



CIGNA Dental

B1R04

## 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 Dentist (Endodontist, Periodontist, Orthodontist, Oral Surgeon or Pediatric Dentist (up to 7th birthday unless medical reasons justify an exception)). You must verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by CIGNA Dental.
- Procedures **NOT** listed on this Patient Charge Schedule are **NOT** covered and are the patient's responsibility at the dentist's usual fees.
- The administration of I.V. sedation, general anesthesia, and/or nitrous oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

**CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company, and CIGNA Dental Health, Inc., and its operating subsidiaries and affiliates. The CIGNA Dental Care plan is provided 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. (Kansas and Nebraska), CIGNA Dental Health of Kentucky, Inc., CIGNA Dental Health of Maryland, Inc., CIGNA Dental Health of Missouri, Inc., CIGNA Dental Health of New Jersey, Inc., CIGNA Dental Health of New Mexico, Inc. (Albuquerque and Santa Fe), 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, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company or CIGNA HealthCare of Connecticut, Inc. and administered by CIGNA Dental Health, Inc.**

**Code** **Patient Charge**

**Diagnostic/Preventive**

D9310	Consultation (Diagnostic Service Provided By Dentist or Physician Other Than Practitioner Providing Treatment)	No Charge
D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	No Charge
D9450	Case Presentation, Detailed and Extensive Treatment Planning	No Charge
D0120	Periodic Oral Evaluation	No Charge
D0140	Limited Oral Evaluation – Problem Focused	No Charge
D0150	Comprehensive Oral Evaluation – New or Established Patient	No Charge
D0170	Re-evaluation – Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	No Charge
D0210	X-Rays Intraoral – Complete Series (including bitewings) ★	No Charge
D0220	X-Rays Intraoral – Periapical First Film	No Charge
D0230	X-Rays Intraoral – Periapical Each Additional Film	No Charge
D0240	X-Rays Intraoral – Occlusal Film	No Charge
D0270	X-Rays (Bitewing) – Single Film	No Charge
D0272	X-Rays (Bitewing) – Two Films	No Charge
D0274	X-Rays (Bitewing) – Four Films	No Charge
D0277	X-Rays (Bitewing, Vertical) – 7 to 8 Films	No Charge
D0330	X-Rays (Panoramic Film) ★	No Charge
D0460	Pulp Vitality Tests	No Charge
D0470	Diagnostic Casts	No Charge
D0472	Accession of Tissue, Gross Examination, Preparation and Transmission of Written Report	No Charge
D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report	No Charge
D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical Margins for Presence of Disease, Preparation and Transmission of Written Report	No Charge
D1110	Prophylaxis – Adult ★★	No Charge
	Prophylaxis – Adult (In Addition to the 1 Prophylaxis Allowed Every 6 Months)	\$50.00
D1120	Prophylaxis – Child ★★	No Charge
	Prophylaxis – Child (In Addition to the 1 Prophylaxis Allowed Every 6 Months)	\$35.00
D1203	Topical Application of Fluoride – (Prophylaxis Not Included) – Child ◆ ★★	No Charge
D1330	Oral Hygiene Instructions	No Charge
D1351	Sealant – Per Tooth ❀	No Charge
D1510	Space Maintainer – Fixed – Unilateral	No Charge
D1515	Space Maintainer – Fixed – Bilateral	No Charge

**Restorative (Fillings)**

D2140	Amalgam – One Surface, Primary or Permanent	No Charge
D2150	Amalgam – Two Surfaces, Primary or Permanent	No Charge
D2160	Amalgam – Three Surfaces, Primary or Permanent	No Charge
D2161	Amalgam – Four or More Surfaces, Primary or Permanent	No Charge

★ Limit 1 every 3 years

★★ Limit 1 every 6 months

◆ Up to 19th birthday

❀ Up to 14th birthday

<b>Code</b>		<b>Patient Charge</b>
D2330	Resin-Based Composite – One Surface, Anterior	No Charge
D2331	Resin-Based Composite – Two Surfaces, Anterior	No Charge
D2332	Resin-Based Composite – Three Surfaces, Anterior	No Charge
D2335	Resin-Based Composite – Four or More Surfaces or Involving Incisal Angle (Anterior)	\$75.00
D2390	Resin-Based Composite Crown, Anterior	\$25.00
D2391	Resin-Based Composite – One Surface, Posterior	\$30.00
D2392	Resin-Based Composite – Two Surfaces, Posterior	\$40.00
D2393	Resin-Based Composite – Three Surfaces, Posterior	\$55.00
D2394	Resin-Based Composite – Four or More Surfaces, Posterior	\$75.00

**Crown and Bridge** *(All charges for crown and bridge are per unit) (Each replacement or supporting tooth equals one unit - replacement limit 1 every 5 years)*

D2510	Inlay – Metallic – One Surface	\$220.00
D2520	Inlay – Metallic – Two Surfaces	\$220.00
D2530	Inlay – Metallic – Three or More Surfaces	\$220.00
D2542	Onlay – Metallic – Two Surfaces	\$140.00
D2543	Onlay – Metallic – Three Surfaces	\$140.00
D2544	Onlay – Metallic – Four or More Surfaces	\$140.00
D2740	Crown – Porcelain/Ceramic Substrate	\$220.00
D2750	Crown – Porcelain Fused to High Noble Metal	\$210.00
D2751	Crown – Porcelain Fused to Predominantly Base Metal	\$140.00
D2752	Crown – Porcelain Fused to Noble Metal	\$200.00
D2780	Crown – 3/4 Cast High Noble Metal	\$210.00
D2781	Crown – 3/4 Cast Predominantly Base Metal	\$140.00
D2782	Crown – 3/4 Cast Noble Metal	\$200.00
D2790	Crown – Full Cast High Noble Metal	\$210.00
D2791	Crown – Full Cast Predominantly Base Metal	\$140.00
D2792	Crown – Full Cast Noble Metal	\$200.00
D2910	Recent Inlay	No Charge
D2920	Recent Crown	No Charge
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	No Charge
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	No Charge
D2932	Prefabricated Resin Crown	\$25.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	\$70.00
D2940	Sedative Filling	No Charge
D2950	Core Buildup, Including Any Pins	\$40.00
D2951	Pin Retention – Per Tooth, In Addition to Restoration	No Charge
D2952	Cast Post and Core, In Addition to Crown	\$55.00
D2954	Prefabricated Post and Core In Addition to Crown	\$40.00
D2960	Labial Veneer (Resin Laminate) – Chairside	\$75.00
D6210	Pontic – Cast High Noble Metal	\$210.00
D6211	Pontic – Cast Predominantly Base Metal	\$140.00
D6212	Pontic – Cast Noble Metal	\$200.00
D6240	Pontic – Porcelain Fused to High Noble Metal	\$210.00
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	\$140.00
D6242	Pontic – Porcelain Fused to Noble Metal	\$200.00
D6245	Pontic – Porcelain/Ceramic	\$220.00
D6602	Inlay – Cast High Noble Metal, Two Surfaces	\$220.00
D6603	Inlay – Cast High Noble Metal, Three or More Surfaces	\$220.00
D6604	Inlay – Cast Predominantly Base Metal, Two Surfaces	\$220.00
D6605	Inlay – Cast Predominantly Base Metal, Three or More Surfaces	\$220.00

Code		Patient Charge
D6606	Inlay – Cast Noble Metal, Two Surfaces	\$220.00
D6607	Inlay – Cast Noble Metal, Three or More Surfaces	\$220.00
D6610	Onlay – Cast High Noble Metal, Two Surfaces	\$140.00
D6611	Onlay – Cast High Noble Metal, Three or More Surfaces	\$140.00
D6612	Onlay – Cast Predominantly Base Metal, Two Surfaces	\$140.00
D6613	Onlay – Cast Predominantly Base Metal, Three or More Surfaces	\$140.00
D6614	Onlay – Cast Noble Metal, Two Surfaces	\$140.00
D6615	Onlay – Cast Noble Metal, Three or More Surfaces	\$140.00
D6740	Crown – Porcelain/Ceramic	\$220.00
D6750	Crown – Porcelain Fused to High Noble Metal	\$210.00
D6751	Crown – Porcelain Fused to Predominantly Base Metal	\$140.00
D6752	Crown – Porcelain Fused to Noble Metal	\$200.00
D6780	Crown – 3/4 Cast High Noble Metal	\$210.00
D6781	Crown – 3/4 Cast Predominantly Base Metal	\$140.00
D6782	Crown – 3/4 Cast Noble Metal	\$200.00
D6790	Crown – Full Cast High Noble Metal	\$210.00
D6791	Crown – Full Cast Predominantly Base Metal	\$140.00
D6792	Crown – Full Cast Noble Metal	\$200.00
	Complex Rehabilitation – Additional Charge Per Unit For Multiple Crown Units/Complex Rehabilitation <i>(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)</i>	\$125.00
D6930	Recent Fixed Partial Denture	No Charge

**Endodontics** *(Root canal treatment, excluding final restorations)*

D3110	Pulp Cap – Direct (Excluding Final Restoration)	No Charge
D3120	Pulp Cap – Indirect (Excluding Final Restoration)	No Charge
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) – Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	No Charge
D3221	Pulpal Debridement, Primary and Permanent Teeth ■	No Charge
D3310	Anterior Root Canal (Excluding Final Restoration) ❖	No Charge
D3320	Bicuspid Root Canal (Excluding Final Restoration) ❖	No Charge
D3330	Molar Root Canal (Excluding Final Restoration) ❖	\$130.00
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access	No Charge
D3332	Incomplete Endodontic Therapy; Inoperable or Fractured Tooth	No Charge
D3333	Internal Root Repair of Perforation Defects	No Charge
D3346	Retreatment of Previous Root Canal Therapy – Anterior	No Charge
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	No Charge
D3348	Retreatment of Previous Root Canal Therapy – Molar	\$160.00
D3410	Apicoectomy/Periradicular Surgery – Anterior	No Charge
D3421	Apicoectomy/Periradicular Surgery – Bicuspid (First Root)	No Charge
D3425	Apicoectomy/Periradicular Surgery – Molar (First Root)	No Charge
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	No Charge
D3430	Retrograde Filling – Per Root	No Charge

**Periodontics** *(Treatment of supporting tissues [gum and bone] of the teeth)*

D0180	Comprehensive Periodontal Evaluation – New or Established Patient	\$15.00
D4210	Gingivectomy or Gingivoplasty – Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$75.00

Code		Patient Charge
D4211	Gingivectomy or Gingivoplasty – One to Three Teeth, Per Quadrant	\$35.00
D4240	Gingival Flap Procedure, Including Root Planing – Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$85.00
D4241	Gingival Flap Procedure, Including Root Planing – One to Three Teeth, Per Quadrant	\$43.00
D4245	Apically Positioned Flap	\$85.00
D4249	Clinical Crown Lengthening – Hard Tissue	\$65.00
D4260	Osseous Surgery – Including Flap Entry and Closure – Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$130.00
D4261	Osseous Surgery – Including Flap Entry and Closure – One to Three Teeth, Per Quadrant	\$80.00
D4263	Bone Replacement Graft – First Site in Quadrant	\$225.00
D4264	Bone Replacement Graft – Each Additional Site in Quadrant	\$175.00
D4266	Guided Tissue Regeneration – Resorbable Barrier, Per Site	\$295.00
D4267	Guided Tissue Regeneration – Nonresorbable Barrier, Per Site (Includes Membrane Removal)	\$335.00
D4270	Pedicle Soft Tissue Graft Procedure	\$70.00
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	\$70.00
D4275	Soft Tissue Allograft	\$70.00
D4341	Periodontal Scaling and Root Planing – Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant *	\$30.00
D4342	Periodontal Scaling and Root Planing – One to Three Teeth, Per Quadrant *	\$20.00
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis ☉	\$30.00
D4381	Localized Delivery of Chemotherapeutic Agents Via a Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth, By Report	\$60.00
D4910	Periodontal Maintenance ▲	\$20.00
D9940	Occlusal Guard – By Report	\$70.00
D9951	Occlusal Adjustment – Limited	\$20.00
D9952	Occlusal Adjustment – Complete	\$55.00

**Prosthetics** *(Removable tooth replacement - dentures) (Includes up to 4 adjustments within first 6 months after insertion - replacement limit 1 every 5 years)*

D5110	Complete Denture – Maxillary	\$200.00
D5120	Complete Denture – Mandibular	\$200.00
D5130	Immediate Denture – Maxillary	\$180.00
D5140	Immediate Denture – Mandibular	\$180.00
D5211	Maxillary Partial Denture – Resin Base (Including Any Conventional Clasps, Rests & Teeth)	\$205.00
D5212	Mandibular Partial Denture – Resin Base (Including Any Conventional Clasps, Rests & Teeth)	\$205.00
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests & Teeth)	\$260.00
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests & Teeth)	\$260.00
D5410	Adjust Complete Denture – Maxillary	\$15.00
D5411	Adjust Complete Denture – Mandibular	\$15.00
D5421	Adjust Partial Denture – Maxillary	\$15.00
D5422	Adjust Partial Denture – Mandibular	\$15.00

☉1 Per Lifetime      \* Limit 4 Quadrants Per Consecutive 12 Months  
 ▲Limit 2 Within the First 12 Months After Active Therapy

Code	Patient Charge
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**Repairs to Prosthetics**

D5510	Repair Broken Complete Denture Base	\$30.00
D5520	Replace Missing or Broken Teeth – Complete Denture (Each Tooth)	\$30.00
D5610	Repair Resin Denture Base	\$30.00
D5630	Repair or Replace Broken Clasp	\$35.00
D5640	Replace Broken Teeth – Per Tooth	\$30.00
D5650	Add Tooth to Existing Partial Denture	\$30.00
D5660	Add Clasp to Existing Partial Denture	\$35.00

**Denture Relining** *(Limit 1 every 36 months)*

D5710	Rebase Complete Maxillary Denture	\$70.00
D5711	Rebase Complete Mandibular Denture	\$70.00
D5720	Rebase Maxillary Partial Denture	\$70.00
D5721	Rebase Mandibular Partial Denture	\$70.00
D5730	Reline Complete Maxillary Denture (Chairside)	No Charge
D5731	Reline Complete Mandibular Denture (Chairside)	No Charge
D5740	Reline Maxillary Partial Denture (Chairside)	No Charge
D5741	Reline Mandibular Partial Denture (Chairside)	No Charge
D5750	Reline Complete Maxillary Denture (Laboratory)	\$70.00
D5751	Reline Complete Mandibular Denture (Laboratory)	\$70.00
D5760	Reline Maxillary Partial Denture (Laboratory)	\$70.00
D5761	Reline Mandibular Partial Denture (Laboratory)	\$70.00

**Interim Dentures** *(Limit 1 every 5 years)*

D5810	Interim Complete Denture (Maxillary)	\$120.00
D5811	Interim Complete Denture (Mandibular)	\$120.00
D5820	Interim Partial Denture (Maxillary)	\$95.00
D5821	Interim Partial Denture (Mandibular)	\$95.00

**Oral Surgery** *(Includes routine post-operative treatment)*

D7111	Coronal Remnants – Deciduous Tooth	No Charge
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	No Charge
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	No Charge

*Surgical removal of impacted tooth – (not covered unless pathology [disease] exists). Surgical removal of wisdom tooth/3rd molar for orthodontic reasons only is not covered.*

D7220	Removal of Impacted Tooth – Soft Tissue	No Charge
D7230	Removal of Impacted Tooth – Partially Bony	\$20.00
D7240	Removal of Impacted Tooth – Completely Bony	\$40.00
D7241	Removal of Impacted Tooth – Completely Bony, With Unusual Surgical Complications	\$40.00
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	No Charge
D7260	Oroantral Fistula Closure	\$45.00
D7261	Primary Closure of a Sinus Perforation	\$45.00

Code		Patient Charge
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	No Charge
D7280	Surgical Access of an Unerupted Tooth ❖	No Charge
D7281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	No Charge
D7285	Biopsy of Oral Tissue – Hard (Bone, Tooth) ❁	\$40.00
D7286	Biopsy of Oral Tissue – Soft (All Others) ❁	\$30.00
D7310	Alveoplasty in Conjunction with Extractions – Per Quadrant	No Charge
D7320	Alveoplasty Not in Conjunction with Extractions – Per Quadrant	No Charge
D7450	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter Up to 1.25cm	No Charge
D7451	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter Greater Than 1.25cm	No Charge
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	No Charge
D7472	Removal of Torus Palatinus	No Charge
D7473	Removal of Torus Mandibularis	No Charge
D7485	Surgical Reduction of Osseous Tuberosity	No Charge
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	No Charge
D7960	Frenulectomy (Frenectomy or Frenotomy) – Separate Procedure	No Charge

**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 ●	\$275.00
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition ●	\$275.00
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition ●	\$300.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition ●	\$300.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition ●	\$300.00
D8660	Pre-Orthodontic Treatment Visit	\$40.00
D8670	Periodic Orthodontic Treatment Visit (As Part of Contract) Children ◆	
	24 Month Treatment Fee	\$1,100.00
	Charge Per Month for 24 Months	\$45.83
	Adults	
	24 Month Treatment Fee	\$1,700.00
	Charge Per Month for 24 Months	\$70.83
D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	\$300.00
D8999	Unspecified Orthodontic Procedure, By Report ■■	\$150.00

❖ Excluding Wisdom Teeth  
● Banding

◆ Up to 19th birthday  
❁ Tooth Related - Not Allowed When in Conjunction with Another Surgical Procedure

■■ Orthodontic Treatment Plan and Records

Code	Patient Charge
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**General Anesthesia/I.V. Sedation** (Covered when performed by a Periodontist or Oral Surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule.)

D9220	Deep Sedation/General Anesthesia – First 30 Minutes	\$115.00
D9221	Deep Sedation/General Anesthesia – Each Additional 15 Minutes	\$60.00
D9241	Intravenous Conscious Sedation/Analgesia – First 30 Minutes	\$115.00
D9242	Intravenous Conscious Sedation/Analgesia – Each Additional 15 Minutes	\$60.00

**Emergency Services**

D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	No Charge
D9440	Office Visit – After Regularly Scheduled Hours	\$55.00

**Broken Appointment**

*(Note: This fee will not be charged if patient is unable to provide 24-hours notice through no fault of his or her own.)*

Broken Appointment – Less Than 24-hours Notice (Per 15-Minute Appointment)	\$10.00
Maximum Fee For Broken Appointment:	
Sealant	\$10.00
Prophylaxis	\$20.00
Any Other Appointment	\$40.00

**After your enrollment is effective:**

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

**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.

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