

CIGNA Dental Companies

CIGNA Dental Health Plan of Arizona, 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. (Kansas and Nebraska)

CIGNA Dental Health of Maryland, Inc.

CIGNA Dental Health of North Carolina, Inc.

CIGNA Dental Health of Ohio, Inc.

CIGNA Dental Health of Pennsylvania, Inc.

CIGNA Dental Health of Virginia, Inc.

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This Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage is intended for your information; it constitutes a summary of the Dental Plan and is included as a part of the agreement between CIGNA Dental and your Group (collectively, the "Group Contract"). The Group Contract must be consulted to determine the rates and the exact terms and conditions of coverage. If rates or coverages are changed under your Group Contract, your rates and coverage will also change. A prospective member has the right to view the Combined Evidence of Coverage and Disclosure Form prior to enrollment. It should be read completely and carefully. Members with special health care needs should read carefully those sections that apply to them. Please read the following information so you will know from whom or what group of providers dental care may be obtained.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS OR HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE DUAL COVERAGE SECTION.

Important Cancellation Information - Please Read the Provision Entitled "Disenrollment from the Dental Plan-Termination of Benefits."

READ YOUR PLAN BOOKLET CAREFULLY

Please call Member Services at 1.800.CIGNA24 if you have any questions. The hearing impaired may call the state TTY toll-free relay service listed in their local telephone directory.

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In some instances, state laws will supersede or augment the provisions contained in this booklet. These requirements are listed at the end of this booklet as a State Rider. In case of a conflict between the provisions of this booklet and your State Rider, the State Rider will prevail.

I. DEFINITIONS

Capitalized terms, unless otherwise defined, have the meanings listed below.

Adverse Determination - a decision by CIGNA Dental not to authorize payment for certain limited specialty care procedures on the basis of necessity or appropriateness of care. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and meet the following requirements:

- A. be consistent with the symptoms, diagnosis or treatment of the condition present;
- B. conform to commonly accepted standards throughout the dental field;
- C. not be used primarily for the convenience of the member or provider of care; and
- D. not exceed the scope, duration, or intensity of that level of care needed to provide safe and appropriate treatment.

Requests for payment authorizations that are declined by CIGNA Dental based upon the above criteria will be the responsibility of the member at the dentist's Usual Fees. A licensed dentist will make any such denial.

CIGNA Dental - the CIGNA Dental Health organization that provides dental benefits in your state as listed on the face page of this booklet.

Contract Fees - the fees contained in the Network Specialty Dentist agreement with CIGNA Dental.

Covered Services - the dental procedures listed on your Patient Charge Schedule.

Dental Office - your selected office of Network General Dentist(s).

Dental Plan - managed dental care plan offered through the Group Contract between CIGNA Dental and your Group.

Dependent - your lawful spouse,[or your domestic partner];

Your unmarried child (including newborns, adopted children, stepchildren, a child for whom you must provide dental coverage under a court order; or, a dependent child who resides in your home as a result of court order or administrative placement) who is:

- (a) less than [19] years old; or
- (b) less than [23] years old if he or she is both:
 - i. a full-time student enrolled at an accredited educational institution, and
 - ii. reliant upon you for maintenance and support; or
- (c) any age if he or she is both:
 - i. incapable of self-sustaining employment due to mental or physical disability, and
 - ii. reliant upon you for maintenance and support.

For a dependent child [19] years of age or older who is a full-time student at an educational institution, coverage will be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student.

For a child who falls into category (b) or (c) above, you will need to furnish CIGNA Dental evidence of the child's reliance upon you, in the form requested, within 31 days after the Dependent reaches the age of [19] and once a year thereafter for as long as the child is claimed as a Dependent under the Plan.

A Newly Acquired Dependent is a dependent child who is adopted, born, or otherwise becomes your dependent after you become covered under the Plan.

Coverage for dependents living outside a CIGNA Dental service area is subject to the availability of an approved network where the dependent resides.

The following definition of Domestic Partner applies:

[A. A person of the same or opposite sex who:

1. shares your permanent residence;
2. has resided with you for no less than one year;
3. is no less than eighteen years of age;
4. is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property, common ownership of a motor vehicle, a joint bank account or a joint credit account, designation as a beneficiary for life insurance or retirement benefits or under your partner's will, assignment of durable power of attorney or health care power of attorney, or such other proof as is considered by CIGNA Dental Health to be sufficient to establish financial interdependency under the circumstances of your particular case;
5. is not your blood relative any closer than would be prohibited for a legal marriage; and
6. has signed jointly with you a notarized affidavit in form and content satisfactory to CIGNA Dental Health which shall be made available to CIGNA Dental Health upon request; or

B. A person of the same or opposite sex who has registered jointly with you as Domestic Partners with a governmental entity pursuant to a state or local law authorizing such registration and signed jointly with you a notarized affidavit of such registration which can be made available to CIGNA Dental Health upon request.

The above definition applies so long as neither you nor your Domestic Partner hereunder:

- A. has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- B. is currently legally married to another person; or
- C. has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

Domestic Partner coverage cannot be transferred to states in which such coverage has been disapproved by regulatory authorities.]

Group - employer, labor union or other organization that has entered into a Group Contract with CIGNA Dental for managed dental services on your behalf.

Network Dentist - a licensed dentist who has signed an agreement with CIGNA Dental to provide general dentistry or specialty care services to you. The term, when used, includes both Network General Dentists and Network Specialty Dentists.

Network General Dentist - a licensed dentist who has signed an agreement with CIGNA Dental under which he or she agrees to provide dental care services to you.

Network Specialty Dentist - a licensed dentist who has signed an agreement with CIGNA Dental under which he or she agrees to provide specialized dental care services to You.

Patient Charge - the amount you owe your Network Dentist for any dental procedure listed on your Patient Charge Schedule.

Patient Charge Schedule - list of services covered under your Dental Plan and how much they cost you.

Premiums - fees that your Group remits to CIGNA Dental, on your behalf, during the term of your Group Contract.

Service Area - the geographical area designated by CIGNA Dental within which it shall provide benefits and arrange for dental care services.

Subscriber/You - the enrolled employee or member of the Group.

Usual Fee - the customary fee that an individual dentist most frequently charges for a given dental service.

II. INTRODUCTION TO YOUR CIGNA DENTAL PLAN

Welcome to the CIGNA Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the Dental Plan allows the release of patient records to CIGNA Dental or its designee for health plan operation purposes.

III. ELIGIBILITY/WHEN COVERAGE BEGINS

To enroll in the Dental Plan, you and your Dependents must be able to seek treatment for Covered Services within a CIGNA Dental Service Area. Other eligibility requirements are determined by your Group.

If you enrolled in the Dental Plan before the effective date of your Group Contract, you will be covered on the first day the Group Contract is effective. If you enrolled in the Dental Plan after the effective date of the Group Contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your Group Contract).

Dependents may be enrolled in the Dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a life status change such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your Dependents only during the open enrollment periods for your Group, unless there is a change

in status such as divorce. CIGNA Dental may require evidence of good dental health at your expense if you or your Dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of Premiums.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the Dental Plan and you must begin paying Premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your Group the portion of the Premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through your Benefits Representative.

IV. YOUR CIGNA DENTAL COVERAGE

The information below outlines your coverage and will help you to better understand your Dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the Group Contract will be furnished to you upon your request.

A. MEMBER SERVICES

If you have any questions or concerns about the Dental Plan, Member Services Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Member Services from any location at [1.800.CIGNA24]. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

B. PREMIUMS

Your Group sends a monthly fee to CIGNA Dental for members participating in the Dental Plan. The amount and term of this fee is set forth in your Group Contract. You may contact your Benefits Representative for information regarding any part of this fee to be withheld from your salary or to be paid by you to the Group.

C. OTHER CHARGES - PATIENT CHARGES

Network General Dentists are typically reimbursed by CIGNA Dental through fixed monthly payments and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network Dentists are also compensated by the fees which you pay, as set out in your Patient Charge Schedule.

Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change in accordance with your Group Contract. CIGNA Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

D. CHOICE OF DENTIST

You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise CIGNA Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when CIGNA Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Member Services at [1.800.CIGNA24] to get a list of network Pediatric Dentists in your Service Area or if your Network General Dentist sends your child under the age of 7 to a network Pediatric Dentist, the network Pediatric Dentist's office will have primary responsibility for your child's care. For children 7 years and older, your Network General Dentist will provide care. If your child continues to visit the Pediatric Dentist upon the age of 7, you will be fully responsible for the Pediatric Dentist's Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, CIGNA Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at [1.800.CIGNA24]. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Member Services.

E. YOUR PAYMENT RESPONSIBILITY (General Care)

For Covered Services at your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, CIGNA Dental will let you know and you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. CIGNA Dental will pay the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See Section IX, *Specialty Referrals*, regarding payment responsibility for specialty care.

All contracts between CIGNA Dental and Network Dentists state that you will not be liable to the Network Dentist for any sums owed to the Network Dentist by CIGNA Dental.

F. EMERGENCY DENTAL CARE - REIMBURSEMENT

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network General Dentist if you have an emergency in your Service Area.

1. **Emergency Care Away From Home**

If you have an emergency while you are out of your Service Area or you are unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. CIGNA Dental will reimburse you the difference, if any, between the dentist's Usual Fee for emergency Covered Services and your Patient Charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to CIGNA Dental at the address listed for your state on the front of this booklet.

2. **Emergency Care After Hours**

There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

G. LIMITATIONS ON COVERED SERVICES

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

1. **Frequency** - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
2. **Pediatric Dentistry** - Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
3. **Oral Surgery** - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
4. **Periodontal** (gum tissue and supporting bone) **Services** - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

5. **Clinical Oral Evaluations** - Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under three years of age are limited to a total of 4 evaluations during a 12 consecutive month period.

GENERAL LIMITATIONS

DENTAL BENEFITS

No payment will be made for expenses incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for 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;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted.

H. SERVICES NOT COVERED UNDER YOUR DENTAL PLAN

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

1. services not listed on the Patient Charge Schedule.
2. services provided by a non-Network Dentist without CIGNA Dental's prior approval (except emergencies, as described in Section IV.F).
3. services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
5. services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your PCS, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
7. general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. (Maryland residents: General anesthesia is covered when medically necessary and authorized by your physician.) There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
8. prescription drugs.
9. procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. diagnose

or treat conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or, if your Patient Charge Schedule ends in "-04" or higher, c. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

10. 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.
11. Surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant.
12. services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards..
13. procedures or appliances for minor tooth guidance or to control harmful habits.
14. hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
15. services to the extent you or your enrolled Dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)
16. the completion of crowns, bridges, dentures, root canal treatment, or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your CIGNA Dental coverage. (California and Texas residents: Pre-existing conditions, including the completion of crowns, bridges, dentures, root canal treatment or implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule.)
17. consultations and/or evaluations associated with services that are not covered.
18. endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
19. bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.
20. intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

21. services performed by a prosthodontist.
22. localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
23. any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
24. infection control and/or sterilization. CIGNA dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
25. the recementation of any inlay, onlay, crown, post and core, fixed bridge or implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. CIGNA Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.
26. services to correct congenital malformations, including the replacement of congenitally missing teeth.
27. the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period.
28. crowns, bridges and/or implant supported prosthesis used solely for splinting.
29. resin bonded retainers and associated pontics.

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

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

V. APPOINTMENTS

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will ask for your identification number and will check your eligibility.

VI. BROKEN APPOINTMENTS

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients.

If you or your enrolled Dependent breaks an appointment with less than 24 hours notice to the Dental Office, you may be charged a broken appointment fee.

VII. OFFICE TRANSFERS

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Member Services at [1.800.CIGNA24]. To obtain a list of Dental Offices near you, visit our website at www.cigna.com, or call the Dental Office Locator at [1.800.CIGNA24].

Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective.

There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

VIII. SPECIALTY CARE

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the CIGNA Dental Network includes the following types of specialty dentists:

- Pediatric Dentists – children's dentistry.
- Endodontists – root canal treatment.
- Periodontists – treatment of gums and bone.
- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

See Section IV.D, *Choice of Dentist*, regarding treatment by a Pediatric Dentist.

IX. SPECIALTY REFERRALS

A. IN GENERAL

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to CIGNA Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by CIGNA Dental before treatment begins.

When CIGNA Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply, except as set out in Section IX.B., Orthodontics. Treatment by the Network Specialty Dentist must begin within 90 days from the date of CIGNA Dental's authorization. If you are unable to obtain treatment within the 90 day period, please call Member Services to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if CIGNA Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist's Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Member Services.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist's Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by CIGNA Dental, CIGNA Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. CIGNA Dental will reimburse the non-Network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist's Usual Fee.

B. ORTHODONTICS (This section is applicable only when Orthodontics is listed on your Patient Charge Schedule.)

- 1. Definitions** - If your Patient Charge Schedule indicates coverage for orthodontic treatment, the following definitions apply:
 - a. Orthodontic Treatment Plan and Records** - the preparation of orthodontic records and a treatment plan by the Orthodontist.
 - b. Interceptive Orthodontic Treatment** - treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
 - c. Comprehensive Orthodontic Treatment** - treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
 - d. Retention (Post Treatment Stabilization)** - the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient Charges

The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if a. banding/appliance insertion does not occur within 90 days of such visit, b. your treatment plan changes, or c. there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a pro-rated basis.

3. Additional Charges

You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

- a. incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
- b. orthognathic surgery and associated incremental costs;
- c. appliances to guide minor tooth movement;
- d. appliances to correct harmful habits; and
- e. services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis.

4. Orthodontics In Progress

If Orthodontic Treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Member Services at [1.800.CIGNA24] to find out if you are entitled to any benefit under the Dental Plan.

X. COMPLEX REHABILITATION/MULTIPLE CROWN UNITS

Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

XI. WHAT TO DO IF THERE IS A PROBLEM

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf. **Time frames or requirements may vary depending on the laws in your State. Consult your State Rider for further details.**

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the Dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. START WITH MEMBER SERVICES

We are here to listen and to help. If you have a concern about your Dental Office or the

Dental Plan, you can call [1.800.CIGNA24] toll-free and explain your concern to one of our Member Services Representatives. You can also express that concern in writing to CIGNA Dental, P.O. Box 188047, Chattanooga, TN 37422-8047. We will do our best to resolve the matter during your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

B. APPEALS PROCEDURE

CIGNA Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to CIGNA Dental, P.O. Box 188047, Chattanooga, TN 37422-8047, within 1 year from the date of the initial CIGNA Dental decision. You should state the reason you feel your appeal should be approved and include any information to support your appeal. If you are unable or choose not to write, you may ask Member Services to register your appeal by calling [1.800.CIGNA24].

1. Level-One Appeals

Your level-one appeal will be reviewed and the decision made by someone not involved in the initial review. Appeals involving dental necessity or clinical appropriateness will be reviewed by a dental professional.

If your appeal concerns a denied pre-authorization, we will respond with a decision within 15 calendar days after we receive your appeal. For appeals concerning all other coverage issues, we will respond with a decision within 30 calendar days after we receive your appeal. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, CIGNA Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level-one appeal decision, you may request a level-two appeal.

2. Level Two Appeals

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or

clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review. The Level-Two Appeals process does not apply to resolutions made solely on the basis that the Dental Plan does not provide benefits for the service performed or requested.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

3. Independent Review Procedure

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas. Consult your State Rider for more details.

4. Appeals to the State

You have the right to contact your State's Department of Insurance and/or Department of Health for assistance at any time. **See your State Rider for further details.**

CIGNA Dental will not cancel or refuse to renew your coverage because you or your Dependent has filed a complaint or an appeal involving a decision made by CIGNA Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

XII. DUAL COVERAGE

You and your Dependents may not be covered twice under this Dental Plan. If you and your spouse have enrolled each other or the same Dependents twice, please contact your Benefit Administrator.

If you or your Dependents have dental coverage through your spouse's employer or other sources such as an HMO or similar dental plan, applicable coordination of benefit rules will determine which coverage is primary or secondary. In most cases, the plan covering you as an employee is primary for you, and the plan covering your spouse as an employee is primary for him or her. Your children are generally covered as primary by the plan of the parent whose birthday occurs earlier in the year. Dual coverage should result in lowering or eliminating your out-of-pocket expenses. It should not result in reimbursement for more than 100% of your expenses.

Coordination of benefit rules are attached to the Group Contract and may be reviewed by contacting your Benefit Administrator. CIGNA Dental coordinates benefits only for specialty care services.

XIII. DISENROLLMENT FROM THE DENTAL PLAN - TERMINATION OF BENEFITS

A. TIME FRAMES FOR DISENROLLMENT/TERMINATION

Except as otherwise provided in the sections titled "Extension/Continuation of Benefits" or in your Group Contract, disenrollment from the Dental Plan and termination of benefits will occur on the last day of the month:

1. in which Premiums are not remitted to CIGNA Dental.
2. in which eligibility requirements are no longer met.
3. after 30 days notice from CIGNA Dental due to permanent breakdown of the dentist-patient relationship as determined by CIGNA Dental, after at least two opportunities to transfer to another Dental Office.
4. after 30 days notice from CIGNA Dental due to fraud or misuse of dental services and/or Dental Offices.
5. after 60 days notice by CIGNA Dental, due to continued lack of a Dental Office in your Service Area.
6. after voluntary disenrollment.

B. EFFECT ON DEPENDENTS

When one of your Dependents is disenrolled, you and your other Dependents may continue to be enrolled. When you are disenrolled, your Dependents will be disenrolled as well.

XIV. EXTENSION OF BENEFITS

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the Dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of Premiums.

Coverage for orthodontic treatment which was started before disenrollment from the Dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of Premiums.

XV. CONTINUATION OF BENEFITS (COBRA)

For Groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required Premiums to the Group. Additional information is available through your Benefits Representative.

XVI. CONVERSION COVERAGE

If you are no longer eligible for coverage under your Group's Dental Plan, you and your enrolled Dependents may continue your dental coverage by enrolling in the CIGNA Dental conversion plan. You must enroll within three (3) months after becoming ineligible for your Group's Dental Plan. Premium payments and coverage will be retroactive to the date coverage under your Group's Dental Plan ended. You and your enrolled Dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship,
- Fraud or misuse of dental services and/or Dental Offices,
- Nonpayment of Premiums by the Subscriber,
- Selection of alternate dental coverage by your Group; or
- Lack of network/Service Area.

Benefits and rates for CIGNA Dental conversion coverage and any succeeding renewals will be based on the Covered Services listed in the then-current standard conversion plan and may not be the same as those for your Group's Dental Plan. Please call the CIGNA Dental Conversion Department at [1.800.CIGNA24] to obtain current rates and make arrangements for continuing coverage.

XVII. CONFIDENTIALITY/PRIVACY

CIGNA Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about CIGNA Dental's confidentiality policies and procedures is made available to you during the enrollment process and/or as part of your member plan materials. You may obtain additional information about CIGNA Dental's confidentiality policies and procedures by calling Member Services at [1.800.CIGNA24], or via the Internet at www.cigna.com.

XVIII. MISCELLANEOUS

As a CIGNA Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at www.cigna.com for details.

As a CIGNA Dental plan member, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and members participating in certain disease management programs. Please review your plan enrollment materials for details.

SEE YOUR STATE RIDER FOR ADDITIONAL DETAILS.

County of San Bernardino
Cigna Dental Care® (*DHMO)
Patient Charge Schedule

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

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Cigna Dental as described in your plan documents.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialty Periodontist, Orthodontist or Oral Surgeon. You must verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental. Prior authorization is not required for specialty referrals for Pediatric and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 7 by calling Member Services at 1.800.238.5834 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 7th birthday.
- Procedures **NOT** listed on this Patient Charge Schedule are NOT covered and are the patient's responsibility at the dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or Nitrous Oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- Cigna Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.
- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.

Cigna Dental Care®

Patient Charge Schedule (BER07 AZ)

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.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

Code	Procedure Description	Patient Charge
<p>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) If your Network Dentist certifies to Cigna Dental that, due to medical necessity, you require certain Covered Services more frequently than the limitation allows, Cigna Dental will waive the applicable limitation. The relevant Covered Services are identified with a ☼.</p>		
D9310	Consultation (Diagnostic Service Provided By Dentist or Physician Other Than Requesting Dentist or Physician)	\$0.00
D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	\$5.00
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	\$0.00
D0170	Re-evaluation – Limited, Problem Focused (Not Post-Operative Visit)	\$0.00
D0210	X-Rays Intraoral – Complete Series (Including Bitewings) (Limit 1 Every 3 Years) ☼	\$0.00
D0220	X-Rays Intraoral – Periapical First Film	\$0.00
D0230	X-Rays Intraoral – Periapical Each Additional Film	\$0.00

Cigna Dental Care®

Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D0240	X-Rays Intraoral – Occlusal Film	\$0.00
D0250	X-Rays Extraoral – First Film	\$0.00
D0260	X-Rays Extraoral – Each Additional Film	\$0.00
D0270	X-Rays (Bitewing) – Single Film	\$0.00
D0272	X-Rays (Bitewings) – 2 Films	\$0.00
D0273	X-Rays (Bitewings) – 3 Films	\$0.00
D0274	X-Rays (Bitewings) – 4 Films	\$0.00
D0277	X-Rays (Bitewings, Vertical) – 7-8 Films	\$0.00
D0330	X-Rays (Panoramic Film) – <i>(Limit 1 Every 3 years)</i> ☼	\$0.00
D0415	Collection of Microorganisms for Culture and Sensitivity	\$0.00
D0425	Caries Susceptibility Tests	\$0.00
D0460	Pulp Vitality Tests	\$0.00
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
D0999	Unspecified Diagnostic Procedure, By Report	\$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
D1120	Prophylaxis (Cleaning) – Child <i>(Limit 2 per Calendar Year)</i> ☼	\$0.00
	Additional Prophylaxis (Cleaning), In Addition to the Two Prophylaxes (Cleaning) Allowed per Calendar Year	\$35.00
D1203	Topical Application of Fluoride – Child <i>(Up to 19th Birthday) (Limited to 2 per Calendar Year). There is a Combined Limit of a Total of Two D1203s and/or D1206s per Calendar Year.</i> ☼	\$0.00

Cigna Dental Care®

Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D1204	Topical Fluoride Application – Adult (<i>Limited to 2 per Calendar Year</i>) ☼	\$0.00
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients. Child (<i>Up to 19th Birthday</i>)(<i>Limited to 2 per Calendar Year</i>). <i>There is a Combined Limit of a Total of 2 D1203s and/or D1206s per Calendar Year.</i> ☼	\$0.00
D1310	Nutritional Counseling for Control of Dental Disease	\$0.00
D1330	Oral Hygiene Instructions	\$0.00
D1351	Sealant – per Tooth	\$5.00
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient – Permanent Tooth	\$5.00
D1510	Space Maintainer – Fixed – Unilateral	\$15.00
D1515	Space Maintainer – Fixed – Bilateral	\$15.00
D1520	Space Maintainer – Removable – Unilateral	\$15.00
D1525	Space Maintainer – Removable – Bilateral	\$15.00
D1550	Recementation of Space Maintainer	\$0.00
D1555	Removal of Fixed Space Maintainer	\$0.00
Restorative (Fillings)		
D2140	Amalgam – 1 Surface, Primary or Permanent	\$0.00
D2150	Amalgam – 2 Surfaces, Primary or Permanent	\$0.00
D2160	Amalgam – 3 Surfaces, Primary or Permanent	\$0.00
D2161	Amalgam – 4 or More Surfaces, Primary or Permanent	\$0.00
D2330	Resin-Based Composite – 1 Surface, Anterior	\$0.00
D2331	Resin-Based Composite – 2 Surfaces, Anterior	\$0.00
D2332	Resin-Based Composite – 3 Surfaces, Anterior	\$0.00
D2335	Resin-Based Composite – 4 or More Surfaces or Involving Incisal Angle (Anterior)	\$0.00
D2390	Resin-Based Composite Crown, Anterior	\$0.00

Cigna Dental Care®
Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D2391	Resin-Based Composite – 1 Surface, Posterior	\$45.00
D2392	Resin-Based Composite – 2 Surfaces, Posterior	\$55.00
D2393	Resin-Based Composite – 3 Surfaces, Posterior	\$65.00
D2394	Resin-Based Composite – 4 or More Surfaces, Posterior	\$75.00
Crown and Bridge All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals one unit).		
D2510	Inlay – Metallic – 1 Surface	\$0.00
D2520	Inlay – Metallic – 2 Surfaces	\$0.00
D2530	Inlay – Metallic – 3 or More Surfaces	\$0.00
D2542	Onlay – Metallic – 2 Surfaces	\$0.00
D2543	Onlay – Metallic – 3 Surfaces	\$0.00
D2544	Onlay – Metallic – 4 or More Surfaces	\$0.00
D2610	Inlay – Porcelain/Ceramic – 1 Surface	\$135.00
D2620	Inlay – Porcelain/Ceramic – 2 Surfaces	\$150.00
D2630	Inlay – Porcelain/Ceramic – 3 or More Surfaces	\$160.00
D2642	Onlay – Porcelain/Ceramic – Two Surfaces	\$150.00
D2643	Onlay – Porcelain/Ceramic – Three Surfaces	\$165.00
D2644	Onlay – Porcelain/Ceramic – 4 or More Surfaces	\$175.00
D2650	Inlay – Resin-Based Composite – 1 Surface	\$85.00
D2651	Inlay – Resin-Based Composite – 2 Surfaces	\$95.00
D2652	Inlay – Resin-Based Composite – 3 or More Surfaces	\$115.00
D2662	Onlay – Resin-Based Composite – 2 Surfaces	\$110.00
D2663	Onlay – Resin-Based Composite – 3 Surfaces	\$120.00
D2664	Onlay – Resin-Based Composite – 4 or More Surfaces	\$145.00
D2710	Crown – Resin (Laboratory)	\$40.00
D2712	Crown – 3/4 Resin-Based Composite (Indirect)	\$40.00

Cigna Dental Care®
 Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D2720	Crown – Resin with High Noble Metal	\$160.00
D2721	Crown – Resin with Predominantly Base Metal	\$60.00
D2722	Crown – Resin with Noble Metal	\$60.00
D2740	Crown – Porcelain/Ceramic Substrate	\$60.00
D2750	Crown – Porcelain Fused to High Noble Metal	\$160.00
D2751	Crown – Porcelain Fused to Predominantly Base Metal	\$60.00
D2752	Crown – Porcelain Fused to Noble Metal	\$60.00
D2780	Crown – 3/4 Cast High Noble Metal	\$160.00
D2781	Crown – 3/4 Cast Predominantly Base Metal	\$60.00
D2782	Crown – 3/4 Cast Noble Metal	\$60.00
D2783	Crown –3/4 Porcelain/Ceramic	\$195.00
D2790	Crown – Full Cast High Noble Metal	\$160.00
D2791	Crown – Full Cast Predominantly Base Metal	\$60.00
D2792	Crown – Full Cast Noble Metal	\$60.00
D2794	Crown – Titanium	\$160.00
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	\$0.00
D2915	Recement Cast or Prefabricated Post and Core	\$0.00
D2920	Recement Crown	\$0.00
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	\$0.00
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	\$0.00
D2932	Prefabricated Resin Crown	\$10.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	\$10.00
D2940	Protective Restoration	\$10.00
D2950	Core Buildup, Including Any Pins	\$10.00
D2951	Pin Retention – per Tooth, In Addition to Restoration	\$10.00
D2952	Post and Core In Addition to Crown, Indirectly Fabricated	\$10.00

Cigna Dental Care®
 Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D2953	Each Additional Cast Post – Same Tooth	\$10.00
D2954	Prefabricated Post and Core In Addition to Crown – Base Metal Post	\$10.00
D2957	Each Additional Prefabricated Post – Same Tooth – Base Metal Post	\$10.00
D2970	Temporary Crown – Fractured Tooth	\$5.00
D2971	Additional Procedures to Construct New Crown Under Existing Partial Denture Framework	\$12.00
D2980	Crown Repair	\$10.00
D6210	Pontic – Cast High Noble Metal	\$160.00
D6211	Pontic – Cast Predominantly Base Metal	\$60.00
D6212	Pontic – Cast Noble Metal	\$60.00
D6240	Pontic – Porcelain Fused to High Noble Metal	\$160.00
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	\$60.00
D6242	Pontic – Porcelain Fused to Noble Metal	\$60.00
D6245	Pontic – Porcelain/Ceramic	\$195.00
D6250	Pontic – Resin with High Noble Metal	\$160.00
D6251	Pontic – Resin with Predominantly Base Metal	\$60.00
D6252	Pontic – Resin with Noble Metal	\$60.00
D6600	Inlay – Porcelain/Ceramic, 2 Surfaces	\$150.00
D6601	Inlay – Porcelain/Ceramic, 3 or More Surfaces	\$160.00
D6602	Inlay – Cast High Noble Metal – 2 Surfaces	\$0.00
D6603	Inlay – Cast High Noble Metal – 3 or More Surfaces	\$0.00
D6604	Inlay – Cast Predominantly Base Metal, 2 Surfaces	\$0.00
D6605	Inlay – Cast Predominantly Base Metal, 3 or More Surfaces	\$0.00
D6606	Inlay – Cast Noble Metal, 2 Surfaces	\$0.00
D6607	Inlay – Cast Noble Metal, 3 or More Surfaces	\$0.00

Cigna Dental Care®

Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D6608	Onlay – Porcelain/Ceramic, 2 Surfaces	\$150.00
D6609	Onlay – Porcelain/Ceramic, 3 or More Surfaces	\$165.00
D6610	Onlay –Cast High Noble Metal – 2 surfaces	\$0.00
D6611	Onlay –Cast High Noble Metal – 3 or More surfaces	\$0.00
D6612	Onlay – Cast Predominantly Base Metal, 2 Surfaces	\$0.00
D6613	Onlay – Cast Predominantly Base Metal, 3 or More Surfaces	\$0.00
D6614	Onlay – Cast Noble Metal, 2 Surfaces	\$0.00
D6615	Onlay – Cast Noble Metal, 3 or More Surfaces	\$0.00
D6720	Crown – Resin with High Noble Metal	\$160.00
D6721	Crown – Resin with Predominantly Base Metal	\$60.00
D6722	Crown – Resin with Noble Metal	\$60.00
D6740	Crown – Porcelain/Ceramic	\$195.00
D6750	Crown – Porcelain Fused to High Noble Metal	\$160.00
D6751	Crown – Porcelain Fused to Predominantly Base Metal	\$60.00
D6752	Crown – Porcelain Fused to Noble Metal	\$60.00
D6780	Crown – 3/4 Cast High Noble Metal	\$160.00
D6781	Crown – 3/4 Cast Predominantly Base Metal	\$60.00
D6782	Crown – 3/4 Cast Noble Metal	\$60.00
D6783	Crown – 3/4 Porcelain/Ceramic	\$195.00
D6790	Crown – Full Cast High Noble Metal	\$160.00
D6791	Crown – Full Cast Predominantly Base Metal	\$60.00
D6792	Crown – Full Cast Noble Metal	\$60.00
D6930	Recement Fixed Partial Denture	\$0.00
D6940	Stress Breaker	\$0.00
D6970	Cast Post and Core, In Addition to Fixed Partial Denture Retainer	\$10.00

Cigna Dental Care®
Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D6972	Prefabricated Post and Core In Addition to Fixed Partial Denture Retainer – Base Metal Post	\$10.00
D6973	Core Buildup For Retainer, Including Any Pins	\$10.00
D6976	Each Additional Cast Post – Same Tooth	\$10.00
D6977	Each Additional Prefabricated Post – Same Tooth	\$10.00
D6980	Fixed Partial Denture Repair	\$15.00
Endodontics (Root Canal Treatment, Excluding Final Restorations)		
D3110	Pulp Cap – Direct (Excluding Final Restoration)	\$0.00
D3120	Pulp Cap – Indirect (Excluding Final Restoration)	\$0.00
D3220	Pulpotomy – Removal of Pulp, Not Part of a Root Canal	\$0.00
D3221	Pulpal Debridement (Not to be used when root canal is done on the same day)	\$6.00
D3222	Partial Pulpotomy for Apexogenesis–Permanent Tooth with Incomplete Root Development	\$0.00
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)	\$6.00
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)	\$6.00
D3310	Anterior Root Canal (Excluding Final Restoration)	\$30.00
D3320	Bicuspid Root Canal (Excluding Final Restoration)	\$60.00
D3330	Molar Root Canal (Excluding Final Restoration)	\$90.00
D3331	Treatment of Root Canal Obstruction – Non-Surgical Access	\$45.00
D3332	Incomplete Endodontic Therapy – Inoperable or Fractured Tooth	\$45.00
D3333	Internal Root Repair of Perforation Defects	\$45.00
D3346	Retreatment of Previous Root Canal Therapy – Anterior	\$45.00
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	\$75.00

Cigna Dental Care®

Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D3348	Retreatment of Previous Root Canal Therapy – Molar	\$105.00
D3351	Apexification/Recalcification – Initial Visit (Apical Closure/ Calcific Repair of Perforations, Root Resorption, etc.)	\$70.00
D3352	Apexification/Recalcification – Interim Medication Replacement (Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	\$45.00
D3353	Apexification/Recalcification – Final Visit (Includes Completed Root Canal Therapy – Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	\$45.00
D3410	Apicoectomy/Periradicular Surgery – Anterior	\$50.00
D3421	Apicoectomy/Periradicular Surgery – Bicuspid (First Root)	\$50.00
D3425	Apicoectomy/Periradicular Surgery – Molar (First Root)	\$50.00
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$0.00
D3430	Retrograde Filling – per Root	\$50.00
D3450	Root Amputation – per Root (Not Covered in Conjunction with Procedure D3920)	\$0.00
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	\$0.00
Periodontics Includes Postoperative Evaluations and Treatment Under a Local Anesthetic		
D0180	Comprehensive Periodontal Evaluation – New or Established Patient ☼	\$0.00
D4210	Gingivectomy or Gingivoplasty – 4 or More Teeth, per Quadrant	\$75.00
D4211	Gingivectomy or Gingivoplasty – 1 to 3 Teeth, per Quadrant	\$15.00
D4240	Gingival Flap, Including Root Planing – 4 or More Teeth, per Quadrant	\$75.00
D4241	Gingival Flap, Including Root Planing – 1 to 3 Teeth, per Quadrant	\$75.00
D4245	Apically Positioned Flap	\$75.00
D4249	Clinical Crown Lengthening – Hard Tissue	\$75.00

Cigna Dental Care®
Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D4260	Osseous Surgery – 4 or More Teeth, per Quadrant	\$150.00
D4261	Osseous Surgery – 1 to 3 Teeth, per Quadrant	\$150.00
D4263	Bone Replacement Graft – First Site in Quadrant	\$195.00
D4264	Bone Replacement Graft – Each Additional Site in Quadrant	\$60.00
D4270	Pedicle Soft Tissue Graft Procedure	\$195.00
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	\$195.00
D4274	Distal or Proximal Wedge Procedure (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	\$45.00
D4341	Periodontal Scaling and Root Planing – 4 or More Teeth per Quadrant (<i>Limit 4 Quadrants per Consecutive 12 Months</i>)	\$0.00
D4342	Periodontal Scaling and Root Planing – 1 to 3 Teeth, per Quadrant (<i>Limit 4 Quadrants per Consecutive 12 Months</i>)	\$0.00
D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	\$0.00
D4910	Periodontal Maintenance (<i>Limited to 2 per Calendar Year (Only Covered after Active Therapy).</i>)	\$0.00
	Additional Periodontal Maintenance Procedures (Beyond 2 per Calendar Year)	\$55.00
D9940	Occlusal Guard – By Report (<i>Limit 1 per 24 Months</i>)	\$95.00
D9951	Occlusal Adjustment Limited	\$20.00
D9952	Occlusal Adjustment Complete	\$40.00
<p>Prosthetics (Removable Tooth Replacement – Dentures) (Includes Up to 4 adjustments within first 6 months after insertion)</p>		
D5110	Full Upper Denture	\$75.00
D5120	Full Lower Denture	\$75.00
D5130	Immediate Full Upper Denture	\$90.00
D5140	Immediate Full Lower Denture	\$90.00

Cigna Dental Care®
Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D5211	Upper Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	\$85.00
D5212	Lower Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	\$85.00
D5213	Upper Partial Denture – Cast Metal Framework (Including Clasps, Rests and Teeth)	\$85.00
D5214	Lower Partial Denture – Cast Metal Framework (Including Clasps, Rests and Teeth)	\$85.00
D5225	Upper Partial Denture – Flexible Base (Including Clasps, Rests and Teeth)	\$135.00
D5226	Lower Partial Denture – Flexible Base (Including Clasps, Rests and Teeth)	\$135.00
D5410	Adjust Complete Denture – Upper	\$0.00
D5411	Adjust Complete Denture – Lower	\$0.00
D5421	Adjust Partial Denture – Upper	\$0.00
D5422	Adjust Partial Denture – Lower	\$0.00
Repairs to Prosthetics		
D5510	Repair Broken Complete Denture Base	\$15.00
D5520	Replace Missing or Broken Teeth – Complete Denture (Each Tooth)	\$5.00
D5610	Repair Resin Denture Base	\$15.00
D5620	Repair Cast Framework	\$15.00
D5630	Repair or Replace Broken Clasp	\$15.00
D5640	Replace Broken Teeth – per Tooth	\$5.00
D5650	Add Tooth to Existing Partial Denture	\$5.00
D5660	Add Clasp to Existing Partial Denture	\$5.00
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Upper)	\$75.00
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Lower)	\$75.00

Cigna Dental Care®
Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
Denture Relining (Limit 1 Every 36 Months)		
D5710	Rebase Complete Upper Denture	\$30.00
D5711	Rebase Complete Lower Denture	\$30.00
D5720	Rebase Upper Partial Denture	\$30.00
D5721	Rebase Lower Partial Denture	\$30.00
D5730	Reline Complete Upper Denture – Chairside	\$15.00
D5731	Reline Complete Lower Denture – Chairside	\$15.00
D5740	Reline Upper Partial Denture – Chairside	\$15.00
D5741	Reline Lower Partial Denture – Chairside	\$15.00
D5750	Reline Complete Upper Denture – Laboratory	\$30.00
D5751	Reline Complete Lower Denture – Laboratory	\$30.00
D5760	Reline Upper Partial Denture – Laboratory	\$30.00
D5761	Reline Lower Partial Denture – Laboratory	\$30.00
Interim Dentures (Limited to Initial Placement of Interim Partial Denture/Stayplate to Replace Extracted Anterior Teeth During Healing)		
D5820	Interim Partial Denture – Upper	\$0.00
D5821	Interim Partial Denture – Lower	\$0.00
D5850	Tissue Conditioning – Upper	\$0.00
D5851	Tissue Conditioning – Lower	\$0.00
Oral Surgery Includes Routine Postoperative Treatment. Surgical Removal of Impacted Tooth – Not covered for ages below 15 unless pathology (disease) exists. Surgical removal of wisdom tooth/3rd molar for orthodontic reasons only is not covered.		
D7111	Extraction of Coronal Remnants – Deciduous Tooth	\$0.00
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	\$0.00

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Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D7210	Surgical Removal of Erupted Tooth – Removal of Bone and/or Section of Tooth	\$0.00
D7220	Removal of Impacted Tooth – Soft Tissue	\$0.00
D7230	Removal of Impacted Tooth – Partially Bony	\$30.00
D7240	Removal of Impacted Tooth – Completely Bony	\$40.00
D7241	Removal of Impacted Tooth – Completely Bony, Unusual Complications (Narrative Required)	\$40.00
D7250	Surgical Removal of Residual Tooth Roots – Cutting Procedure	\$0.00
D7251	Coronectomy – Intentional Partial Tooth Removal	\$0.00
D7270	Tooth Stabilization of Accidentally Evulsed or Displaced Tooth	\$50.00
D7280	Surgical Access of an Unerupted Tooth (<i>Excluding Wisdom Teeth</i>)	\$85.00
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	\$85.00
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	\$0.00
D7286	Biopsy of Oral Tissue – Soft (All Others) (<i>Tooth Related – Not allowed when in conjunction with another surgical procedure</i>)	\$0.00
D7310	Alveoplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces – per Quadrant	\$30.00
D7311	Alveoplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces – per Quadrant	\$30.00
D7320	Alveoplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces – per Quadrant	\$40.00
D7321	Alveoplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces – per Quadrant	\$40.00
D7450	Removal of Benign Odontogenic Cyst or Tumor – Up to 1.25cm	\$0.00
D7451	Removal of Benign Odontogenic Cyst or Tumor – Greater than 1.25cm	\$0.00
D7471	Removal of Exostosis – per Site	\$0.00
D7472	Removal of Torus Palatinus	\$0.00

Cigna Dental Care®
Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D7473	Removal of Torus Mandibularis	\$0.00
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	\$0.00
D7960	Frenulectomy – Also Known as Frenectomy or Frenotomy – Separate Procedure Not Incidental to Another	\$0.00
D7970	Excision of Hyperplastic Tissue – per Arch	\$50.00
D7971	Excision of Pericoronal Gingiva	\$50.00
<p>Orthodontics (Tooth Movement) Orthodontic Treatment (Maximum lifetime benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)</p>		
D8010	Limited Orthodontic Treatment of the Primary Dentition	\$230.00
D8020	Limited Orthodontic Treatment of the Transitional Dentition	\$230.00
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	\$230.00
D8040	Limited Orthodontic Treatment of the Adult Dentition	\$430.00
D8050	Interceptive Orthodontic Treatment of the Primary Dentition – Banding	\$230.00
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition – Banding	\$230.00
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition – Banding	\$490.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition – Banding	\$490.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition – Banding	\$490.00
D8660	Pre-Orthodontic Treatment Visit	\$0.00
D8670	Periodic Orthodontic Treatment Visit – As Part of Contract	
	Charge per Month for 24 Months	\$40.00
D8680	Orthodontic Retention – Removal of Appliances, Construction and Placement of Retainer(s)	\$0.00
D8999	Unspecified Orthodontic Procedure, By Report (<i>Orthodontic Treatment Plan and Records</i>)	\$620.00

Cigna Dental Care®

Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
	<p>Pre- and Post-Orthodontic Records may include any of the following:</p> <p>D0210 – Intraoral – Complete Series D0220 – Intraoral – Periapical First Film D0230 – Intraoral – Periapical Each Additional Film D0240 – Intraoral – Occlusal D0250 – Extraoral – First Film D0260 – Extraoral – Each Additional Film D0270 – Bitewing – Single Film D0272 – Bitewings – Two Films D0273 – Bitewings – Three Films D0274 – Bitewings – Four Films D0277 – Vertical Bitewings – 7 to 8 Films D0322 – Tomographic Survey* D0330 – Panoramic Film D0340 – Cephalometric Film* D0350 – Oral/Facial Photographic Images* D0470 – Diagnostic Casts</p> <p>*Only covered when used for orthodontic treatment plan and records</p>	
<p>Adjunctive Services</p>		
D9211	Regional Block Anesthesia	\$0.00
D9212	Trigeminal Division Block Anesthesia	\$0.00
D9215	Local Anesthesia	\$0.00
<p>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 one hour per appointment. There is no coverage for general anesthesia or intravenous sedation when used for the purpose of anxiety control or patient management.</p>		
D9220	General Anesthesia – First 30 Minutes	\$165.00
D9221	General Anesthesia – Each Additional 15 Minutes	\$80.00
D9241	IV Conscious Sedation – First 30 Minutes	\$165.00

Cigna Dental Care®
 Patient Charge Schedule (BER07 AZ)

Code	Procedure Description	Patient Charge
D9242	IV Conscious Sedation – Each Additional 15 Minutes	\$80.00
Emergency Services		
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	\$5.00
D9440	Office Visit – After Regularly Scheduled Hours	\$20.00
Miscellaneous Services External Bleaching (D9972) is limited to the use of take-home bleaching trays. All other bleaching methods are not covered.		
D9972	External Bleaching – per Arch	\$125.00
D9999	Broken Appointment Fee	\$10.00
<p>This may contain CDT codes and/or portions of, or excerpts from the Nomenclature contained within the Current Dental Terminology, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.</p>		

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling Cigna Dental at the toll-free number listed on your ID card or plan materials.

Multiple ways to locate a *DHMO Network General Dentist:

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

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

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

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