

# CIGNA Dental Care

See, we weren't kidding  
when we said *savings*:

## What You'll Pay

	With CIGNA Dental Care	Without Dental Coverage
<b>Typical Adult Annual Cost</b>		
Two periodic exams	\$ 0	\$ 66
Four bitewing x-rays	\$ 0	\$ 74
Periodontal scaling and root planing, one to three teeth, per quadrant	\$ 40	\$ 103
Two routine cleanings	\$ 0	\$ 130
One resin/composite 1-surface filling (anterior)	\$ 5	\$ 105
Anterior root canal	\$ 210	\$ 529
Porcelain crown	\$ 415	\$ 886
<b>Subtotal</b>	<b>\$ 670</b>	<b>\$1,893</b>
<b>Typical Child Annual Cost</b>		
Two periodic exams	\$ 0	\$ 66
Two bitewing x-rays	\$ 0	\$ 37
Two routine cleanings	\$ 0	\$ 94
Two fluoride treatments	\$ 0	\$ 48
Single extraction	\$ 5	\$ 106
Orthodontic evaluation, treatment plan, and records	\$ 200	\$ 293
Banding for Comprehensive Orthodontic Treatment*	\$ 400	\$ 1,155
12 months Comprehensive Orthodontic Treatment, child*	\$ 900	\$ 1,217
<b>Subtotal</b>	<b>\$1,505</b>	<b>\$3,016</b>
<b>Grand Total</b>	<b>\$2,175</b>	<b>\$4,909</b>

**Total Savings with CIGNA Dental Care — \$2,734**

\*Orthodontic treatment is limited to a maximum benefit of 24 months. Additional charges apply for retention and/or interceptive orthodontic treatment. Patient charges listed are not applicable to orthodontics in progress.

1.800.367.1037  
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## Exclusions and Limitations

### Limitations on Covered Services

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

- Frequency** – The frequency of certain covered services, such as cleanings, is limited. The Patient Charge Schedule lists any limitations on frequency.
- Specialty Care** – Payment authorization is required for coverage of services by a Network Specialty Dentist.
- Pediatric Dentistry** – Coverage for referral to a Pediatric Dentist ends on your enrolled child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care after your child's 7th birthday.
- Oral Surgery** – The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

### Exclusions

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

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-Network Dentist without CIGNA Dental's prior approval (except emergencies).
- Services related to an injury or illness paid under workers' compensation, occupational disease, or similar laws.
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- Services required while serving in the armed forces of any country or international authority, or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
- 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.)
- Prescription drugs.
- Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) diagnose or treat abnormal conditions of the temporomandibular joint ("TMJ"), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or (3) restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction. (For California, the word "attrition" is modified as follows: "except for medically necessary treatment where functionality of teeth has been impaired.")
- Replacement of fixed and/or removable prosthodontic or orthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Services associated with the placement or prosthodontic restoration of a dental implant.
- Services considered to be unnecessary or experimental in nature. (California and Maryland residents: This exclusion should read "Services considered to be unnecessary." Pennsylvania residents: This exclusion should read "Services considered experimental in nature.")
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- 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.
- Services to the extent you, or your Dependent, are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy. (Arizona and Pennsylvania residents: Services compensated under group medical plan, no-fault auto insurance policies or insured motorist policies are not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or insured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)
- The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your CIGNA Dental coverage. (N/A in TX and CA).
- Crowns and bridges used solely for splinting.
- Resin-bonded retainers and associated pontics.

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

In case of any discrepancy between this brochure and your plan documents, the plan documents prevail.

# CIGNA Dental Care

Health  
coverage  
for your mouth.

Significant savings.  
*No surprises.*

With CIGNA Dental Care, you'll know exactly  
what you pay — even for specialty care with a  
referral approved for payment.

## Porcelain Crown

What you may pay without dental coverage \$886

What you'll pay with CIGNA Dental Care \$415

**Savings \$471**

This *fee overview* shows the highlights of your  
CIGNA Dental Care plan.

See more *savings* inside!



**CIGNA Dental**  
A Business of Caring.

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	What You'll Pay	
	With CIGNA Dental Care	Without Dental Coverage
<b>Diagnostic/Preventive</b>		
Periodic Oral Evaluation	\$ 0	\$ 33
Limited Oral Evaluation – Problem Focused	0	51
Comprehensive Oral Evaluation – New or Established Patient	0	51
Re-evaluation – Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	0	44
X-Rays Intraoral – Complete Series (Including Bitewings)★	0	97
X-Rays Intraoral – Periapical First Film	0	19
X-Rays Intraoral – Periapical Each Additional Film	0	15
X-Rays (Bitewing) – Single Film	0	37
X-Rays (Bitewing) – Two Films	0	37
X-Rays (Bitewing) – Four Films	0	37
X-Rays (Panoramic Film) ★	0	78
Prophylaxis – Adult ★★	0	65
Prophylaxis – Adult (In addition to the 1 Prophylaxis Allowed Every 6 months)	41	65
Prophylaxis – Child ★★	0	47
Prophylaxis – Child (In addition to the 1 Prophylaxis Allowed every 6 months)	30	47
Topical Application of Fluoride – (Prophylaxis Not Included) – Child ◆★★	0	24
Oral Hygiene Instructions	0	37
Sealant (Per Tooth) ❖	15	38
<b>Restorative (Fillings)</b>		
Amalgam – One Surface, Primary or Permanent	\$ 5	\$ 81
Amalgam – Two Surfaces, Primary or Permanent	5	100
Amalgam – Three Surfaces, Primary or Permanent	10	123
Amalgam – Four or More Surfaces, Primary or Permanent	15	148
Resin-Based Composite – One Surface, Anterior	5	105
Resin-Based Composite – Two Surfaces, Anterior	10	129
Resin-Based Composite – Three Surfaces, Anterior	15	158
Resin-Based Composite – Four or More Surfaces or Involving Incisal Angle (Anterior)	75	320
Resin-Based Composite – One Surface, Posterior	35	114
Resin-Based Composite – Two Surfaces, Posterior	45	151
Resin-Based Composite – Three Surfaces, Posterior	65	191
Resin-Based Composite – Four or More Surfaces, Posterior	85	201
<b>Crown &amp; Bridge (Including Temporaries)<sup>1</sup></b>		

All charges for crown and bridge are per unit (each replacement or supporting tooth equals one unit) – replacement limit 1 every 5 years. 6 or more units of crown and/or bridge in the same treatment plan requires a complex rehabilitation fee for each unit.<sup>2</sup>

Crown – Porcelain/Ceramic Substrate	\$ 415	\$ 886
Crown – Porcelain Fused to High Noble Metal	380	818
Crown – Porcelain Fused to Predominantly Base Metal	335	716
Crown – Porcelain Fused to Noble Metal	360	767
Crown – Full Cast High Noble Metal	380	784
Recement Crown	0	68
Sedative Filling	0	69
Core Buildup, Including Any Pins	90	176
Prefabricated Post and Core In Addition to Crown	110	236

	What You'll Pay	
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<b>Endodontics (Root Canal Treatment, Excluding Final Restorations)</b>		
Pulp Cap – Direct (Excluding Final Restoration)	\$ 0	\$ 47
Pulp Cap – Indirect (Excluding Final Restoration)	0	47
Therapeutic Pulpotomy (Excluding Final Restoration)– Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	62	122
Anterior Root Canal (Excluding Final Restoration) ▼	210	529
Bicuspid Root Canal (Excluding Final Restoration) ▼	245	620
Molar Root Canal (Excluding Final Restoration) ▼	335	802
<b>Periodontics (Treatment of Supporting Tissues [Gum &amp; Bone] of the Teeth)</b>		
Comprehensive Periodontal Evaluation – New or Established Patient	\$ 40	\$ 81
Periodontal Scaling and Root Planing, Four or More Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant (Limit 4 Quadrants Per Consecutive 12 Months)	80	172
Periodontal Scaling and Root Planing, One to Three Teeth, Per Quadrant (Limit 4 Quadrants Per Consecutive 12 Months)	40	103
Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis <sup>1</sup> ☉	55	109
Periodontal Maintenance (Limit 2 Within First 12 Months After Active Therapy)	50	105
<b>Prosthetics</b>		
<i>Removable tooth replacement – dentures. Includes up to 4 adjustments within first 6 months after insertion – replacement limit 1 every 5 years.</i>		
Complete Denture – Maxillary	\$ 420	\$ 925
Complete Denture – Mandibular	420	925
Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	485	1,092
Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	485	1,092
<b>Repairs To Prosthetics</b>		
Add Tooth to Existing Partial Denture	\$ 50	\$ 119

This Sample is an overview of your costs at your CIGNA Dental Care network office. The complete Patient Charge Schedule will be sent to you after you enroll. Estimated costs without dental coverage are based on Connecticut General Life Insurance Company national claims analysis, prepared September 2003. Actual charges without dental coverage may differ from your area charges or local dentist's fees. Call Member Services for information on procedures not listed.

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 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.

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<b>Oral Surgery (Includes Routine Post-Operative Treatment)</b>		
<i>Surgical removal of impacted tooth – (not covered unless pathology [disease] exists). Surgical removal of wisdom tooth/3rd molar for orthodontic reasons <u>only</u> is not covered.</i>		
Extraction, Erupted Tooth or Exposed Root	\$ 5	\$ 106
Removal of Impacted Tooth – Partially Bony	95	292
<b>Orthodontics (Tooth Movement)</b>		
<i>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.</i>		
Full Orthodontic Case, 24 Months including Initial Evaluation, Treatment Plan and Records, Banding, 24 Months of Treatment, and Retention		
Children (Up to 19th Birthday) 24 Month Treatment Fee	\$ 2,700	\$ 4,584
Adults 24 Month Treatment Fee	\$ 3,300	\$ 4,827
<b>General Anesthesia/IV Sedation<sup>1</sup></b>		
<i>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.</i>		
Deep Sedation/General Anesthesia – First 30 Minutes ▲	\$ 130	\$ 268
Deep Sedation/General Anesthesia – Each Additional 15 Minutes ▲	65	97
Intravenous Conscious Sedation/Analgesia – First 30 Minutes ▲	130	268
Intravenous Conscious Sedation/Analgesia – Each Additional 15 Minutes ▲	65	97
<b>Emergency Services</b>		
Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	\$ 0	\$ 75
Office Visit – After Regularly Scheduled Hours	54	96

<sup>1</sup>Limitations may be different for California residents. Refer to your plan booklet for complete details.

<sup>2</sup>Complex rehabilitation procedures and limitations are more favorable for California residents. Refer to your plan booklet for complete details.

Exclusions and limitations may apply. Consult your group agreement for details. This Fee Overview reflects the patient charges on your Patient Charge Schedule. In case of any discrepancy between this Dental Fee Overview and your Patient Charge Schedule sent to you after your enrollment, the Patient Charge Schedule will prevail.

★ Limit 1 every 3 years. ◆ Up to 19th birthday. ☉ 1 per lifetime. ▼ Permanent tooth.  
★★ Limit 1 every 6 months. ❖ Up to 14th birthday. ▲ Limited to a maximum of 1 hour.