

- "My dentist told me I need a root canal. Does my dental plan cover this?"
- "My husband has a painful toothache, but he's in Phoenix on a business trip. Can you help me find a dentist?"

Visit us online

myCigna.com

Completely personalized, so it's easy to quickly find what you're looking for.

- Plan information
- Network directory of dentists
- Oral Health assessments and quizzes
- Out-of-pocket dental cost estimates
- ID Card info
- Claim information
- Discounts on a variety of health and wellness products and services[2]

Online tools

We've created easy and intuitive online tools to help you make smart decisions about your dental care.[3]

If you choose a Cigna Dental Care DHMO plan, you get access to:

- Dentist information. Including professional experience and associations.
- Location information. With maps and contact information.
- Office information. Photos, videos, amenities and technology, if your dentist provides this information.

If you choose a DPPO plan, you can also access:

- Brighter Score™. Use this score to compare dentists, based on affordability, patient experience and professional history.
- Office reviews and comparisons. Read verified patient reviews and view dentist profiles, including pictures and videos.
- Online appointment scheduling. If your dentist offers this service, you can book appointments online and then receive reminders.
- Enhanced search and transparent pricing. Search by dentist or procedures to estimate out-of-pocket costs, including coinsurance and deductibles, for your specific plan.

Always on the go? You can also use many of the above services on the myCigna® App!

Cigna.com/StateofCT

Visit the customized website developed by Cigna just for State of CT employees with:

- Information on plan specifics
- Help finding participating dentists and specialists
- Programs and plan features available to you

Programs to support your overall health

Your health. Our focus.

In the real world, you have to balance your time, commitments and priorities. At Cigna, we keep our focus on helping you live healthier. Value-added programs, such as wellness and discount programs are included with your Cigna dental plan.

Cigna Dental Oral Health Integration Program®

Research shows an association between oral health and overall health.[4] With the right oral health care, and regular medical treatments, high-risk individuals may be able to improve their overall health.

With this program, eligible members with certain medical conditions may receive 100% reimbursement of their out-of-pocket costs for select covered dental services.[5]

The qualifying medical conditions for this program are:

- Heart disease
- Stroke
- Diabetes
- Pregnancy
- Chronic kidney disease
- Organ transplants
- Head and neck cancer radiation

For additional information regarding this program please review the flyer and Frequently Asked Questions section at the end of this document or visit **myCigna.com**.

Cigna Healthy Rewards®

Cigna's Healthy Rewards[2] Program gives discounts on healthy programs, products and services. There's no time limit or maximum. Just visit a participating provider or shop online to enjoy these instant savings. No referrals or claim forms are needed. The following Healthy Rewards programs are available:

- Weight and nutrition management
- Fitness
- Vision and hearing care
- Vitamins, health and wellness products

After you enroll in one of the Cigna Dental insurance plans, you can learn more about Healthy Rewards by visiting **myCigna.com**.

Your dental plan choices at a glance

Basic Plan – This plan allows you to visit any dentist or specialist.

Enhanced Plan – This plan offers dental services both within and outside of a network of dentists and dental specialists without a referral. **However, your out-of-pocket expenses may be higher if you see an out-of-network provider.**

Cigna Dental Care Dental HMO (DHMO) Plan – This plan provides in-network dental services. You must select a primary care dentist (PCD) to coordinate all care and referrals are required for some specialist services.[6]

	BASIC PLAN (any dentist)	ENHANCED PLAN (network)	CIGNA DENTAL CARE DHMO PLAN (network only)[6]
Annual deductible	None	$25/individual, $75/family	None
Annual maximum	None (Maximum $500 per person for periodontics)	Maximum $3,000 per person (excluding orthodontics)	None
Exams, cleanings, and Routine X-rays	Covered at 100%	Covered at 100%[8] no deductible	Covered at 100%
Periodontics:			
Periodontal maintenance	Covered at 80%[7]	Covered at 100%[8] no deductible	Covered[9]
Periodontal scaling and root planing	Covered at 50% (to a maximum of $500)[7]	Covered at 80%[8]	Covered[9]
All other covered periodontal services	Covered at 50% (to a maximum of $500)	Covered at 80%	Covered[9]
Simple restoration (Fillings)	Covered at 80%	Covered at 80%	Covered[9]
Oral surgery	Covered at 67%	Covered at 80%	Covered[9]
Major restoration (Crowns)	Covered at 67%	Covered at 67%	Covered[9]
Dentures, fixed bridges	Not covered[10]	Covered at 50%	Covered[9]
Implants	Not covered[10]	Covered at 50% (to a maximum of $500)	Covered[9]
Orthodontia	Not covered[10]	Maximum: $1,500 per person per lifetime	Covered[9]

Sample out-of-pocket costs for common dental procedures

Here's a comparison of sample out-of-pocket costs for common dental procedures under each State of Connecticut dental plan option. **Keep in mind this information is for illustrative purposes only and that costs may differ based on your dentist and/or geographic location. These costs are based on average in- and out-of-network dental fees within the State of Connecticut, according to utilization data (February 2017).**

	BASIC PLAN (any dentist)		ENHANCED PLAN (network)		CIGNA DENTAL CARE DHMO PLAN
DENTAL PROCEDURE/TREATMENT	In-network	Out-of-network	In-network	Out-of-network	Network only[6]
Oral exam	$0	$0	$0	$35	$0
Bitewings – four films	$0	$0	$0	$43	$0
Routine cleaning – adult	$0	$0	$0	$56	$0
Routine cleaning – child	$0	$0	$0	$45	$0
Surgical placement of implant body: Endosteal implant	$2,095 (implants not covered)	$2,095 (implants not covered)	$1,415	$1,596	$1,025
One amalgam fillings (two Surface)	$21	$38	$21	$131	$6
Simple extraction – performed by general dentist	$24	$44	$24	$160	$12
Deep sedation/general anesthesia – first 30 minutes	$49	$77	$30	$144	$90
Crown – core buildup, including any pins	$63	$105	$63	$217	$97
Crown – porcelain fused to high noble metal	$298	$430	$298	$833	$420
Total:	**$360**	**$535**	**$360**	**$1,050**	**$517**
Comprehensive orthodontic treatment – adolescent: Includes pre-orthodontic treatment visit, orthodontic treatment plan and records, banding, 24-month treatment fee, removal of appliances, and retention	$6,897	$6,897	$3,473	$5,397	$3,402

These are only the highlights. Review the information in this guide for additional details, including related plan exclusions and limitations.

Coverage for fillings under the Basic and Enhanced Plans

There's not always one simple answer for treating a dental condition. You and your dentist should discuss the various options, and then you can decide on the best approach. Your costs may vary based on the treatment plan you choose.

The Basic and Enhanced Plans provide coverage for **amalgam (silver) fillings only** on posterior (back) teeth. If you decide to get a composite (white) filling on a posterior tooth, you'll be responsible for paying the dentist the difference between the silver filling covered by the plan and the more expensive restoration. Both of these methods are recognized by the dental profession as acceptable treatment plans; however, the silver filling is the least costly alternative for treatment.

Coverage for bridges, crowns and dentures under the Basic and Enhanced Plans

Replacement of bridge, crown or dentures will not be covered if it is replaced within seven years of the original installation date unless the following is occurs: The replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture. No coverage for replacement of crowns if damage or breakage was directly due to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.

Savings on non-covered services

Many of our Basic or Enhanced DPPO network dentists have agreed to offer network discounts to you and your covered dependents for non-covered services. **These savings may also apply to services that would not be covered** because you reached your annual benefit maximum, or due to other plan limitations such as frequency, age or missing tooth limitations.[11]

- You can obtain savings on most services not covered under the Basic or Enhanced Plans.[11]
- You **must visit network dentists** in order to take advantage of the Cigna Dental PPO network discounts.
- Savings will not apply if you or your covered dependents visit a non-participating dentist.
- You must **verify that a procedure is listed on the dentist's fee schedule** prior to receiving treatment.
- You are responsible for paying the negotiated fees directly to the dentist.

STATE OF CONNECTICUT – BASIC PLAN

Effective Date: July 01, 2018

This is a summary of benefits for your dental plan.

CIGNA DENTAL BENEFITS	
Maximum	
Periodontics	$500[12]
All categories except periodontics	Unlimited
Calendar year deductible	$0
Preventive and diagnostic care	**Plan pays**
Cleanings – limit: Two per calendar year Oral exams – limit: Two per calendar year Bitewing X-rays – limit: One per calendar year	100%
Basic restorative care	
Fillings[13] Fluoride application – under age 16 two per calendar year Sealants – under age 16, one treatment per tooth every three years Non-routine X-rays – limit: Once every five calendar years Emergency care to relieve pain Oral surgery – simple extractions Root canal therapy/endodontics Stainless steel/resin crowns – limit: Replacement every seven years Relines, rebases and adjustment – allowable six months after install Repairs – bridges, crowns, and inlays Repairs – dentures	80%
Major restorative care	
Crowns/inlays/onlays – replacement every seven years Surgical extraction of impacted teeth Oral surgery – all except simple extraction Space maintainers (limited to non-orthodontic treatment)	67%
Periodontics	
Periodontal scaling and root planing – only one per person in any 24 consecutive months	50%, to a maximum of $500[12]
All other periodontal services: Osseous surgery – only one per person in any 36 consecutive months Clinical crown lengthening Bone replacement graft Gingivectomy Full mouth debridement	50%, to a maximum of $500[12]
Pretreatment review	Voluntary basis when extensive work in excess of $200 is proposed.

Where allowed by state law, in-network providers will charge no more than negotiated rate for non-covered services.

Please refer to the Summary Plan Description posted at **Cigna.com/StateofCT** for a full listing of covered benefits, exclusions and limitations.

CIGNA DENTAL PPO/INDEMNITY EXCLUSIONS AND LIMITATIONS	
Procedure	**Exclusions and limitations**
Missing Tooth Limitation	Not applicable
Oral Exams	2 per calendar year
X-rays (routine)	Bitewings: 1 per calendar year
X-rays (non-routine)	Full mouth: 1 every 5 calendar years; Panorex: 1 every 5 calendar years
Cleanings	2 routine and 2 periodontal cleanings per calendar year
Fluoride Application	2 per calendar year for children under 16 years of age
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 3 calendar years on children under 16
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Study Models or Diagnostic Casts	Not covered
Periodontal Treatment	Various limitations depending on the service, Frequency limit of once per 24 months
Periodontal Surgery	Various limitations depending on the service, Frequency limit of once per 36 months
Inlays and Crowns	Replacement every 7 years if unserviceable and cannot be repaired
Anesthesia	Not Covered
Dentures, Bridges and Partials	Not Covered
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	1 per 7 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.

Benefit exclusions:

Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not listed under Benefit Highlights;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Periodontic: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Implants: implants or implant related services;
- Orthodontics: orthodontic treatment;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;
- Athletic mouth guards; Replacement of a lost or stolen appliance; Services performed primarily for cosmetic reasons; Personalization;
- Services that are deemed to be medical in nature; Services and supplies received from a hospital; Drugs: prescription drugs
- Contracted providers are not obligated to provide discounts on non-covered services and may charge their usual fees.

STATE OF CONNECTICUT – ENHANCED PLAN

Effective Date: July 01, 2018

This is a summary of benefits for your dental plan.

CIGNA DENTAL NETWORK BENEFITS	
Maximum	
Dental implants	$500
Orthodontia	$1,500 per member lifetime maximum
All other categories (except those noted above)	$3,000
Calendar year deductible	
Per individual	$25
Per family	$75
Preventive and diagnostic care	**Plan pays**
Cleanings – limit: Two per calendar year Oral exams – limit: Two per calendar year Bitewing X-rays – limit: One per calendar year Nonroutine X-rays – once every five calendar years Fluoride application – under age 16 two per calendar year Sealants – under age 16, one treatment per tooth every three years	100%, no deductible
Basic restorative care	
Fillings[14] Emergency care to relieve pain Oral surgery – simple extractions Root canal therapy/endodontics Surgical extraction of impacted teeth Oral surgery – all except simple extraction Relines, rebases and adjustments – allowable six months after install Repairs – bridges, crowns and inlays Repairs – dentures Space maintainers (limited to non-orthodontic treatment)	80%
Major restorative care	
Crowns/inlays/onlays – replacement every seven years Stainless steel/resin crowns – replacement every seven years	67%
Periodontics	
Periodontal maintenance[15] – two per calendar year	100%, no deductible
Periodontal scaling and root planing[15] – only one per person in any 24 consecutive months Osseous surgery – only one per person in any 36 consecutive months Clinical crown lengthening Bone replacement graft Gingivectomy Full mouth debridement	80%
Prosthetics	
Bridges (replacement every seven years) Dentures (replacement every seven years)	50%
Implants	50%, to a maximum of $500
Orthodontia	
Coverage for children and adults	50%, no deductible ($1,500 per member lifetime maximum)
Pretreatment review	Voluntary basis when extensive work in excess of $200 is proposed.

If using an out of network dentist, reimbursement based on maximum allowable charge.
Where allowed by state law, in-network providers will charge no more than negotiated rate for non-covered services.
Please refer to the Summary Plan Description posted at **Cigna.com/StateofCT** for a full listing of covered benefits, exclusions and limitations.

EXCLUSIONS AND LIMITATIONS	
Procedure	**Exclusions and limitations**
Missing Tooth Limitation	Not applicable.
Oral Exams	2 per calendar year
X-rays (routine)	Bitewings: 1 per calendar year
X-rays (non-routine)	Full mouth: 1 every 5 calendar years; Panorex: 1 every 5 calendar years
Cleanings	2 routine and 2 periodontal cleanings per calendar year
Fluoride Application	2 per calendar year for children under 16 years of age
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 3 calendar years on children under 16
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Study Models or Diagnostic Casts	Payable only when in conjunction with ortho work up
Periodontal Treatment	Various limitations depending on the service, Frequency limit of once per 24 months
Periodontal Surgery	Various limitations depending on the service, Frequency limit of once per 36 months
Inlays and Crowns	Replacement every 7 years if unserviceable and cannot be repaired
Dentures, Bridges and Partials	Replacement every 7 years if unserviceable and cannot be repaired
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	1 per 7 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.

Benefit exclusions:

Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not listed under Benefit Highlights;
- Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- Periodontic: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;
- Athletic mouth guards; Replacement of a lost or stolen appliance; Services performed primarily for cosmetic reasons; Personalization;
- Services that are deemed to be medical in nature; Services and supplies received from a hospital; Drugs: prescription drugs
- Charges in excess of the Maximum Reimbursable Charge.
- Contracted providers are not obligated to provide discounts on non-covered services and may charge their usual fees.

CIGNA DENTAL CARE® – DHMO[1]

ECONOMICAL, EASY-TO-USE DENTAL COVERAGE

State of Connecticut **SCT07**

Under your plan, you have coverage for hundreds of dental procedures. This overview shows the list of covered services and what you will pay when you visit a participating Cigna Dental Care DHMO network dentist.[6]

Review your plan materials to understand how your plan works including how to choose an in-network provider. For questions on the plan, or to ask for a full list of covered services and exclusions and limitations, call **800.Cigna24 (800.244.6224)**.

Regular dental visits may do more than brighten your smile. Receiving regular dental care often catches minor problems before they become major and more expensive to treat.

And there's an association between gum disease and other conditions, such as preterm birth, heart disease, stroke, diabetes and other health issues.[4] So taking good care of your teeth and gums may help you live a healthier life.

Get the most value from your plan

Take advantage of your plan's preventive care services – most are covered at low cost or no cost to you. Your plan also covers many other dental services that can help you achieve and maintain a healthy mouth..

Key plan features

- **No deductibles** – you don't have to reach a certain level of out-of-pocket expenses before your insurance kicks in.
- **No dollar maximums** – Your coverage isn't limited by a dollar amount.
- **Easy to understand plan –** The fees you pay your dentist are clearly listed on your Patient Charge Schedule (PCS).
- There are no claim forms to file when using an in-network dentist.
- The network general dentist you choose will manage your overall dental care.
- Covered family members can choose their own network general dentists near home, work or school.
- You don't need a referral for children under seven to visit a network pediatric dentist. And you don't need a referral to see a network orthodontist.
- There's no age limit on sealants, which help prevent tooth decay.
- Your plan covers certain procedures to help detect oral cancer in its early stages.
- 24/7 access to the Dental Information Line, staffed by trained professionals who can help if you have questions about dental treatment and clinical symptoms.

Finding an in-network dentist is easy.

There are several ways to select your network general dentist:

- Go to the Provider Directory at **Cigna.com/StateofCT, myCigna.com**, or the **myCigna App**. Our online dental directory is updated weekly.
- Call **800.Cigna24 (800.244.6224)** to speak with a customer service representative. Our representatives can send you a customized dental directory listing via email if you'd like.

Make sure you read this important information

WHAT'S COVERED[16]

You can save money on a wide range of services, including:

- **Preventive care** – cleanings, fluoride, sealants, bitewing X-rays, full mouth X-rays, and more
- **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam)
- **Major services** – crowns, bridges, and dentures, root canals, oral surgery, extractions, treatment for periodontal (gum) disease, and more
- **Specialty care** – at the same fee as general care, with an approved referral
- **Orthodontic care** – braces for children and adults
- **General anesthesia** – when medically necessary
- **Teeth whitening** – using take-home bleaching trays and gel

See following pages for covered procedures and patient charges.

Code	Procedure Description	SCTI9
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
D9430	Office visit for observation – No other services performed	$0.00
D9450	Case presentation – Detailed and extensive treatment planning	$0.00
D0120	Periodic oral evaluation – Established patient	$0.00
D0140	Limited oral evaluation – Problem focused	$0.00
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation – New or established patient	$0.00
D0160	Detailed and extensive oral evaluation – problem focused, by report (Limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)	$0.00
D0170	Reevaluation – Limited, problem focused (Not postoperative visit)	$0.00
D0180	Comprehensive periodontal evaluation – New or established patient	$45.00
D0210	X-rays intraoral – Complete series of radiographic images (Limit 1 every 3 years)	$0.00
D0220	X-rays intraoral – Periapical – First radiographic image	$0.00
D0230	X-rays intraoral – Periapical – Each additional radiographic image	$0.00
D0240	X-rays intraoral – Occlusal radiographic image	$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) – (Limit 1 every 3 years)	$0.00
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw (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)	$200.00
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – Mandible (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)	$220.00

Code	Procedure Description	SCTI9
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – Maxilla, with or without cranium (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)	$220.00
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium (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)	$240.00
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures (Limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)	$240.00
D0431	Oral cancer screening using a special light source	$50.00
D0460	Pulp vitality tests	$14.00
D0470	Diagnostic casts	$0.00
D0472	Pathology report – Gross examination of lesion (Only when tooth related)	$0.00
D0473	Pathology report – Microscopic examination of lesion (Only when tooth related)	$0.00
D0474	Pathology report – Microscopic examination of lesion and area (Only when tooth related)	$0.00
D1110	Prophylaxis (Cleaning) – Adult (Limit 2 per calendar year)	$0.00
	Additional prophylaxis (Cleaning) – In addition to the 2 prophylaxes (Cleanings) allowed per calendar year	$45.00
D1120	Prophylaxis (Cleaning) – Child (Limit 2 per calendar year)	$0.00
Additional prophylaxis (Cleaning) – In addition to the 2 prophylaxes (Cleanings) allowed per calendar year		$30.00
Coverage for treatment by a pediatric dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your network general dentist will provide care upon your child's 7th birthday.		
D1206	Topical application of fluoride varnish – (Limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.	$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) per calendar year.		$15.00
D1208	Topical application of fluoride (Limit 2 per calendar year) There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.	$0.00
Additional topical application of fluoride – In addition to any combination of two (2) D1206s (Topical applications of fluoride varnish) and/or D1208s (Topical application of fluoride) per calendar year		$15.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant – Per tooth	$17.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth	$17.00
D1510	Space maintainer – Fixed – Unilateral	$110.00
D1515	Space maintainer – Fixed – Bilateral	$170.00
D1555	Removal of fixed space maintainer	$0.00
Restorative (Fillings, 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	$88.00
D2390	Resin-based composite crown, anterior	$88.00
D2391	Resin-based composite – 1 surface, posterior	$47.00
D2392	Resin-based composite – 2 surfaces, posterior	$59.00
D2393	Resin-based composite – 3 surfaces, posterior	$82.00
D2394	Resin-based composite – 4 or more surfaces, posterior	$115.00

Code	Procedure Description	SCTI9
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		
Per tooth charge 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	$440.00
D2543	Onlay – Metallic – 3 surfaces	$440.00
D2544	Onlay – Metallic – 4 or more surfaces	$440.00
D2740	Crown – Porcelain/ceramic substrate	$460.00
D2750	Crown – Porcelain fused to high noble metal	$420.00
D2751	Crown – Porcelain fused to predominantly base metal	$370.00
D2752	Crown – Porcelain fused to noble metal	$400.00
D2780	Crown – 3/4 cast high noble metal	$430.00
D2781	Crown – 3/4 cast predominantly base metal	$380.00
D2782	Crown – 3/4 cast noble metal	$410.00
D2790	Crown – Full cast high noble metal	$430.00
D2791	Crown – Full cast predominantly base metal	$380.00
D2792	Crown – Full cast noble metal	$410.00
D2794	Crown – Titanium	$430.00
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
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) – Chairside	$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	$430.00
D6240	Pontic – Porcelain fused to high noble metal	$420.00
D6241	Pontic – Porcelain fused to predominantly base metal	$380.00
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

Code	Procedure Description	SCTI9
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
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	$430.00
Complex rehabilitation – Additional charge per unit for multiple crown units/complex rehabilitation (6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – Ask your dentist for the guidelines)		$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 (Not to be used when root canal is done on the same day)	$83.00
D3222	Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development	$89.00
D3310	Anterior root canal – Permanent tooth (Excluding final restoration)	$275.00
D3320	Bicuspid root canal – Permanent tooth (Excluding final restoration)	$320.00
D3330	Molar root canal – Permanent tooth (Excluding final restoration)	$440.00
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
D3347	Retreatment of previous root canal therapy – Bicuspid	$445.00
D3348	Retreatment of previous root canal therapy – Molar	$565.00
D3410	Apicoectomy/periradicular surgery – Anterior	$360.00
D3421	Apicoectomy/periradicular surgery – Bicuspid (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
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.		
D4210	Gingivectomy or gingivoplasty – 4 or more contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4211	Gingivectomy or gingivoplasty – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$105.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$105.00
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	$340.00
D4260	Osseous surgery (Including elevation of a full thickness flap and closure) – 4 or more contiguous teeth or tooth bounded spaces per quadrant	$540.00
D4261	Osseous surgery (Including elevation of a full thickness flap and closure) – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	$310.00

Code	Procedure Description	SCTI9
D4263	Bone replacement graft – First site in quadrant	$290.00
D4264	Bone replacement graft – Each additional site in quadrant	$225.00
D4266	Guided tissue regeneration – Resorbable barrier per site	$380.00
D4267	Guided tissue regeneration – Nonresorbable barrier per site (Includes membrane removal)	$430.00
D4270	Pedicle soft tissue graft procedure	$415.00
D4275	Non-autogenous connective tissue graft (Including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$415.00
D4277	Free soft tissue graft procedure (Including recipient donor surgical sites), first tooth implant or edentulous (Missing) tooth position in graft	$415.00
D4278	Free soft tissue graft procedure (Including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous (Missing) tooth position in same graft site	$210.00
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant (Limit 4 quadrants per consecutive 12 months)	$110.00
D4342	Periodontal scaling and root planing – 1 to 3 teeth – Per quadrant (Limit 4 quadrants per consecutive 12 months)	$60.00
D4355	Full mouth debridement to allow evaluation and diagnosis (1 per lifetime)	$84.00
D4381	Localized delivery of antimicrobial agents per tooth	$45.00
D4910	Periodontal maintenance (Only covered after active periodontal therapy)	$77.00
Prosthetics (removable tooth replacement – dentures) includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years.		
D5110	Full upper denture	$535.00
D5120	Full lower denture	$535.00
D5130	Immediate full upper denture	$575.00
D5140	Immediate full lower denture	$575.00
D5211	Upper partial denture – Resin base (Including clasps, rests and teeth)	$400.00
D5212	Lower partial denture – Resin base (Including clasps, rests and teeth)	$400.00
D5213	Upper partial denture – Cast metal framework (Including clasps, rests and teeth)	$625.00
D5214	Lower partial denture – Cast metal framework (Including clasps, rests and teeth)	$625.00
D5225	Upper partial denture – Flexible base (Including clasps, rests and teeth)	$430.00
D5226	Lower partial denture – Flexible base (Including clasps, 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
Repairs to prosthetics		
D5510	Repair broken complete denture base	$71.00
D5520	Replace missing or broken teeth – Complete denture (Each tooth)	$71.00
D5610	Repair resin denture base	$71.00
D5630	Repair or replace broken clasp – 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 – Chairside	$120.00
D5731	Reline complete lower denture – Chairside	$120.00
D5740	Reline upper partial denture – Chairside	$120.00
D5741	Reline lower partial denture – Chairside	$120.00
D5750	Reline complete upper denture – Laboratory	$185.00
D5751	Reline complete lower denture – Laboratory	$185.00
D5760	Reline upper partial denture – Laboratory	$185.00
D5761	Reline lower partial denture – Laboratory	$185.00
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 – Upper	$255.00
D5821	Interim partial denture – Lower	$255.00

Code	Procedure Description	SCTI9
Implant Services – Surgical Placement of Implants (D6010, D6012, 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
D6012	Surgical placement of interim implant body for transitional prosthesis: Endosteal implant	$390.00
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)	$355.00
D6057	Custom fabricated abutment – Includes placement (Limit 1 per calendar year)	$455.00
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (Limit 1 per calendar year)	$65.00
D6090	Repair implant supported prosthesis, by report (Limit 1 per calendar year)	$130.00
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment (Limit 1 per calendar year)	$60.00
D6095	Repair implant abutment, by report (Limit 1 per calendar year)	$245.00
D6100	Implant removal, by report (Limit 1 per calendar year)	$245.00
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure (Limit 1 per calendar year)	$125.00
D6102	Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure (Limit 1 per calendar year)	$240.00
D6103	Bone graft for repair of periimplant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to	$290.00
D6104	Bone graft at time of implant placement (Limit 1 per calendar year)	$290.00
D6190	Radiographic/surgical implant index, by report (Limit 1 per calendar year)	$165.00

Code	Procedure Description	SCTI9
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.		
Per tooth charge 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
D6058	Abutment supported porcelain/ceramic crown	$760.00
D6059	Abutment supported porcelain fused to metal crown (High noble metal)	$720.00
D6060	Abutment supported porcelain fused to metal crown (Predominantly base metal)	$670.00
D6061	Abutment supported porcelain fused to metal crown (Noble metal)	$700.00
D6062	Abutment supported cast metal crown (High noble metal)	$720.00
D6063	Abutment supported cast metal crown (Predominantly base metal)	$670.00
D6064	Abutment supported cast metal crown (Noble metal)	$700.00
D6065	Implant supported porcelain/ceramic crown	$760.00
D6066	Implant supported porcelain fused to metal crown (Titanium, titanium alloy, high noble metal)	$720.00
D6067	Implant supported metal crown (Titanium, titanium alloy, high noble metal)	$720.00
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	$760.00
D6069	Abutment supported retainer for porcelain fused to metal fixed partial denture (High noble metal)	$720.00
D6070	Abutment supported retainer for porcelain fused to metal fixed partial denture (Predominantly base metal)	$670.00
D6071	Abutment supported retainer for porcelain fused to metal fixed partial denture (Noble metal)	$700.00
D6072	Abutment supported retainer for cast metal fixed partial denture (High noble metal)	$720.00
D6073	Abutment supported retainer for cast metal fixed partial denture (Predominantly base metal)	$670.00
D6074	Abutment supported retainer for cast metal fixed partial denture (Noble metal)	$700.00

Code	Procedure Description	SCTI9
D6075	Implant supported retainer for ceramic fixed partial denture	$760.00
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (Titanium, titanium alloy, high noble metal)	$720.00
D6077	Implant supported retainer for cast metal fixed partial denture (Titanium, titanium alloy, high noble metal)	$720.00
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)	$720.00
D6110	Implant /abutment supported removable denture for edentulous arch – Maxillary	$835.00
D6111	Implant /abutment supported removable denture for edentulous arch – Mandibular	$835.00
D6112	Implant /abutment supported removable denture for partially edentulous arch – Maxillary	$925.00
D6113	Implant /abutment supported removable denture for partially edentulous arch – Mandibular	$925.00
D6114	Implant /abutment supported fixed denture for edentulous arch – Maxillary	$835.00
D6115	Implant /abutment supported fixed denture for edentulous arch – Mandibular	$835.00
D6116	Implant /abutment supported fixed denture for partially edentulous arch – Maxillary	$925.00
D6117	Implant /abutment supported fixed denture for partially edentulous arch – Mandibular	$925.00
D6194	Abutment supported retainer crown for fixed partial denture (Titanium)	$720.00
Complex rehabilitation on implant/abutment supported prosthetic procedures – Additional charge per unit for multiple crown units/complex rehabilitation (6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – Ask your dentist for the guidelines)		$135.00
Oral surgery (Includes routine postoperative treatment) Surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (Disease) exists.		
D7111	Extraction of coronal remnants – Deciduous tooth	
D7140	Extraction, erupted tooth or exposed root – Elevation and/or forceps removal	$12.00
D7210	Surgical removal of erupted tooth – Removal of bone and/or section of tooth	$89.00

Code	Procedure Description	SCTI9
D7220	Removal of impacted tooth – Soft tissue	$71.00
D7230	Removal of impacted tooth – Partially bony	$145.00
D7240	Removal of impacted tooth – Completely bony	$185.00
D7241	Removal of impacted tooth – Completely bony, unusual complications(Narrative required)	$200.00
D7250	Surgical removal of residual tooth roots – Cutting procedure	$89.00
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
D7280	Surgical access of an unerupted tooth (Excluding wisdom teeth)	$14.00
D7283	Placement of device to facilitate eruption of impacted tooth $8.00	$8.00
D7285	Incisional biopsy of oral tissue – Hard (Bone, tooth) (Tooth related – not allowed when in conjunction with another surgical procedure)	$145.00
D7286	Incisional biopsy of oral tissue – Soft (all others) (Tooth related – not allowed when in conjunction with another surgical procedure)	$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	Surgical reduction of osseous tuberosity	$120.00

Code	Procedure Description	SCTI9
D7510	Incision and drainage of abscess – Intraoral soft tissue	$14.00
D7511	Incision and drainage of abscess – Intraoral soft tissue – Complicated	$20.00
D7880	Occlusal orthotic device, by report – (Limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment)	$425.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach (Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)	$850.00
D7952	Sinus augmentation via a vertical approach (Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)	$640.00
D7953	Bone replacement graft for ridge preservation – per site (Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)	$100.00
D7960	Frenulectomy – Also known as frenectomy or frenotomy – Separate procedure not incidental to another procedure	$14.00
D7963	Frenuloplasty	$20.00
Orthodontics (Tooth movement) Orthodontic treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8050	Interceptive orthodontic treatment of the primary dentition – Banding	$480.00
D8060	Interceptive orthodontic treatment of the transitional dentition – Banding	$480.00
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
D8670	Periodic orthodontic treatment visit	
	Children – Up to 19th birthday:	
	24-month treatment fee	$2,280.00
	Charge per month for 24 months	$95.00
	Adults:	
	24-month treatment fee	$3,000.00
	Charge per month for 24 months	$125.00
D8680	Orthodontic retention – Removal of appliances, construction and placement of retainer(s)	$345.00
D8999	Unspecified orthodontic procedure – By report (Orthodontic treatment plan and records)	$195.00
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 intravenous sedation when used for the purpose of anxiety control or patient management.		
D9223	Deep sedation/general anesthesia – each 15 minute increment	$90.00
D9243	Intravenous moderate (Conscious) sedation/ analgesia – each 15 minute increment	$90.00
Emergency services		
D9110	Palliative (Emergency) treatment of dental pain – Minor procedure	$0.00
D9440	Office visit – After regularly scheduled hours	$66.00
Miscellaneous services		
D9940	Occlusal guard – By report (Limit 1 per 24 months)	$265.00
D9941	Fabrication of athletic mouthguard – (Limit 1 per 12 months)	$110.00
D9951	Occlusal adjustment – Limited	$58.00
D9952	Occlusal adjustment – Complete	$255.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays (All other methods of bleaching are not covered)	$165.00

Listed below are the services or expenses which are NOT covered under your dental plan and which are your responsibility at the dentist's usual fees. There is no coverage for:

- Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States government or by a state or municipal government if the person had no insurance
- Services received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- Services for the charges which the person is not legally required to pay
- Charges which would not have been made if the person had no insurance
- Services received due to injuries which are intentionally self-inflicted
- Services not listed on the PCS
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)[6]
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war[17]
- Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- General anesthesia or IV sedation when used for the purpose of anxiety control or patient management
- Prescription medications
- Procedures, appliances or restorations if the main purpose is to: A. change vertical dimension (degree of separation of the jaw when teeth are in contact); B. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- Any services related to surgical implants, including placement, repair, maintenance, removal, and implant abutment(s) unless specifically listed on your PCS
- Services considered unnecessary or experimental in nature or do not meet commonly accepted dental standards
- Procedures or appliances for minor tooth guidance or to control harmful habits
- Services and supplies received from a hospital
- Services to the extent you or your enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy[20]
- The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage****
- The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS[19]
- Consultations and/or evaluations associated with services that are not covered
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service
- Infection control and/or sterilization
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics
- As to orthodontic treatment: Incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment.

CIGNA DENTAL ORAL HEALTH INTEGRATION PROGAM®

How does it work?

Before you receive treatment, you must enroll in the program to be eligible for reimbursement. When you visit your dentist, you will pay your usual copay or coinsurance amount. As a reminder, your copay is the fixed amount you pay for covered services. And your coinsurance is the percentage of costs you pay for covered services. Next, your dentist will send Cigna a claim. We review the claim and will refund your copay or coinsurance for eligible services. Once we receive your claim, you can expect to be reimbursed in about 30 days.

What is the Cigna Dental Oral Health Integration Program (OHIP)?

It's a program that reimburses out-of-pocket costs for specific dental services used to treat or help prevent gum disease and tooth decay. The program is for people with certain medical conditions that may be impacted by dental care. There's no additional cost for the program – if you qualify, you get reimbursed![5]

Do I qualify?

If you have a Cigna dental plan, you're eligible for the program. The only requirement is that you're currently being treated by a doctor for:

- Heart disease
- Stroke
- Diabetes
- Maternity
- Chronic kidney disease
- Organ transplants
- Head and neck cancer radiation

How do I enroll?

1. Fill out the registration form. This is required only one time per qualifying medical condition. You can find the form on **myCigna.com**. Or by calling the number on your ID card. Remember to check off any additional information you may want about Cigna Home Delivery Pharmacy discounts and/or behaviors that can affect oral health.[20]
2. Mail in your completed form to Cigna at the address listed on the registration form.
3. Visit your dentist and pay your usual copay or coinsurance amount for the covered service. We'll send your reimbursement in about 30 days.

Please note: The OHIP registration form is not used to enroll in dental benefits.

Frequently Asked Questions about the Cigna Dental Oral Health Integration Program®

Do I only have to enroll in the program once or, do I have to contact Cigna each time I go to the dentist?

You only enroll once in the program. Once enrolled, Cigna will automatically reimburse you for the eligible dental services covered for your medical condition.

How and when will I get reimbursed for my out-of-pocket expenses?

As with any dental service, you will pay your dentist at the time the service is performed. A claim form is typically submitted to Cigna by your dentist. Once we receive the claim form from the dentist, we pay him/her for their services and you will then receive reimbursement for the amount of your coinsurance or copay. This may take 2-4 weeks, depending on when the dentist submits the claim. Please keep in mind that only dental services eligible under the Cigna Dental Oral Health Integration Program will be reimbursed.

How do I know if my enrollment has been processed?

Once your enrollment has been approved, Cigna will send you a program welcome email.

What procedures are eligible for reimbursement?

Please refer to the list of procedures for each qualifying condition on the front of the page.

If my dental coverage has a plan maximum or deductible, how do procedures covered under the program get applied?

Any procedures covered under the program are not applied toward your plan's annual deductible; however, do count towards your plan's annual maximum.

If I go out-of-network, will the services covered under this program still apply?

If your plan does not include coverage for out-of-network services, then you must use a dentist in your plan's network for coverage under this program to apply. If your plan includes out-of-network coverage, you will be reimbursed for your covered expenses whether you choose to use an in-network or out-of-network dentist. However, if you use an out-of-network dentist you may have out-of-pocket costs because the dentist may choose to bill you for charges that are in excess of what your plan reimburses for covered expenses.

If I'm a dependent (spouse, partner or child), do I provide my ID number or the person who is the primary covered individual?

Please provide the ID number of the person who is the primary covered individual.

Where can I find my Group/Account Number?

Please check a previous Explanation of Benefits, your dental page on mycigna.com, call Customer Service at the number on your ID card and follow the prompts to get your Group/Account Number. You can also provide your ID and/or social security number and a Customer Service Representative will identify your Group/Account Number for you. If you have a Cigna Medical or Dental ID card the Group/Account Number is listed on the cards.

What does "Other Coverage" mean?

Please complete the Other Coverage section if you have additional coverage through a different carrier (sometimes referred to as secondary insurance), typically through your spouse or partner.

If I don't have an e-mail address but still want information on discounted prescription products, discounted non-prescription products or information on behavioral conditions affecting my oral health, how can I get the information?

Please include a note when you submit your Cigna Dental Oral Health Integration Registration Form indicating the address where you would like the information mailed and it will be sent through the U.S. Postal Service.

Do I have to include anything that proves I have a condition and does Cigna have the right to verify my condition?

You do not have to include any documentation with your Registration Form that proves you have a specific condition. However, at the bottom of the form you must sign your name verifying that you have the condition and acknowledge that Cigna reserves the right to request medical records or check with your physician prior to reimbursement.

If I have questions about the Cigna Dental Oral Health Integration Program or how to complete and submit the Registration Form who do I call?

Please call Customer Service at the number on your ID card with any questions. One of our associates will be happy to help you, 24 hours a day, 7 days a week.

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Product availability may vary by location and plan type and is subject to change. The information provided in this brochure outlines only the highlights of these plans. For a complete list of both covered and non-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description – the official plan documents. If there are any differences between the information in this brochure and the plan documents, the information in the plan documents takes precedence.

1. The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.
2. Healthy Rewards is a discount program. If your plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your benefits. **A discount program is NOT insurance, and you must pay the entire discounted charge.** Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time.
3. Dentist directory features vary by plan type and dentist. These and other dentist directory features are for educational purposes only and should not be the sole basis for decision making. They are not a guarantee of quality or cost. You should consider all factors when choosing a dentist.
4. "Preventive Dental Treatment Associated with Lower Medical Utilization and Costs", national Cigna study presented at the International Association for Dental Research Meeting, March 2015, Boston.
5. For Dental Basic and Enhanced customers, your plan deductible does not apply. However, reimbursement is applied to and subject to your plan's calendar year maximum. You must register for this program prior to receiving qualifying dental treatment to be eligible for reimbursement.
6. **Minnesota residents:** If you are considering enrollment or are enrolled in a Cigna Dental Care (DHMO) plan through your employer, you must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. Of course, you'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Service for more information.

   Oklahoma residents: DHMO for Oklahoma is an Employer Group Prepaid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. You'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Service for more information.
7. If enrolled in the Health Enhancement Program (HEP): No annual maximum on services for periodontal maintenance (limit: 2 per calendar year) or scaling and root planing (frequency limits and cost shares may still apply). Please also note the Periodontal Maintenance procedure is covered at 100%.
8. In the Enhanced Plan be sure to use an in-network dentist to get the most out of your plan coverage; with out-of-network dentists, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.
9. See the DHMO section of this brochure for patient co-pay amounts or by calling 800.Cigna24 (800.244.6224).
10. While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law or discounts are not offered by your dentist.
11. Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. Please speak with your provider or contact Cigna member services prior to receiving care to determine if these discounts will apply to you.
12. If enrolled in HEP, maximums are waived on periodontal maintenance, periodontal scaling and root planning procedures.
13. For fillings other than amalgam, an alternate benefit may apply. If enrolled in HEP, periodontal maintenance is covered at 100%.
14. For fillings other than amalgam, an alternate benefit may apply.
15. If enrolled in HEP, maximums are waived on periodontal maintenance and periodontal scaling and root planning procedures. Deductible waived on certain procedures.
16. Age and frequency limitations may apply to some covered services. Review the full DHMO Patient Charge Schedule for details.
17. **Oklahoma residents:** This exclusion is replaced by the following: War or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer
18. **Arizona and Pennsylvania residents:** This exclusion does not apply. **Kentucky and North Carolina residents:** Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. **Maryland residents:** Services compensated under group medical plans are not excluded.
19. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under your PCS.
20. Pharmacy discounts are available through Cigna Home Delivery Pharmacy only. **This is a discount and is NOT insurance.** This discount is separate from your dental benefits and you are required to pay the entire discounted charge. You should check any insurance or other benefits you have before using these discounts, as those benefits may result in lower costs to you.

The dentists who participate in the Cigna network are independent contractors solely responsible for the treatment provided to their patients. They are not agents of Cigna.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. Cigna Dental Care (DHMO) plans are insured by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., **a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes,** Cigna Dental Health of Kansas, Inc. (KS & NE), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, DHMO plans are insured by Cigna Health and Life Insurance Company (CHLIC) or Cigna HealthCare of Connecticut, Inc., and administered by Cigna Dental Health, Inc. Cigna DPPO plans are insured or administered by CHLIC, with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. All pictures are used for illustrative purposes only.