

HIXV9
HOUSTON INDEPENDENT SCHOOL DISTRICT
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. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.
- ▶ This Patient Charge Schedule applies to Specialty Care. 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 Pediatric, Orthodontist and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 7 by calling Customer Service at **1.800.Cigna24** to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 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.



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PATIENT CHARGE SCHEDULE (HOUSTON ISD HIXV9)

Important Highlights (Continued)

- ▶ Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.
- ▶ All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.

Procedure codes listed are from the American Dental Association’s CDT 2015 Dental Procedure Codes ©. The American Dental Association may periodically change the Code on Dental Procedures and Nomenclature (CDT Code). Different codes may be used to describe these covered procedures. The language in *italics* is intended to clarify the members’ benefit.

Code	Procedure Description	Copayment
Office visit fee (Per patient, per office visit in addition to any other applicable patient charges)		
	Office visit fee	\$5.00
Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145). The frequency of certain Covered Services, like cleanings, is limited. If your Network General 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 ☉.		
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	Reevaluation – Limited, problem focused (Not postoperative visit)	\$0.00
D0180	Comprehensive periodontal evaluation – New or established patient	\$0.00
D0210	X-rays intraoral – Complete series of radiographic images (<i>Limit 1 every 3 years</i>) ☉	\$0.00

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Code	Procedure Description	Copayment
D0220	X-rays intraoral – Periapical – First radiographic image	\$0.00
D0230	X-rays intraoral – Periapical – Each additional radiographic image	\$0.00
D0240	X-rays intraoral – Occlusal radiographic image	\$0.00
D0250	Extraoral – 2D projection radiographic image created using a stationary radiation source, and detector	\$0.00
D0270	X-rays (Bitewing) – Single radiographic image	\$0.00
D0272	X-rays (Bitewings) – 2 radiographic images	\$0.00
D0273	X-rays (Bitewings) – 3 radiographic images	\$0.00
D0274	X-rays (Bitewings) – 4 radiographic images	\$0.00
D0277	X-rays (Bitewings, vertical) – 7 to 8 radiographic images	\$0.00
D0330	X-rays (Panoramic radiographic image) – <i>(Limit 1 every 3 years)</i> ☉	\$0.00
D0364	Cone beam CT capture and interpretation with limited field of view – Less than one whole jaw <i>(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)</i>	\$200.00
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – Mandible <i>(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)</i>	\$220.00
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – Maxilla, with or without cranium <i>(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)</i>	\$220.00
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium <i>(Only covered in conjunction with the surgical placement of an implant; limit of a total of only one D0364, D0365, D0366, or D0367 per calendar year)</i>	\$240.00
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures <i>(Limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)</i>	\$240.00
D0415	Collection of microorganisms for culture and sensitivity	\$0.00

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Code	Procedure Description	Copayment
D0416	Viral culture	\$0.00
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	\$0.00
D0425	Caries susceptibility tests	\$0.00
D0460	Pulp vitality tests	\$0.00
D0470	Diagnostic casts	\$0.00
D1110	Prophylaxis (Cleaning) – Adult (<i>Limit 2 per calendar year</i>) ◊	\$0.00
D1120	Prophylaxis (Cleaning) – Child (<i>Limit 2 per calendar year</i>) (<i>Children up to age 14</i>) ◊	\$0.00
D1206	Topical application of fluoride varnish – (<i>Limit 2 per calendar year</i>). <i>There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.</i> ◊	\$0.00
D1208	Topical application of fluoride (<i>Limit 2 per calendar year</i>) <i>There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.</i> ◊	\$0.00
D1351	Sealant – Per tooth (<i>Children up to age 14</i>)	\$5.00
D1510	Space maintainer – Fixed – Unilateral	\$45.00
D1515	Space maintainer – Fixed – Bilateral	\$45.00
D1520	Space maintainer – Removable – Unilateral	\$45.00
D1525	Space maintainer – Removable – Bilateral	\$45.00
D1550	Re-cement or rebond space maintainer	\$11.00
D1555	Removal of fixed space maintainer	\$11.00
Restorative (Fillings, including polishing)		
D2140	Amalgam – 1 surface, primary or permanent	\$10.00
D2150	Amalgam – 2 surfaces, primary or permanent	\$12.00
D2160	Amalgam – 3 surfaces, primary or permanent	\$15.00
D2161	Amalgam – 4 or more surfaces, primary or permanent	\$15.00
D2330	Resin-based composite – 1 surface, anterior	\$10.00
D2331	Resin-based composite – 2 surfaces, anterior	\$12.00

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Code	Procedure Description	Copayment
D2332	Resin-based composite – 3 surfaces, anterior	\$15.00
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle, anterior	\$60.00
D2390	Resin-based composite crown, anterior	\$25.00
D2391	Resin-based composite – 1 surface, posterior	\$40.00
D2392	Resin-based composite – 2 surfaces, posterior	\$60.00
D2393	Resin-based composite – 3 surfaces, posterior	\$80.00
D2394	Resin-based composite – 4 or more surfaces, posterior	\$80.00
<p>Crown and bridge – All charges for crown and bridge (Fixed partial denture) are per unit (Each replacement or supporting tooth equals 1 unit). Coverage for replacement of crowns and bridges is limited to 1 every 5 years. You may be charged up to these additional amounts, based on the type of material the dentist uses for your restoration. The relevant procedure codes are identified with an *.</p> <ul style="list-style-type: none"> • No more than \$80.00 per tooth for any noble metal alloys • No more than \$130.00 per tooth for any high noble metal alloys, titanium or titanium alloys 		
D2750	Crown – Porcelain fused to high noble metal*	\$230.00
D2751	Crown – Porcelain fused to predominantly base metal	\$230.00
D2752	Crown – Porcelain fused to noble metal*	\$230.00
D2780	Crown – 3/4 cast high noble metal*	\$230.00
D2781	Crown – 3/4 cast predominantly base metal	\$230.00
D2782	Crown – 3/4 cast noble metal*	\$230.00
D2790	Crown – Full cast high noble metal*	\$230.00
D2791	Crown – Full cast predominantly base metal	\$230.00
D2792	Crown – Full cast noble metal*	\$230.00
D2794	Crown – Titanium*	\$230.00
D2799	Provisional crown – Further treatment or completion of diagnosis necessary prior to final impression	\$54.00
D2910	Re-Cement Inlay, Onlay, or Partial Coverage Restoration	\$12.00
D2915	Re-Cement Cast or Prefabricated Post and Core	\$12.00
D2920	Re-Cement Crown	\$12.00

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Code	Procedure Description	Copayment
D2930	Prefabricated Stainless Steel Crown – Primary Tooth <i>(Children up to age 14)</i>	\$48.00
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth <i>(Children up to age 14)</i>	\$48.00
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth <i>(Children up to age 14)</i>	\$48.00
D2940	Protective restoration	\$5.00
D2950	Core buildup – Including any pins	\$30.00
D2951	Pin retention – Per tooth, in addition to restoration	\$30.00
D2952	Cast post and core In addition to crown – Indirectly fabricated	\$50.00
D2953	Each additional indirectly fabricated post – Same tooth	\$15.00
D2954	Prefabricated post and core in addition to crown	\$50.00
D2955	Post removal (Not in conjunction with endodontic therapy)	\$15.00
D2957	Each additional prefabricated post – Same tooth	\$12.00
D6210	Pontic – Cast high noble metal*	\$230.00
D6211	Pontic – Cast predominantly base metal	\$230.00
D6212	Pontic – Cast noble metal *	\$230.00
D6214	Pontic – Titanium*	\$230.00
D6240	Pontic – Porcelain fused to high noble metal *	\$230.00
D6241	Pontic – Porcelain fused to predominantly base metal	\$230.00
D6242	Pontic – Porcelain fused to noble metal *	\$230.00
D6250	Pontic – Resin with high noble metal *	\$230.00
D6251	Pontic – Resin with predominantly base metal	\$230.00
D6252	Pontic – Resin with noble metal *	\$230.00
D6720	Retainer crown – Resin with high noble metal *	\$230.00
D6721	Retainer crown – Resin with predominantly base metal	\$230.00
D6722	Retainer crown – Resin with noble metal *	\$230.00

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Code	Procedure Description	Copayment
D6750	Retainer crown – Porcelain fused to high noble metal *	\$230.00
D6751	Retainer crown – Porcelain fused to predominantly base metal	\$230.00
D6752	Retainer crown – Porcelain fused to noble metal *	\$230.00
D6780	Retainer crown – 3/4 cast high noble metal *	\$230.00
D6781	Retainer crown – 3/4 cast predominantly base metal	\$230.00
D6782	Retainer crown – 3/4 cast noble metal *	\$230.00
D6790	Retainer crown – Full cast high noble metal *	\$230.00
D6791	Retainer crown – Full cast predominantly base metal	\$230.00
D6792	Retainer crown – Full cast noble metal *	\$230.00
D6794	Retainer crown – Titanium*	\$230.00
D6930	Re-cement fixed partial denture	\$0.00
D6940	Stress breaker	\$35.00
D6980	Fixed partial denture repair, by report	\$45.00
Endodontics (Root canal treatment, excluding final restorations)		
D3110	Pulp cap – Direct (Excluding final restoration)	\$12.00
D3120	Pulp cap – Indirect (Excluding final restoration)	\$0.00
D3220	Therapeutic pulpotomy (Excluding final restoration) – Removal of pulp coronal to the dentinocemental junction and application of medicament	\$20.00
D3221	Pulpal debridment, primary and permanent tooth	\$0.00
D3222	Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development	\$20.00
D3230	Pulpal therapy (Resorbable filling) – Anterior, primary tooth (Excluding final restoration)	\$20.00
D3240	Pulpal therapy (Resorbable filling) – Posterior, primary tooth (Excluding final restoration)	\$20.00
D3310	Root canal therapy – Anterior (Excluding final restoration)	\$95.00
D3320	Root canal therapy – Bicuspid (Excluding final restoration)	\$118.00
D3330	Root canal therapy – Molar (Excluding final restoration)	\$162.00

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Code	Procedure Description	Copayment
D3410	Apicoectomy/periradicular surgery – Anterior	\$80.00
D3421	Apicoectomy/periradicular surgery – Bicuspid (First root)	\$80.00
D3425	Apicoectomy/periradicular surgery – Molar (First root)	\$80.00
D3426	Apicoectomy/periradicular surgery (Each additional root)	\$80.00
D3430	Retrograde filling – Per root	\$20.00
<p>Periodontics (Treatment of supporting tissues (Gum and bone) of the teeth) 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>		
D4210	Gingivectomy or gingivoplasty – Four or more contiguous teeth or bounded teeth spaces, per quadrant	\$95.00
D4211	Gingivectomy or gingivoplasty – One to three contiguous teeth or bounded teeth spaces, per quadrant	\$64.00
D4240	Gingival flap procedure, including root planing – Four or more contiguous teeth or bounded teeth spaces, per quadrant	\$150.00
D4241	Gingival flap procedure, including root planing – One to three contiguous teeth or bounded teeth spaces, per quadrant	\$100.00
D4260	Osseous surgery (Including flap entry and closure) – Four or more contiguous teeth or bounded teeth spaces, per quadrant	\$195.00
D4261	Osseous surgery (Including flap entry and closure) – One to three contiguous teeth or bounded teeth spaces, per quadrant	\$130.00
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant <i>(Limit 4 quadrants per consecutive 12 months)</i> ☉	\$35.00
D4342	Periodontal scaling and root planing – 1 to 3 teeth – Per quadrant <i>(Limit 4 quadrants per consecutive 12 months)</i> ☉	\$24.00
D4355	Full mouth debridement to allow evaluation and diagnosis <i>(1 per lifetime)</i>	\$30.00
D4910	Periodontal maintenance <i>(Limit 4 per calendar year) (Only covered after active periodontal therapy)</i> ☉	\$24.00
<p>Prosthetics (Removable tooth replacement – Dentures) includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years.</p>		
D5110	Complete denture – Maxillary	\$260.00

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Code	Procedure Description	Copayment
D5120	Complete denture – Mandibular	\$260.00
D5130	Immediate denture – Maxillary	\$300.00
D5140	Immediate denture – Mandibular	\$300.00
D5211	Maxillary partial denture – Resin base (Including any conventional clasps, rests, and teeth)	\$275.00
D5212	Mandibular partial denture – Resin base (Including any conventional clasps, rests, and teeth)	\$275.00
D5213	Maxillary partial denture – Cast metal framework with resin base (Including any conventional clasps, rests, and teeth)	\$300.00
D5214	Mandibular partial denture – Cast metal framework with resin base (Including any conventional clasps, rests, and teeth)	\$300.00
D5410	Adjust complete denture – Maxillary	\$10.00
D5411	Adjust complete denture – Mandibular	\$10.00
D5421	Adjust partial denture – Maxillary	\$10.00
D5422	Adjust partial denture – Mandibular	\$10.00
D5510	Repair broken complete denture base	\$25.00
D5520	Replace missing or broken teeth – Complete denture (Each tooth)	\$19.00
D5610	Repair resin (Partial) denture base	\$25.00
D5620	Repair cast (Partial denture) framework	\$25.00
D5630	Repair or replace broken clasp – Per tooth	\$25.00
D5640	Replace broken teeth (Partial denture) – Per tooth	\$19.00
D5650	Add tooth to existing partial denture	\$25.00
D5660	Add clasp to existing partial denture – Per tooth	\$35.00
D5670	Replace all teeth and acrylic on cast metal (Partial) framework (Maxillary)	\$248.00
D5671	Replace all teeth and acrylic on cast metal (Partial) framework (Mandibular)	\$248.00
D5710	Rebase complete maxillary denture	\$65.00
D5711	Rebase complete mandibular denture	\$65.00

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Code	Procedure Description	Copayment
D5720	Rebase maxillary partial denture	\$65.00
D5721	Rebase mandibular partial denture	\$65.00
Denture relining (Limit 1 every 36 months)		
D5730	Reline complete maxillary denture (Chairside)	\$25.00
D5731	Reline complete mandibular denture (Chairside)	\$25.00
D5740	Reline maxillary partial denture (Chairside)	\$25.00
D5741	Reline mandibular partial denture (Chairside)	\$25.00
D5750	Reline complete maxillary denture (Laboratory)	\$65.00
D5751	Reline complete mandibular denture (Laboratory)	\$65.00
D5760	Reline maxillary partial denture (Laboratory)	\$65.00
D5761	Reline mandibular partial denture (Laboratory)	\$65.00
D5820	Interim partial denture (Maxillary)	\$45.00
D5821	Interim partial denture (Mandibular)	\$45.00
D5850	Tissue conditioning (Maxillary)	\$25.00
D5851	Tissue conditioning, (Mandibular)	\$25.00
Implant services – Surgical placement of implants (D6010, D6012, D6040, and D6050 have a limit of 1 implant per calendar year with a replacement of 1 per 10 years)		
D6010	Surgical placement of implant body: Endosteal implant	\$1,025.00
D6012	Surgical placement of interim implant body for transitional prosthesis: Endosteal implant	\$390.00
D6013	Surgical placement of mini implant	\$530.00
D6040	Surgical placement: Eposteal implant	\$940.00
D6050	Surgical placement: Transosteal implant	\$900.00
D6055	Connecting bar – Implant supported or abutment supported <i>(Limit 1 per calendar year)</i>	\$1,170.00
D6056	Prefabricated abutment – Includes modification and placement <i>(Limit 1 per calendar year)</i>	\$355.00

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Code	Procedure Description	Copayment
D6057	Custom fabricated abutment – Includes placement <i>(Limit 1 per calendar year)</i>	\$455.00
D6058	Abutment supported porcelain/ceramic crown	\$975.00
D6065	Implant supported porcelain/ceramic crown	\$1,040.00
D6076	Implant supported retainer for porcelain fused to metal fixed partial denture (Titanium, titanium alloy, high noble metal)	\$1,080.00
D6077	Implant supported retainer for cast metal fixed partial denture (Titanium, titanium alloy, high noble metal)	\$1,060.00
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis <i>(Limit 1 per calendar year)</i>	\$110.00
D6090	Repair implant supported prosthesis, by report <i>(Limit 1 per calendar year)</i>	\$130.00
D6091	Replacement of semi-precision or precision attachment (Male or female component) of implant/abutment supported prosthesis, per attachment <i>(Limit 1 per calendar year)</i>	\$60.00
D6095	Repair implant abutment, by report <i>(Limit 1 per calendar year)</i>	\$130.00
D6100	Implant removal, by report <i>(Limit 1 per calendar year)</i>	\$245.00
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure <i>(Limit 1 per calendar year)</i>	\$125.00
D6102	Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure <i>(Limit 1 per calendar year)</i>	\$240.00
D6103	Bone graft for repair of peri-implant defect – Does not include flap entry and closure. <i>(Limit 1 per calendar year)</i>	\$290.00
D6104	Bone graft at time of implant placement <i>(Limit 1 per calendar year)</i>	\$290.00
D6110	Implant/abutment supported removable denture for edentulous arch – Upper	\$1,725.00
D6111	Implant/abutment supported removable denture for edentulous arch – Lower	\$1,725.00
D6112	Implant/abutment supported removable denture for partially edentulous arch – Upper	\$1,550.00

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Code	Procedure Description	Copayment
D6113	Implant/abutment supported removable denture for partially edentulous arch – Lower	\$1,550.00
D6190	Radiographic/surgical implant index, by report (<i>Limit 1 per calendar year</i>)	\$165.00
Oral surgery (Includes routine postoperative treatment) Surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (Disease) exists.		
D7111	Extraction, coronal remnants – Deciduous tooth	\$10.00
D7140	Extraction, erupted tooth or exposed root (Elevation and/or forceps removal)	\$10.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$20.00
D7220	Removal of impacted tooth – Soft tissue	\$30.00
D7230	Removal of impacted tooth – Partially bony	\$50.00
D7240	Removal of impacted tooth – Completely bony	\$75.00
D7241	Removal of impacted tooth – Completely bony, with unusual surgical complications	\$75.00
D7250	Surgical removal of residual tooth roots (Cutting procedure)	\$30.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$50.00
D7280	Surgical access of an unerupted tooth (<i>Excluding wisdom teeth</i>)	\$50.00
D7310	Alveoloplasty in conjunction with extractions – Four or more teeth or tooth spaces, per quadrant	\$36.00
D7311	Alveoloplasty in conjunction with extractions – One to three teeth or tooth spaces, per quadrant	\$24.00
D7320	Alveoloplasty not in conjunction with extractions – Four or more teeth or tooth spaces, per quadrant	\$36.00
D7321	Alveoloplasty not in conjunction with extractions – One to three teeth or tooth spaces, per quadrant	\$24.00
D7510	Incision and drainage of abscess – Intraoral soft tissue	\$26.00
D7520	Incision and drainage of abscess – Extraoral soft tissue	\$26.00
D7880	Occlusal orthotic device, by report – (<i>Limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment</i>)	\$330.00

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Code	Procedure Description	Copayment
D7910	Suture of Recent Small Wounds up to 5 cm	\$0.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach <i>(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)</i>	\$850.00
D7952	Sinus augmentation via a vertical approach <i>(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)</i>	\$640.00
D7953	Bone replacement graft for ridge preservation – Per site <i>(Limit 1 per calendar year; only covered in conjunction with the surgical placement of implant)</i>	\$100.00
D7960	Frenulectomy (Also known as Frenectomy or Frenotomy) – Separate Procedure Not Incidental to Another Procedure	\$60.00
<p>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.)</p>		
D8050	Interceptive orthodontic treatment of the primary dentition (Phase 1)	\$300.00
D8060	Interceptive orthodontic treatment (Primary/transitional dentition) (Phase 1)	\$300.00
D8070	Comprehensive orthodontic treatment of the transitional dentition (24 month case)	\$300.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition (24 month case)	\$300.00
D8090	Comprehensive orthodontic treatment of the adult dentition (24 month case)	\$400.00
D8210	Removable appliance therapy	\$560.00
D8220	Fixed appliance therapy	\$560.00
D8660	Pre-orthodontic treatment visit (Orthodontic consultation)	\$120.00
D8670	Periodic orthodontic treatment visit	
	24-month treatment fee	\$1,800.00
	Charge per month for 24 months	\$75.00
D8680	Orthodontic retention – Per arch (Removal of appliances, construction and placement of retainer(s))	\$95.00

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Code	Procedure Description	Copayment
D8999	Unspecified orthodontic procedure, by report <i>(Other than those procedures listed, no other unspecified procedures are covered)</i>	
	Diagnostic workup	\$200.00
	Premium transparent brackets (Per arch)	\$200.00

Adjunctive

D9110	Palliative (Emergency) treatment of dental pain – Minor procedure	\$0.00
D9120	Fixed partial denture sectioning	\$45.00
D9211	Regional block anesthesia	\$0.00
D9212	Trigeminal division block anesthesia	\$0.00
D9215	Local anesthesia	\$0.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$10.00
D9310	Consultation (Diagnostic service provided by dentist or physician other than requesting dentist or physician)	\$0.00
D9430	Office visit – Observation (During office hours)	\$0.00
D9440	Office visit – After regularly scheduled hours	\$35.00
D9450	Case presentation, detailed and extensive treatment planning	\$0.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays <i>(All other methods of bleaching are not covered)</i>	\$165.00

This may contain CDT Codes and/or portions of, or excerpts from the Code on Dental Procedures and Nomenclature (CDT Code) contained within the current version of the “Dental Procedure Codes”, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.”

After your enrollment is effective:

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

Multiple ways to locate a *DHMO Network General Dentist:

- ▶ On-line provider directory at **www.Cigna.com**
- ▶ On-line 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 dental office, dental clinic, or other comparable facility. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group’s plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.



*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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