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Welcome to the Cigna Dental Care Network

We value your participation as a Cigna Dental Care® Network Dentist, and strive to partner with you to support your success. Our philosophy stresses the importance of preventive dentistry and early intervention in the disease process. We believe this approach benefits both the patient and the dentist. We know that a successful managed dental care program is built on long-term relationships, mutual rewards and common goals: A commitment to the practice of good dentistry, respect for your freedom to exercise sound professional judgment and quality patient care provided in a supportive atmosphere.

As a participating Cigna Dental Care Network Dentist, you have access to many resources, including a full-time Dental Network Management Team, the Cigna for Health Care Professionals website (CignaforHCP.com) and experienced customer service representatives. You can also take advantage of tools such as electronic claims submission and electronic funds transfer (direct deposit) to get paid faster than traditional methods.

In this guide you will find all of the information you need to make the most of your association with Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries (collectively “Cigna”). It will help you to understand Cigna’s expectations of you as a participating Network Dentist (e.g., patient record-keeping, how to submit patient encounters and the elements of quality management). You will also learn what you can expect from us (e.g., monthly reporting, compensation and administrative support).

This guide incorporates both the Cigna policies and the Cigna Dental Health Procedure Manual referenced in your Network General Dentist Agreement. Please review this Agreement for further information. Note that certain policies may vary depending on state regulations.

The dental marketplace is continuously changing. We welcome your feedback about these changes and our plan policies. Contact Cigna Dental Network Management to share your thoughts on technology, utilization review, quality management criteria or other matters of interest. Call our Cigna Dental Provider Service Unit at 800.Cigna24 (800.244.6224).
Application process

Cigna requires you (the specialist) to submit proper documentation for each location where you practice, even if you are already contracted at another location. This requirement is for payment purposes, as Cigna cannot pay for performed covered services without the proper documentation at each location. More detail of this process is described below.

Adding a specialist(s) or location(s)

1. Call Cigna at **800.Cigna24 (800.244.6224)** to request the necessary forms from Customer Service. For example, new applicants will need a Specialist Application and Network Specialist Agreement (contract). Existing specialists who are adding locations will need an Additional Location Form.

   **Note:** In general, one application and one contract must be completed by each specialist. If there are additional locations, you will need to attach a list to the back of the contract. We will verify all specialists’ credentials before allowing them to participate in the Network. If additional locations are added at a later date, you will need to complete and submit the Additional Location Form.

2. Upon receipt of the forms from Cigna, the specialist should complete and sign the application and the Network Specialist Agreement (contract). **Note:** To avoid delays in the processing of the application, please do not leave any questions or sections blank.

3. You may be asked to return a copy of any of the following with the above forms.
   - Certificate/permit/letter of specialty training, where applicable

4. Upon receipt of documentation from the specialist, Cigna will request written information from the:
   - Respective State Board of Dental Examiners
   - National Practitioner Data Bank

   **Note:** The completion of this process is contingent upon receipt of all the above-listed documents, completed forms and any other requested responses for clarification.

Terminating your participation

1. Contact the Cigna Dental Provider Service Unit by calling **800.Cigna24 (800.244.6224)**.

2. Termination requests must be submitted in writing on your company letterhead or on a Cigna Request to Terminate Participation form. Please include the provider’s name, Tax ID number, office address, and the reason for terminating your Network participation. The request must be signed by the contracted dentist.

3. Upon receipt of your request, Cigna will process your termination effective on the last day of the month of the termination period set forth in your Network Agreement with the appropriate notification required under the terms and conditions of your Agreement.

**Member Notices due to Provider Termination**

Cigna Dental will notify all plan members of any network provider terminations.

- When a network provider is no longer participating in a Cigna Dental network, Cigna will review the provider’s network affiliations and generate member letters accordingly.

- The member notice timeframes will vary based on state requirements (e.g., some states require a 30-day member notification prior to the provider termination date).

- If a provider network termination is rescinded, Cigna will send out a retraction letter to the members.
Cigna Dental Health Provider Solutions

Cigna offers multiple solutions to help you efficiently handle the administrative details of health care.

**Online credentialing tool**

Cigna’s online credentialing intake tool automates the credentialing process. It allows you to complete, sign and submit all required documents electronically. This includes uploading required credentials to participate in the Cigna Network. This tool drives efficiencies for your practice by eliminating the manual paper process so that you can get up and running quicker.

Email DentistEnrollment@Cigna.com for more information, or call the Cigna Dental Provider Service Unit at 800.Cigna24 (800.244.6224).

**Services to promote your practice**

Network dentists get access to free services developed by Brighter, Inc. – now part of the Cigna family – to help you attract and retain patients.

**Brighter Profile™**

Your free Brighter Profile highlights your practice’s strengths and makes it easier for you to connect with Cigna Dental customers.

**Brighter Score™**

The Brighter Score is a component of the Brighter Profile. It is designed to meet the needs of patients who want more information – while also providing you with the opportunity to maximize your Brighter Score by ensuring it is based on an accurate, comprehensive, and continuously growing set of information.

**Brighter Schedule™**

Brighter Schedule provides convenient appointment scheduling and automated appointment reminders to patients that are Cigna Dental customers, and helps improve administrative efficiency for your office.

Activate your free Brighter Profile today at providers.brighter.com.

**Cigna for Health Care Professionals website (CignaforHCP.com)**

CignaforHCP.com allows you to make the most of your time with the latest tools to handle the administrative tasks of dental health care. It offers secure, easy and convenient access to:

› Check your patients’ eligibility and benefit information
› View claim detail and payment information
› Enroll in electronic funds transfer
› Download and print:
  ─ Dental office reports, including direct deposit advices (available the same day as the electronic payment)
  ─ Dental office reference guides and commonly used forms
› View the Cigna Network Rewards Program® vendors and discounts

You can also learn more about using an electronic data interchange (EDI) vendor to eliminate paper claims and submit your claims electronically.

**How to register**

There are two ways you can register for CignaforHCP.com.

1. **Register directly for the website.**

   If your office does not have an Access Manager for the website, you should go to CignaforHCP.com > Register Now and complete the registration form.*

2. **Gain access from your website Access Manager.**

   If someone in your dental office is already registered for CignaforHCP.com, and has been designated as the office’s Access Manager, he or she may be able to grant you immediate, full and secure access. The website Access Manager can assign access by logging in to CignaforHCP.com > Working with Cigna > Modify Existing Users/Add New Users.

   Once the required information has been completed, your website Access Manager will receive a temporary ID and password, which can then be given to you.

* Brighter Profile features may vary by Cigna Dental product or customer plan.
** Important note: To have the immediate ability to view patients’ eligibility and benefits information, you must enter the dentist’s tax identification number and date of birth in the optional fields. Otherwise, you will have limited use of the website until you receive an outreach call from Cigna to verify your information and provide you with full access.
Endodontist  |  Dental Office Reference Guide

Using Payer ID 62308, you can electronically submit all claims and encounters at the same time – indemnity, PPO and Cigna Dental Care. This includes general dentistry and specialty encounters. Both primary and secondary COB claims should be submitted to Cigna electronically.

Submit X-rays electronically
You can submit X-rays and other attachments electronically through any of the following options.

› Standard EDI 275 attachment transactions through your clearinghouse
› DentalXChange Attachment Service available free of charge for DentalXChange Claim Connect™ subscribers
› NEA FastAttach® – Secure information exchange that is cost-effective and reliable. To learn more, visit National Electronic Attachment (NEA) FastAttach at nea-fast.com or call 800.782.5150. Discounts are available for Cigna Dental network dentists through the Cigna Network Rewards Program® (refer to page 9 of this reference guide for more details).

Visit CignaforHCP.com > Resources > Payment Guidelines > Electronic Claim Submission to learn more.

How to assign specific levels of access to staff
Your office can restrict or expand access to CignaforHCP.com for individual staff members as needed. For example, certain employees may need full access to the website’s functionality while others may need more limited access, such as to patient eligibility and benefit details only. The website Access Manager in your office can assign each user a specific level of access by logging in to CignaforHCP.com > Working with Cigna > Modify Existing Users/Add New Users.

Electronic claims submission
Submitting dental claims electronically can help you save time, money and improve claim processing accuracy. Using one of Cigna’s EDI options allows you to send, view and track claims – no faxing, printing or mailing. Everything is right on your desktop.

Benefits of submitting claims to Cigna electronically
› Quicker claims submission, including Cigna Dental Care® encounters
› Receive payments faster
› Improve claims accuracy – reduces errors and missing data
› Track claims received electronically, which are automatically archived before processing
› Save time on resubmissions – incomplete or invalid claims can be reviewed and corrected online
› View, track and monitor claim status reports
› Send primary and secondary coordination of benefits (COB) claims quickly, reduce paperwork, and eliminate printing and mailing expenses

How to submit claims electronically
EDI vendors – To connect electronically with an EDI vendor you only need a computer and a printer. Costs vary by practice management system vendor or clearinghouse. Some practice management software companies may offer free claim submissions for the first three to six months. Cigna is directly connected to three vendors who provide web claim data entry for dental offices that have internet access but no office management system. Visit Cigna.com/EDIvendors to learn more.

Using Payer ID 62308, you can electronically submit all claims and encounters at the same time – indemnity, PPO and Cigna Dental Care. This includes general dentistry and specialty encounters. Both primary and secondary COB claims should be submitted to Cigna electronically.

Submit X-rays electronically
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Visit CignaforHCP.com > Resources > Payment Guidelines > Electronic Claim Submission to learn more.

Save time – submit your claims electronically
To learn more about electronic claims submission with Cigna, log in to the Cigna for Health Care Professionals website at CignaforHCP.com > Resources > eCourses, or call 800.Cigna24 (800.244.6224).

Not registered to use the website? Go to CignaforHCP.com and click “Register Now.”

Note: For claims with no service dates, the 276/277 transaction will default to the process date.

For questions about claims submitted through your clearinghouse, contact the clearinghouse directly. For questions about Cigna claim processing, call Customer Service at 800.Cigna24 (800.244.6224).

Claim inquiry and follow-up
You can inquire about the status of your claims through several methods: EDI transaction 276/277, the Cigna for Health Care Professionals website at CignaforHCP.com, our interactive voice response system or by speaking with a customer service representative.
NPI needed for EDI transactions

When you submit claims or encounters electronically, or transmit other electronic transactions, you must include your NPI. Inclusion of the NPI has been a Health Insurance Portability and Accountability Act (HIPAA) requirement since May 2008. Also, the TIN (Employee Identification Number or Social Security number) of the billing provider must be submitted on electronic claims.

Beginning in May 2005, the National Plan and Provider Enumeration System (NPPES), an entity established by the federal government, began issuing NPIs to health care providers who apply and qualify for them. For general information about the NPI and the NPI application process, visit www.cms.hhs.gov/apps/npi/npiviewlet.asp at the Centers for Medicare & Medicaid Services web page. To apply online for an NPI, visit www.nppes.cms.hhs.gov/NPPES/Welcome.do.

ADA codes and electronic transactions

Federal HIPAA regulations require use of only the latest Code on Dental Procedures and Nomenclature (CDT) codes for electronic claims transactions. Since the American Dental Association (ADA) has announced that it plans to revise the CDT code every year, it is important to understand that administration may change slightly from time to time. However, procedure codes and descriptions that are comparable to those on your fee schedule will be considered covered services in accordance with each member’s dental plan. We expect you to use the current CDT codes for claims transactions.

Electronic funds transfer and electronic remittance advice

Improve your office workflow and productivity, and shorten the payment cycle by enrolling in electronic funds transfer (EFT). When used together, EFT and electronic remittance advice (ERA) can help eliminate claims payment paperwork and improve your cash flow – no more waiting for paper checks to clear.

What is EFT?

› Electronic funds transfer (EFT) is Cigna’s standard payment method for provider reimbursement.

EFT is a secure, direct deposit into your bank account. It is a proven method for securely receiving your payments. To take advantage of the benefits of EFT, you must enroll.

› A calendar of payment dates can be accessed by visiting CignaforHCP.com > Resources > Payment Guidelines > Direct Deposit Payment Schedule.

Benefits of enrolling in EFT

› Eliminate paper check mail delivery and handling
› Access funds on the same day of the deposit
› View a separate remittance report online for each deposit, which shows the:
  — Deposit transaction
  — Details about the claims processed
  — Payments included in that fund transfer
› Easily reconcile payments using a single remittance tracking number:
  — Ask your bank to provide the payment-related information from field 3 of record 7 on the EFT report they send to you
  — “Reference Identification Field” (or TRN02) on your ERA
  — Number located on the right side of the first page of your online claim payment report

Payment bulking options

Choose between two options to receive your payments:

› By dental office – All of your claims will be grouped into a single payment based on your dental office
› By National Provider Identifier (NPI) – All of your claims will be grouped into a single payment for each “Billing Provider” NPI from the submitted claim, for each dental office
  — The ERA or payment report will be bulked by a Taxpayer Identification Number (TIN) or NPI, depending on your payment bulking preference with your EDI vendor
  — You can elect a separate bank account for each “Billing Provider” NPI
If you use more than one TIN, complete a separate enrollment for each TIN.

Your EDI vendor will send the completed enrollment information to Cigna for processing.

Cigna will finalize your registration within 10 business days of receiving it.

You may begin receiving ERAs on your next payment cycle.

Tips for enrolling in ERA and EFT

› Make sure that your payment bulking preferences are the same for ERA and EFT.

› If you are enrolled in ERA and elect EFT bulking by National Provider Identifier (NPI), you should contact your EDI vendor to have your ERA enrollment updated to bulking by NPI.

› To learn more, log in to CignaforHCP.com > Resources > eCourses, or call 800.Cigna24 (800.244.6224)

Zelis Payments

Cigna has partnered with Zelis Payments®, an electronic payments solutions company, through which you can improve your automated claim payment experience and ease of doing business with Cigna. This service supports both Cigna DPPO and Cigna Dental Care® provider payments. There are fees associated with this service.

For details on how to enroll, associated fees, or more information on the program, please call Zelis Payments directly, Monday through Friday, between 9:00 a.m. and 7:00 p.m. ET, at 1.877.828.8770 or send an email to www.zelispayments.com.

Online reports

You will access all of your dental reports at CignaforHCP.com. Either click on Payments (Claim Payment Reports) or Reports (Office Management and Financial Reports). Claim payment reports, office management reports and financial reports are all available whether enrolled in EFT or not.

To have your payments bulked or grouped based on your billing NPI and dental office from the submitted claim, visit CignaforHCP.com > Working With Cigna > Manage EFT Settings, and update your payment bulking preferences.
Cigna Dental Health Provider Solutions (continued)

Cultural competency training and resources
Cultural competency training and resources are available to dental health care providers at no additional cost on Cigna.com. Resources include articles, training, videos, a health equity brochure and a powerful public service announcement on the importance of language interpreters in health care. Visit Cigna.com > Health Care Professionals > Resources for Health Care Professionals > Health & Wellness Programs > Cultural Competency Training and Resources.

Interactive voice response (IVR) – Speech recognition technology
Cigna’s enhanced speech recognition technology gives you and your staff instant access to information for customers with Cigna Dental Care, PPO and indemnity plans – all by using a touch-tone phone. With IVR, you are able to request and acquire eligibility information on multiple customers during the same call, and have that information provided to you over the phone or via fax.

IVR features
Important: Before you call, please be prepared to enter the patient’s Cigna ID, the patient’s date of birth and the dentist’s TIN.

- Call Customer Service at 800.Cigna24 (800.244.6224).
- Identify yourself as a “health care professional.”
- Enter your tax ID number and then you will be asked if you are calling about claims, eligibility, covered services, approvals, network participation, credentialing or contracting, or if you received a letter in the mail.
- State what you are calling about, then follow the voice prompts.
Cigna Network Rewards Program

The Cigna Network Rewards Program – The program that gives you earning power

Your participation in our Dental Network means more than just treating patients – it gives you the opportunity to take advantage of lower costs on key products and services. Membership in the Cigna Network Rewards Program is automatic and free to dentists who participate in the Cigna networks.

This program includes a wide array of vendors that offer discounts to you – just for being a Cigna Network Dentist. Discounts are available on products and services in the following categories: Office and dental supplies/equipment, practice management tools, dental labs, education, website development and services, consulting and legal services, and health and wellness.

To view the entire list of Cigna Network Rewards Program vendors, along with the discounted products and services available to you, log in to the Cigna for Health Care Professionals website at CignaforHCP.com > Resources > Dental Resources > Cigna Dental Network Rewards Program.

THE POWER TO SUCCEED

› New patients
› Expanding markets
› Competitive compensation
› A responsive, professional business ally
› Affiliation with an industry leader
› Tools to help your practice thrive

Did you know that millions of Americans have private dental insurance and that the number is expected to continue to climb? That’s a significant market. With our experience, reputation and national presence, we expect to continue to claim a substantial share of that market. At Cigna, we want to share that success with you.
Administrative policies and procedures
Cigna Dental Medicare Advantage HMO Plan

Payments made under the Cigna DHMO Medicare Advantage plans follow the same compensation arrangements as standard Cigna Dental Care® plans. All referrals for services that cannot be provided in the general dentist setting should only be made to Cigna Dental Care® specialty dentists who also participate in the DHMO Medicare Advantage Plan. The referrals should be provided on a valid Cigna Referral Form. Specialty referrals not in accordance with Cigna guidelines may result in a back charge. Services rendered by Medicare Opt-out providers will not be covered.

Members covered by the MK2V9 patient charge schedule (PCS) are offered only preventative care at their assigned network general dentist and have no comprehensive or specialty coverage. Members covered by PCS MK1V9 and MW1V9 have standard comprehensive plans that include coverage when services are rendered by a contracted specialist.

Questions? Please contact Cigna Medicare Customer Service at 1.800.367.1037.
Cigna Medicare Advantage Dental Allowance Plans

Cigna Medicare Advantage Dental Allowance plans offer a set of dental allowances to patients each calendar year that they can use for dental preventive and comprehensive services, such as fillings and repair of cavities, root canals, crowns, extractions, cleanings, x-rays and other procedures as needed. The allowance is only available for non-Medicare covered preventive dental services and non-Medicare covered comprehensive dental services. The allowance plans do not cover cosmetic procedures.

› Depending on the specific Cigna Medicare Advantage plan, patients are offered a dental allowance ranging from $500 to $3,000 annually.

› Patient is eligible for services up to the annual allowance amount. Once the allowance is exhausted, the patient is responsible for 100% of the provider’s charges.

› The allowance plan is designed for providers to bill Cigna Dental directly and do not require payment up front from the patient.

› Dental allowance plans do not require any pre-authorization or pre-estimates.

› The dental provider will bill Cigna Dental for the cost of dental services and this amount will be applied to the patient’s yearly dental allowance.

› Claims with your billed charges can be submitted electronically using Cigna’s electronic payor ID 62308 or by paper claim to the following address: Cigna, PO Box 188037, Chattanooga, TN 37422-8037

› Claims are paid per billed charges until the total maximum allowance is reached (no discounts or fee schedules will be applied to claims).

Questions? Please contact Cigna Medicare Customer Service at 1.866.213.7295.
Administrative policies and procedures (continued)

Compensation and billing

Claim submission requirements
At Cigna, our goal is to process all claims at initial submission. Before we can process a claim, it must be a “clean” or complete claim submission, which is one that has all procedures properly coded, accurate member demographic and plan information, and any necessary documentation attached for review. This document package offers the best chance for a speedy and efficient processing of the claim. If a provider does not release the necessary information to review a claim or pre-determination, the procedure may be closed or denied.

Cigna Dental reserves the right to modify benefit plans, at any time, to add or eliminate covered services. Not all services listed on the specialty compensation fee schedule may be covered by all plans. For other covered services not listed on the specialty compensation fee schedule, the maximum compensation amount will be determined by Cigna on a case-by-case basis upon submission of treatment plans and x-ray as appropriate. Covered Services not listed on the specialty compensation fee schedule will be compensated at the customary fee charged by most dentists in the geographic area where the service is rendered. In instances where there aren't other dentists in the geographic area, a reasonable discounted fee will be determined. If the code is listed on the patient charge schedule, but not the dentist specialty compensation fee schedule, Cigna Dental will never pay the dentist’s full fee, a discount will always be applied.

Cigna reserves the right to re-code claims as necessary for proper adjudication. Some dental procedures are considered part of other procedures and will not be compensated separately.

Charges other than those allowed for professional services rendered by the Network Dentist are not permitted. Prohibited charges include, but are not limited to, office overhead expenses, infection control costs, charges for completion of claim forms and charges for submission of information to the Dental Plan.

ADA codes and electronic transactions
Federal HIPAA regulations require use of only the latest CDT codes for electronic claims transactions. Since the ADA has announced that it plans to revise the CDT code every year, it is important to understand that administration may change slightly from time to time. However, procedure codes and descriptions that are comparable to those on your fee schedule will be considered covered services in accordance with each member’s dental plan. We expect you to use the current CDT codes for claims transactions.

Electronic claims (837)
- Required data elements such as the “Billing Provider” TIN, “Rendering Provider” name and “Billing Provider” address must always be included on professional, institutional and dental claims. Inclusion of this information does not change because of NPI implementation.
- As with any change to your billing process, if you plan to change the way you submit claims to Cigna, please contact Customer Service at 800.Cigna24 (800.244.6224) to update your information. One example would be an organization that has enumerated multiple NPI subparts and will start to bill using the “lowest enumerated” subpart health care provider.
- When using the NPI to identify the “Billing Provider,” the TIN must be submitted as a secondary provider identifier. This TIN is the number used on the IRS Form 1099, which is either the employer identification number (EIN) for organizations or the SSN for individuals. Both numbers should not be included concurrently. Other identifiers, such as the Medicare provider number, are considered “legacy” identifiers and should not be included.
- Submission of the “Billing Provider” TIN on the electronic claim is a HIPAA requirement. The National EDI Transaction Set Implementation Guide specifically states the following.
  - If ‘code XX - NPI’ is used, then either the employer identification number or the Social Security number of the provider must be carried in the REF in this loop. The number sent is the one which is used on the 1099.
- Under HIPAA 5010 standards, “Pay to Provider” information is limited to an alternate address only. No additional identifiers, neither TIN nor NPI, are permitted. The “Pay to Provider” address
is only needed if it is different from that of the “Billing Provider.”

› Cigna will reject electronic claims received without an NPI unless the submitter is ineligible to receive an NPI. If you are not eligible to receive an NPI, notify Cigna by updating your demographics.

Electronic remittance advice (835)

› In most instances, the “Billing Provider” (claim payee) NPI will be included on the 835. If more than one claim is included in a single 835, the NPI will be included in the 835 only if all NPIs from the submitted claims are equal. The NPI for the “Rendering Provider” will be included in the 835 if the “Rendering Provider” NPI was submitted on the claim.

National Provider Identifier

The National Provider Identifier (NPI) is a unique identification number for use in standard health care transactions. It is a number issued to health care providers and covered entities that transmit standard HIPAA electronic transactions (e.g., electronic claims and claim status inquiries). As of May 2005, the Centers for Medicare and Medicaid Services (CMS) began issuing NPIs to health care providers who apply and qualify.

The NPI fulfills a requirement of HIPAA, and was required to be used by health plans and health care EDI vendors in HIPAA standard electronic transactions by May 23, 2007. In addition, the NPI:

› Replaces other identifiers previously used by health care providers and assigned by payers (e.g., UPIN, Medicare/Medicaid numbers).
› Establishes a national standard and unique identifier for all health care providers.
› Helps simplify health care system administration and encourages the electronic transmission of health care information.

Cigna is capable of accepting the NPI on standard HIPAA transactions as outlined below. This approach should not be confused with any guidance specific to Medicare claims requirements.

Real-time request transactions (270, 276, 278)

› All real-time request transactions will be accepted with NPIs; Cigna will return the NPI when it was submitted on the inquiry. Contact your EDI vendor for details regarding the submission of NPIs on these transactions.

› When an NPI is received on a 276 claim status inquiry, the claims that submitted the same NPI will be returned on the 277 claim status response.

› When an NPI is received on a 270 eligibility and benefit inquiry, Cigna will return your network participation status for the patient in the 271 eligibility and benefit response.

Additional information is available on CignaforHCP.com > Resources > Dental Resources > Doing Business with Cigna > National Provider Identifier (NPI).

Use of Social Security numbers

In response to the current legislative and cultural environment surrounding the use of Social Security numbers (SSN) for all nonessential purposes, Cigna removed SSNs from Cigna ID cards and correspondence. SSNs were replaced with an alphanumeric Alternate Member Identifier (AMI). To ensure that both service and access to care are unaffected by these changes, you may simply need to ask for the employee’s SSN or AMI when needed. The collection of SSNs is still permitted for purposes of benefit plan administration, and the continued use of SSNs extends to dental health providers. However, we will submit the member’s AMI to you on reports, Explanation of Benefits, letters and other documents. You are also allowed, under the laws, to continue to submit SSNs or AMIs for the purposes of verifying eligibility and coverage, authorization and claims submission. Please contact Customer Service at 800.Cigna24 (800.244.6224), Monday through Friday between 8:00 am and 5:00 pm if you have any questions about this change. For questions about member eligibility, please call Customer Service at 800.Cigna24 (800.244.6224).
Administrative policies and procedures (continued)

Policy

Cigna coordinates benefits for specialty referral procedures.* If the member has Dental Indemnity/PPO dental coverage through other sources for services received at the Network Dentist’s office, such coverage must be first applied to lower or eliminate the member’s Patient Charge. Network Dentist agreements provide that fully covered services under the Cigna plan shall not, under any circumstances, be paid from fees collected from members or other coverage. Members may not be covered twice under the Cigna Dental Care Plan.

Administrative guidelines

Applicability

This coordination of benefits (COB) provision applies when a member has health care coverage under more than one plan. ("Plan" is defined below.) If a member is covered by this contract and another plan, the Order of Benefit Determination Rules described on the next page determine whether this contract or the other plan is primary. The benefits of this contract:

1. Shall not be reduced when, under the Order of Benefit Determination Rules, this contract is primary.
2. May be reduced for the reasonable cash value of any service provided under this contract that may be recovered from another plan when, under the Order of Benefit Determination Rules, the other plan is primary. (The above reduction is described in the subsection following, entitled “Effect on the benefits of this plan.”)

Definitions

“PLAN” means this contract or any of the following, which provides benefits or services for, or because of, dental care or treatment.

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment or group practice coverage.
2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX of the U.S. Social Security Act, as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private insurance program or other nongovernmental program.
3. Dental benefits coverage of all group and group-type contracts.

“PLAN” does not include coverage under individual policies or contracts. Each contract or other arrangement for coverage under subparagraphs 1, 2 or 3 above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

“PRIMARY” means that a plan’s benefits are to be provided or paid without considering any other plan’s benefits. (The Order of Benefit Determination Rules following determine whether a plan is primary or secondary to another plan.)

“SECONDARY” means that a plan’s benefits may be reduced and it may recover the reasonable cash value of the services it provided from the primary plan. (The Order of Benefit Determination Rules following determine whether a plan is primary or secondary to another plan.)

“ALLOWABLE EXPENSE” means a necessary, reasonable and customary item of expense for dental care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

1. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered is an allowable expense and a benefit paid.
2. When benefits are reduced under a primary plan because a member does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense.

“CLAIM DETERMINATION PERIOD” means a calendar year. However, it does not include any part of a year during which a member has no coverage under this plan, or any part of a year before the date this COB provision or a similar provision takes effect.

*In Arizona, Cigna is considered primary for service rendered by the NGD.
Definitions (continued)

“REASONABLE CASH VALUE” means an amount that a duly licensed provider of dental care services usually charges patients, and that is within the range of fees usually charged for the same service by other dental care providers located within the immediate geographic area where the dental care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

When a member receives services through this plan or is otherwise entitled to claim benefits under this plan, and the services or benefits are a basis for a claim under another plan, this plan shall be secondary and the other plan shall be primary, unless:

› The other plan has rules coordinating its benefits with those of this plan.

› Both the other plan’s rules and this plan’s rules, as stated below, require that this plan’s benefits be determined before those of the other plan.

This plan determines its Order of Benefits using the first of the following rules that applies.

1. The plan under which the member is an employee shall be primary.

2. If the member is not an employee under a plan, then the plan that covers the member’s parent (as an employee) whose birthday occurs earlier in a calendar year shall be primary.

Note: The word “birthday” as used in this subparagraph refers only to month and day in a calendar year, not to the year in which the person was born. For example, if a member’s mother has a birthday on January 1 and the member’s father has a birthday on January 2, the plan which covers the member’s mother would be primary.

3. If two or more plans cover a member as a dependent child of divorced or separated parents, benefits for the member shall be determined in the following order.

› First, the plan of the parent with custody of the child.

› Then, the plan of the spouse of the parent with custody of the child.

› Finally, the plan of the parent not having custody of the child.

4. Notwithstanding subparagraph 3 above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan shall be primary. This subparagraph 4 does not apply with respect to any claim determination period or plan year in which benefits are paid or provided before the entity has that actual knowledge.

5. The benefits of a plan that covers a member as an employee (or as that employee’s dependent) shall be determined before those of a plan that covers that member as a laid-off or retired employee (or as that employee’s dependent). If the other plan does not have this provision and if, as a result, the plans do not agree on the Order of Benefit Determination Rules, this paragraph shall not apply.

6. If a member whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the benefits of the plan covering the member as an employee (or as that employee’s dependent) shall be determined before those of a plan under continuation coverage. If the other plan does not have this provision and if, as a result, the plans do not agree on the Order of Benefit Determination Rules, this paragraph shall not apply.

7. If one of the plans that covers a member is issued out of the state whose laws govern this contract and determines the order of benefits based upon the gender of a parent, and, as a result, the plans do not agree on the Order of Benefit Determination Rules, the plan with the gender rules shall determine the order of benefits.

8. If none of the above rules determines the order of benefits, the plan which has covered the member for the longer period of time shall be primary.
Effect on the benefits of this plan

This subsection applies when, in accordance with the Order of Benefit Determination Rules, this plan is secondary to one or more other plans. In that event, the benefits of this plan may be reduced under this subsection. Such other plan or plans are referred to as “the other plans” in the subparagraphs below. This plan may reduce benefits payable or may recover the reasonable cash value of services provided when the sum of:

› The benefits that would be payable for the allowable expenses under this plan, in the absence of this COB provision.

› The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced, or the reasonable cash value of any services provided by this plan may be recovered from the other plan, so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

Recovery of excess benefits

In the event a service or benefit is provided by Cigna that is not required by this contract, or if it has provided a service or benefit that should have been paid by the primary plan, that service or benefit shall be considered excess benefit. Cigna shall have the right to recover the excess benefit. If the excess benefit is a service, recovery shall be based upon the reasonable cash value for that service.

If the excess benefit is a payment, recovery shall be based upon the actual payment made. Recovery may be sought from among one or more of the following, as Cigna shall determine: Any person to, or for, or with respect to whom, such services were provided or such payments were made; any insurance company, health care plan or other organization. This right of recovery shall be Cigna’s alone and at its sole discretion.

If determined necessary by Cigna, the member (or his or her legal representative if a minor or legally incompetent), upon request, shall execute and deliver to Cigna such instruments and papers required and do whatever else is necessary to secure Cigna’s rights hereunder.

Medicare benefits

Except as otherwise provided by applicable federal law, the services and benefits under this plan for members age 65 and older, or for members otherwise eligible for Medicare payments, shall not duplicate any services or benefits to which such members are eligible under Parts A or B of the Medicare Act. Where Medicare is the responsible payer, all amounts payable pursuant to the Medicare program for services and benefits provided hereunder to members are payable to and shall be retained by Cigna. Members enrolled in Medicare shall cooperate with and assist Cigna in its efforts to obtain reimbursement from Medicare or the member in such instances.

Right to receive and release information

Cigna may, without consent of or notice to any member, release to or obtain from any person, organization or governmental entity any information with respect to the administering of this section. A member shall provide to Cigna any information it requests to implement this provision.
Administrative policies and procedures (continued)

Coverage for accidental injuries

Policy
As a general rule, Cigna does not exclude covered services related to accidental injuries. However, coverage may be excluded for otherwise covered services to the extent that such services are compensated under a group medical plan, no-fault auto insurance policy or insured motorist policy. (See state-specific exceptions to the right.)

Administrative guidelines
Cigna uses the following guidelines to determine benefit coverage in the event of an accident.

› Coverage by medical/automobile plan: When a member is covered by a medical/automobile plan, the member files for benefits with that plan before consideration by Cigna.

› Partial coverage by medical/automobile plan: When (1) The member is covered by a medical/automobile plan; (2) The member receives care by the assigned NGD or by an authorized specialist; and (3) The member is partially reimbursed through the medical/automobile plan, the NGD office/Network Specialist office should first apply any reimbursement from medical/automobile plans to reduce or eliminate the patient charge. Any reimbursement over and above the patient charge will be used to reduce Cigna’s payment responsibility, if any. Under the terms of Cigna’s Network Agreements with dentists, the NGD or Network Specialist may NEVER hold the member financially responsible for more than the charge listed in the Patient Charge Schedule amount for the applicable procedure even when there is other “primary” coverage.

› Medical/automobile plan coverage denial or absence: When a medical/automobile plan denies dental coverage, or when a member is not covered by a medical/automobile plan, the member is covered by Cigna according to the member’s Patient Charge Schedule.

State-specific exceptions
Arizona and Pennsylvania: Services compensated by other insurance are not excluded.

California, Kentucky and North Carolina: Services compensated under no-fault or insured motorist policies are not excluded.

Maryland: Services compensated under group medical plans are not excluded.

New Jersey: Members may choose to designate their dental coverage as their primary insurance instead of their no-fault or insured motorist policies.
Cigna is committed to promoting professional services consistent with accepted dental professional standards of care.

**Initial credentialing requirements**

Dentists must meet the credentialing requirements in the chart below, which are modeled after recognized national standards, to participate in the Cigna Dental Care and Cigna PPO networks.

<table>
<thead>
<tr>
<th>CREDENTIALING REQUIREMENTS</th>
<th>PRIMARY/SECONDARY SOURCE VERIFICATION</th>
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</thead>
<tbody>
<tr>
<td>State license</td>
<td>State dental licensing board</td>
</tr>
<tr>
<td>DEA* certificate (if applicable)</td>
<td>National Technology Information Services website, state dental licensing board or applicable state agency copy of certificate</td>
</tr>
<tr>
<td>Graduation from accredited dental school</td>
<td>State dental licensing board copy of certificate, or applicable dental school verification</td>
</tr>
<tr>
<td>Specialty training verification (if applicable)</td>
<td>State dental licensing board or program accredited by the ADA</td>
</tr>
<tr>
<td>Malpractice history</td>
<td>Dentist Attestation, state dental licensing board and/or National Practitioner Data Bank</td>
</tr>
<tr>
<td>Controlled substance certificate (if applicable)</td>
<td>State dental licensing board or applicable state agency, or copy of certificate</td>
</tr>
<tr>
<td>Application and contract</td>
<td>Both must be signed and dated by the dentist</td>
</tr>
</tbody>
</table>

*Drug Enforcement Administration.

**CAQH ProView** is a registered trademark of Council for Affordable Quality Healthcare, Inc., a non-profit alliance of health plans and related associations. CAQH is an independent company and not an affiliate of Cigna. Cigna does not endorse any third party products or services and has not independently verified the products or services, or any marketing claims made for such products or services. Cigna assumes no responsibility and shall have no liability under any circumstances arising out of the use or misuse of such products or services.

**Recredentialing**

As part of our Quality Management Program to ensure our dental network providers continue to meet the highest industry standards for quality oral care and comply with applicable state laws, all contracted dental providers are required to participate in the recredentialing process every three years or as needed. Providers due for recredentialing will receive a written or electronic notice advising them to complete the recredentialing application and submit certain credentials.

If an HCP does not complete the recredentialing application after our initial request, there will be a series of scheduled outreaches and follow-ups, including additional written attempts and a phone follow-up campaign. A provider that still fails to submit the recredentialing application and credentials after these outreaches may be subject to the termination of his/her contract with Cigna Dental.

**ADA's CAQH ProView™**

This is Cigna Dental's preferred recredentialing method that allows you to speed up the recredentialing process by completing a CAQH application through the American Dental Association's credentialing service (http://www.ada.org/credentialing), powered by CAQH ProView.** This service is available free of charge to all US practicing dentists, and ADA members and non-members alike. Once completed, the recredentialing process will be seamless (if you keep the attestation and supporting documentation up to date), allowing you to provide multiple health care organizations the ability to access your data thereby reducing the number of different applications you are required to complete.

Benefits of using the CAQH's credentialing service:

› A single “provider profile” that can be shared with authorized plans.

› Maintain information on multiple practice locations and dentists.

› A web-based workflow that flags errors and incomplete information for immediate correction.

Administrative policies and procedures (continued)

Dental participation
Sterilization and infection control
All dentists and staff agree to comply with the Centers for Disease Control and Prevention (CDC) guidelines, and the Occupational Safety and Health Administration (OSHA) standards and regulations, as well as all state and local regulations for the prevention and transmission of communicable diseases. Specifically, all dentists and clinical staff should:

› Adhere to Universal Precautions, based upon the generally accepted principle that all patients must be treated as if they were infected with a bloodborne pathogen.

Universal Precautions include:
— Follow work practice controls such as safe recapping techniques for needles and washing hands.
— Wear personal protective equipment such as gloves, protective gowns or jackets, and face shields.
— Maintain care in the use and disposal of “sharps,” including needles, scalpel blades and broken glass.
— Report all exposure incidents according to OSHA guidelines.

› Minimize the chance of cross-contamination by protecting patients and staff from infectious contact with bloodborne pathogens and airborne contaminants by complying with current guidelines for disinfection and sterilization of instruments and equipment that should include the following.
— Provide a written sterilization plan.
— Separate the areas where contaminated items are present from the areas where the instruments are clean.
— Keep the ultrasonic cleaners covered when in use.
— Sterilize all items used intraorally after each use or properly dispose of disposable instruments.
— Store sterilized instruments in the same sealed containers, bags or cassettes that they were packaged in before placing them into the autoclave. The packaging preserves the sterile status of the item until it is used on the patient.
Administrative policies and procedures (continued)

Dental participation (continued)

— Use process indicators to demonstrate that the instruments were processed through heat sterilization.

› Biological monitoring, or “spore testing,” of each autoclave or heat sterilization device is recommended weekly and required at a minimum of once a month, unless state regulations mandate otherwise. Spore testing of sterilizers must be validated by a third-party vendor. Please check the Cigna Network Rewards Program for vendors that may offer discounts on these services.

› When items are disinfected in EPA-approved disinfectant solutions, they should be soaked following the directions of the manufacturer. A logbook should be maintained to demonstrate that the solution was active and chemicals changed according to the manufacturer’s recommendations.

› Environmental surfaces should be appropriately disinfected and disposable covers properly discarded.

› Provide dental laboratory infection control by rinsing and disinfecting impressions and prosthetic devices, sterilizing burs and rag wheels, and changing pumice after each use.

› Have a current hepatitis B (HPV) vaccination for all staff or a written waiver of refusal.

› Compliance with all accepted local, state and federal standards with regards to bloodborne pathogens in the treatment of patients and the protection of dental staff.

Radiology safety

All dentists and staff agree to comply with Cigna, OSHA, the U.S. Department of Health and Human Services (HHS) and state and local regulatory agencies guidelines for radiology safety for patients and staff. Cigna recommends the following radiation safety measures.

› Ensure that radiation protection items used for patients include lead aprons that allow for proper thyroid protection.

› Monitor appropriate personnel to determine acceptable levels of radiation exposure. This is a state-specific regulation.

› Provide proper documentation and posting of state-specific radiation safety posters.

› Ensure that radiographic equipment is in good working order, well maintained and certified according to specific local, state and federal regulations.

Environmental safety

All dentists and staff agree to comply with Cigna, OSHA, the Environmental Protection Agency (EPA), HHS, and specific state and local environmental safety regulations pertaining to patients and staff. Federal OSHA regulations include the following.

› Maintain an in-office hazardous communication program, including:
  — A written, hazardous-communication manual.
  — Employee orientation and training in handling and disposing of hazardous waste, including mercury, developer and fixer, “sharps,” and disinfectants.
  — Current material safety data sheets (MSDS) for all materials used in the office.

› Provide the proper protective measures, including:
  — Use of masks, gloves and protective eyewear.
  — Heavy-duty gloves to be worn while disinfecting treatment areas and handling instruments during the sterilization process.
  — Eyewash equipment according to state regulations.
  — Proper ventilation of chemicals.
  — Laboratory jackets and coats, or disposable protective clothing. These should be appropriately laundered or disposed of according to state-specific regulations.

› Provide special sharps containers and dispose of them according to state regulations.

› Have a current HBV vaccination for all staff or a written waiver of refusal.

› Adhere to accepted mercury safety recommendations.
  — Use of premeasured amalgam capsules is preferred.
Administrative policies and procedures (continued)

Dental participation (continued)

— Scrap amalgam or bulk mercury should be stored appropriately within a sealed unbreakable container.
— A mercury spill kit is recommended. (For amalgam free offices, a mercury spill kit is not required but highly recommended).*

› Provide a nitrous oxide recovery system (scavenger unit) if nitrous oxide is used in the office.

Medical emergency preparedness

Dentists, as health care providers, agree to be prepared to prevent, recognize and properly manage medical emergencies that may occur in a dental office setting. According to the ADA Council on Scientific Affairs, examples of common emergencies include seizures, cardiovascular and respiratory distress, altered consciousness, chest pain and drug-related emergencies. The ADA Council on Scientific Affairs, Office Emergencies and Emergency Kits, March 2002 (latest version), includes the following recommendations.

› All dentists and appropriate office staff should possess current BLS/CPR certification.
› Periodic office emergency drills are encouraged, including a well-defined protocol for activating the EMS system.
› Telephone numbers of EMS and other appropriately trained health care providers should be posted.
› The office should have a readily available emergency drug kit and the skills to properly use all of the items it contains, and a plan to handle medical emergencies. The drugs should be current and not outdated.

The content of the kit is up to each individual dentist but should follow the current recommendations of the ADA Council on Scientific Affairs. The Council suggests that the following drugs be included as a minimum.
— Epinephrine 1:1,000 (injectable)
— Histamine-blocker (injectable)
— Oxygen with positive-pressure administration capability
— Nitroglycerin (sublingual tablet or aerosol spray)
— Bronchodilator (asthma inhaler)
— Sugar
— Aspirin

› Portable oxygen that can be administered under positive pressure should be able to be delivered to any location in the facility.
› Consult the ADA, specialists’ associations and state-specific medical and dental boards for emergency drugs and requirements for dentists and dental specialists using all modalities for producing states of analgesia, sedation and general anesthesia.

Patient recordkeeping

In accordance with professionally recognized standards of dental practice and as part of our Quality Management Program, each Network General Dentist (NGD) agrees to follow the dental record guidelines listed below.

All dental record guidelines are subject to state-specific and federal regulations.

The patient record should be an orderly, standardized, legible document. Patient records should conform to the following requirements.

› Each patient should have an individual patient record/file.
› The same type of patient record should be used for all patients in the practice.
› Confidentiality of the patient record is protected by HIPAA of 1996, with requirements in effect in 2003. Under Sec. 506 (c) Implementation specifications: Treatment, payment or health care operations, of the HIPAA regulations, you may disclose protected health information to Cigna because such information pertains to treatment, payment or Health

Care Operations. Under Sec. 501 of the regulations, Health Care Operations are defined to include:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; or

(2) Reviewing the competence or qualifications of health care providers, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care providers, accreditation, certification, licensing or credentialing activities.

› Members who wish to transfer to another dental office are entitled to a summary or copy of their record and copies of their radiographs at no charge to them.

› If a hard copy record is kept, the record should provide for appropriate storage of all forms and radiographs.

› Radiographs must be of appropriate content, diagnostic in quality, mounted and properly identified with patient name and date taken, and readily accessible in the record/file.

Quality of patient care

Dentists, as health care providers, agree to consistently provide an acceptable level of patient care, including evaluation and diagnosis, treatment planning, treatment rendered and treatment outcomes. Diagnosis must be based on a thorough evaluation, with sufficient information to identify significant clinical problems.

Treatment planning must be appropriate to the needs of the patient. Treatment rendered must be prevention oriented, properly prioritized, timely and of good technical quality.

Office review

Cigna Dental Care Network dental offices must participate in the Quality Management Program. If applicable, scheduled, periodic, onsite, and office reviews will be conducted by Cigna or its designee. On occasion, Network Management staff might visit your office in order to address a facility issue or investigate any member complaints. This assessment program is designed to identify improvement opportunities in the dental practice. You can view the office review evaluation form on the Cigna for Health Care Professionals website at CignaforHCP.com.

Provider data changes

Network Dentists shall provide Cigna with notification of updates to credentialing information, demographic information or other material changes within 30 days of the change.

New York: Network Dentists shall notify Cigna of changes to the above credentialing information, demographic information or other material changes, including but not limited to, languages spoken within the office within 15 days of the change.

Adding an associate

Complete the professional credentials form on the Cigna for Health Care Professionals website at CignaforHCP.com, or call the Cigna Dental Provider Service Unit at 800.Cigna24 (800.244.6224) and request the form. Your associate should complete, sign and submit the form with a copy of any of the following.

› Certificate/permit/letter of specialty training, where applicable

› Anesthesia permit, where applicable

Note: To avoid delays, please do not leave any questions blank.
Administrative policies and procedures (continued)
Dental participation (continued)

Upon receipt of the associate's documentation, Cigna will request written information from the:
› State dental licensing board
› National Practitioner Data Bank

Change of ownership
If your practice should change ownership, please contact the Cigna Dental Provider Service Unit at 800.Cigna24 (800.244.6224). Provider Services can assist in completing the necessary steps to process this change.

Closing the office to new members
› Refer to your Cigna Network General Dentist Agreement for details.
› Submit request in writing to the Network Management Department.
› Call the Cigna Dental Provider Service Unit at 800.Cigna24 (800.244.6224) to find out where to send your request.

Terminating your participation
› Contact the Cigna Dental Provider Service Unit by calling 800.Cigna24 (800.244.6224).
› Termination requests must be submitted in writing on your company letterhead or on a Cigna Request to Terminate Participation form. Please include the provider's name, Tax ID number, office address, and the reason for terminating your Network participation. The request must be signed by the contracted dentist.
› Upon receipt of your request, Cigna will process your termination with the appropriate notification required under the terms and conditions of your Agreement.
› Notification of associate turnover should be submitted to Cigna in writing. Please call the Cigna Dental Provider Service Unit at 800.Cigna24 (800.244.6224) to find out where to submit your request.
Many states are enacting legislation that requires Cigna and other carriers to ensure the accuracy of our provider directories. In response to individual state legislation, Cigna is now implementing additional procedures to validate the accuracy of information displayed in our directories for contracted dental providers. We’re also improving our processes to keep this information current. If your state enacts directory legislation, you must respond to Cigna’s state-mandated email or postal mail requests for update verification. If you do not respond to our outreaches in the respective timeframes, your information may be suppressed in our provider directories or your participation may be terminated in accordance with state law.
Policy

Network General Dentists and Specialists shall provide or arrange for emergency coverage on a 24-hour-per-day, 7-day-per-week basis, such that members shall receive emergency care relating to their services within 24 hours of contacting the dental office or within such lesser time as may be medically indicated.

While this policy requires that emergency care be made available to Cigna members within 24 hours of contacting the dental office (including messages left after hours), or within 24 hours if medically indicated, this policy in no way limits emergency care only to the first 24 hours after the member contacts the dental office.

Definition

A “dental emergency” is defined as a dental condition of recent onset and severity that would lead a sensible layperson possessing an average knowledge of dentistry to believe that his/her condition requires immediate dental treatment necessary to control excessive bleeding, relieve severe pain or eliminate acute infection. Examples include:

- An injury to the mouth area causing significant bleeding, severe pain or acute infection
- The loss of a large filling in a tooth, loss of a crown, or a cracked tooth that results in significant acute pain and discomfort
- Swelling in the mouth area that is the result of an infection, normally associated with an abscess

A true “dental emergency” is one in which the member describes their situation/event to be a condition that needs immediate attention.

If the member is able to postpone treatment until they are able to be treated by their Network General Dentist (NGD)/Network Pediatric Dentist (NPD) or Network Specialist (when applicable), then the situation would NOT be considered a dental emergency. Examples include:

- A slight injury to the mouth that did not result in significant bleeding, severe pain or acute infection
- The loss of a filling in a tooth that resulted in some sensitivity to hot and cold only
- A sore spot under a denture that has created a small ulcer on the gums
- A chipped tooth that has resulted in a sensitive spot that irritates the tongue
- A wisdom tooth that is erupting and is somewhat painful, but without swelling

Routine restorative or definitive treatment (e.g., root canal therapy) is not considered emergency care and should be performed or referred by the NGD or NPD.

Emergency coverage

Network General Dentists and Specialists shall provide or arrange for emergency coverage on a 24-hour-per-day, 7-day-per-week basis, such that members shall receive emergency care relating to their services within 24 hours of contacting the dental office (including messages left after hours) or within such lesser time as may be medically indicated and/or mandated by state law.
California

California Senate Bill 853, The Health Care Language Assistance Act, requires insurers to establish and support a language assistance program for limited English proficient (LEP) individuals in California. To meet the requirements of this law, Cigna has developed a California Language Assistance Program (CALAP) that is available to all our customers and network of health care professionals in California. Through this program, we offer access to free interpreter services and written translation of vital plan documents that can affect a customer's benefits and coverage.

› All patients with Cigna-administered coverage who live in California are eligible for CALAP.

› We do not delegate language assistance services to health care professionals and the use of family and friends as interpreters, especially minors, should be discouraged.

› All dental health care providers and office staff must offer this vendor's services when speaking to any Cigna plan participant in any non-English language, even if someone on staff speaks the language. If the plan participant prefers to use a family member or friend as an interpreter after he or she has been told that a trained interpreter is available free of charge, this refusal must be documented in his or her medical record (in a health care provider setting), administrative file or call tracking record (in the customer service setting).

› Forms are available to request or refuse interpretation services in English, Spanish, and Traditional Chinese. These forms can be used by your patients to track their language service preferences, regardless of who provides their insurance. To access the forms go to the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Forms Center > Dental Forms > CALAP – Request-Refuse Interpretation Services).

To engage the free interpretation services when the California plan participant is ready to receive services, call 800.806.2059. You will need his or her Cigna ID number, date of birth and your TIN to confirm eligibility and access these services. It is not necessary to make arrangements in advance. Language preferences will be available to directly contracted dentists upon request through telephone inquiries.

Face-to-face interpretation services are available upon request for special circumstances and are handled on a case-by-case basis. Please contact 800.806.2059 to schedule a face-to-face interpreter three to five days in advance.

New Mexico

New Mexico law requires health plans to provide free language assistance services to all customers who reside in New Mexico. Cigna provides free interpreter services to all dental plan participants in New Mexico who have limited English proficiency or differing hearing abilities that qualify under the Americans with Disabilities Act (ADA) for sign language.

Limited English proficiency

Please discourage the use of family and friends – especially minors – as interpreters. Offer the patient a trained, qualified telephonic interpreter, even if a provider or office staff speaks in the patient’s language. If a patient insists on using a family member or friend, or refuses to use a trained interpreter, document this in his/her medical record.

If telephonic interpretation services do not meet the needs of your patient in New Mexico with a Cigna-administered plan, you can schedule free face-to-face interpreter services by calling Cigna Customer Service at 800.Cigna24 (800.244.6224). For face-to-face Spanish interpreters, please allow at least three business days to schedule services. For all other languages, or to include American Sign Language (ASL), please allow at least five business days to schedule services.

Deaf patient

› Call Cigna Customer Service at 800.Cigna24 (800.244.6224) to schedule an appointment for free sign language interpreter services. Provide information about the patient’s next scheduled appointment, and type of sign language service needed (e.g., ASL). For ASL interpreters, please allow at least five business days to schedule services.
Call 711 Telecommunications Relay Services (TRS). Both voice and TRS users can initiate a call from any telephone, anywhere in the United States, without having to remember and dial a seven- or ten-digit access number. Simply dial 711 to be automatically connected to a TRS operator. Once connected, the operator will relay your spoken message in writing, and read responses back to you. In some areas, 711 TRS offer speech impairment assistance. Specially-trained speech recognition operators are available to help facilitate communication with individuals that may have speech impairments.*

If a limited English proficiency or deaf patient insists on using a family member or friend, or refuses to use a trained interpreter, document this in their medical record.

**Language assistance services for other states**

Discounts are available to Cigna-contracted health care providers for language assistance services through CQ Fluency, Interpreting Services International (ISI), and Language Line Solutions®. For more information, access our provider website at: https://www.cigna.com/health-care-providers/resources/language-assistance-services.
Administrative policies and procedures (continued)

Member complaints

Cigna offers members a process to address complaints and appeals. Members may have questions related to payment of claims, eligibility, coverage determinations and other procedural or administrative issues. They may also have questions about other aspects of care and services received in your office, which may include providing your billing policies, routine and emergency appointment wait times, sterilization protocols or quality of care.

The member, a representative of the member or a dentist designated by the member may initiate a complaint or appeal. Network providers are contractually required to cooperate with Cigna in resolving member complaints including timely response to requests for information and/or records.

If a member has a question or problem about any matter relating to services and/or coverage, Cigna Customer Service is available to assist them. Customer Service may be contacted by calling 800.Cigna24 (800.244.6224) or the telephone number on the members ID card, or by writing to the following address.

Cigna Dental Health, Inc.
PO Box 188044
Chattanooga, TN 37422-8044

Cigna is committed to responding to Member inquiries and complaints in a timely and fair manner. Customer Service or the National Appeals Unit (NAU) will respond upon the initial contact or respond to the member by the end of the next business day. For problems that cannot be resolved on a timely basis, the member, his/her representative, or the NGD on the member’s behalf may access the complaint and appeal process. The above processes are governed by state law and will vary accordingly.

Cigna nondiscriminatory statement: No plan employee shall retaliate or discriminate against a member (including seeking disenrollment of the member) solely on the basis that the member filed a grievance. Instances of such retaliation or discrimination shall be grounds for disciplinary action (including termination) against the employee.

California residents: To access the Cigna Member Grievance Form, visit our website at https://www.cigna.com/cignacompanynames/cigna-in-california. Scroll down to the section names “Cigna Dental Health of California, Inc., Grievances and Appeals” to access the California specific forms, which are available in English and non-English languages. Additional complaint, grievance and Independent Medical Review information is available in English and non-English languages on the Department of Managed Health Care’s website: www.dmhc.ca.gov. In addition, hard copies may be obtained by submitting a written request to:

Department of Managed Health Care
Attention: HMO Help Notices
980 9th Street, Suite 500
Sacramento, CA 95814
Network Dentists may wish to practice dentistry outside of his or her traditional office locations, either independently or as coordinated with a third party. Cigna must approve any such non-traditional in-network dental care on behalf of Cigna Dental patients.

**Independent Operation**

Network Dentists who seek to independently operate dental mobile units or onsite dental services should contact Cigna Dental Provider Relations for more information about requirements and necessary documentation.

**Partnership with Onsite Dental Vendors**

Network Dentists performing services in coordination with a Cigna-approved Onsite Dental Vendor are also required to notify Cigna. Onsite Dental Vendors are third parties that provide logistical, fee negotiation, and billing assistance for the rendering of dental care outside of an established dental office, typically via a mobile unit or temporary operatory at an employer worksite. If a Network Dentist chooses to work with an Onsite Dental Vendor, the Network Dentist must contact Cigna Dental Provider Relations to complete the necessary documentation and be approved to perform these services in-network.

To learn more about Cigna-approved Onsite Dental Vendors or to report a concern related to an Onsite Dental Vendor with whom you have contracted, please contact Cigna’s Provider Relations Department at (1-800-Cigna24).
Cigna strives to resolve issues raised by health care providers on initial contact whenever possible. An appeal is defined as a request to change a previous adverse decision made by Cigna when it has been determined by Cigna that the original decision was adjudicated properly.

A complaint is considered as an initial expression of dissatisfaction from a provider or their representative regarding any issue about coverage, service, recruitment, contractual disputes, etc.

Cigna offers an appeals process for dentist terminations, contractual disputes regarding post-service payment denials and payment disputes, denial of dentist network participation, or when state law requires appeals for other reasons.

Before beginning an appeals process, please call Cigna Customer Service at 1.800.Cigna24 (800.244.6224) or the number on the member’s ID card to try to solve the issue. Many issues, including denials related to timely filing, incomplete claim submissions, and contract and fee schedule disputes may be quickly solved through a real-time adjustment by providing requested or additional information. If our Customer Service team cannot solve the issue during that call, then our appeal process can be initiated through a written request.

Provider appeals must be submitted in writing within 180 calendar days of the initial denial, EOB or letter and sent to the following address.

Cigna Dental Health, Inc.
PO Box 188044
Chattanooga, TN 37422-8044

Arizona: Appeals should be submitted as follows: first level, submit within 365 calendar days; second level, submit within 60 calendar days. Responses for appeal submissions should be sent within 30 calendar days.

California: Single level appeals should be submitted by the NGD/Network Specialist within 180 calendar days of claim denial. Responses for appeal submissions should be sent within 45 business days.

New Jersey: Providers must initiate an appeal on or before: (1) the 90th calendar day following receipt of the adverse determination; or, (2) the 90th calendar day of a missed due date for the claim determination (including a pended claim). Request for an appeal must be submitted on a form prescribed by the DOBI and is available for download on the Department’s website at www.state.nj.us/dobi/index.html. A written decision of the appeal decision will be communicated to the provider within 30 calendar days after receipt of the appeal on the standardized form. If not communicated within the required 30 days, the provider may refer the dispute to arbitration.
Rationale

The Network General Dentist (NGD)/Network Pediatric Dentist (NPD)

In most cases single canal endodontic treatment and uncomplicated multiple canal endodontic treatment should be rendered by the NGD or NPD. If the NGD or NPD refers a member for endodontic service(s) that are considered to be within the expected range of the NGD/NPD’s clinical skills and expertise, the referring dentist may be backcharged an amount equaling the specialist’s fee minus the patient charge for services rendered.

Network Specialists

Coverage for treatment by a Network Endodontist requires a referral from the member’s NGD or NPD. Such coverage does not require prior coverage authorization by Cigna.

Administrative guidelines

› Generally, coverage is not available for a procedure that is incomplete. Coverage for incomplete endodontic treatment will be considered on a case-by-case basis. See page 43, Pulpotomy and Other Endodontic Procedures (D3332) for additional guidelines.

› Endodontic irrigants and/or specialized equipment used in endodontic therapy are considered to be part of the primary endodontic service. Therefore, neither the member nor Cigna may be charged separately for irrigants or equipment.

› Members requiring endodontic therapy must be informed of, and agree to, restoration of the tooth (e.g., post, build up, crown).

› Radiographic coverage is for diagnostic purposes only. Radiographs taken during the course of treatment (e.g., root canal, crown insertion) are inclusive in nature to the treatment procedure code. Cigna will not make separate allowances for treatment radiographs.

Steps to take after you receive a Specialty Referral Form from the NGD or NPD (or member).

1. Schedule the member’s appointment.
2. Use the toll-free Automated Eligibility Line, 800.Cigna24 (800.244.6224), to check Patient Charge Schedule information and verify member eligibility.

Please note: Patient charges are based on the Patient Charge Schedule in effect on the date services are initiated.

3. Complete the claim form providing all treatment-related information including.
   a. Service(s) rendered
   b. Tooth number(s)
   c. Service date of completed procedure
   d. Prognosis
   e. Sign and date
   f. Complete license number
   g. Tax ID number
   h. NPI
   i. Date the treatment was initiated (if different from completion date)

4. Have the member or parent/guardian sign Referral Form under patient signature.

5. Attach the completed Claim Form to the Referral Form and mail with any supporting documentation, including narrative (if necessary) and pre- and post-treatment radiographs to Cigna. Radiographs are not required for molar teeth unless it is for a retreatment.
Claim review by Cigna

Upon receipt of the Specialty Referral Form with the attached Claim Form, Cigna:

› Reviews all the referral information
› Determines coverage for endodontic covered services
› Mails appropriate communications and/or payment to the specialist
› Returns radiographs to the specialist if the specialist includes a self-addressed, stamped envelope.

Cigna will accept any state-mandated Referral Form in lieu of the Cigna Specialist Referral Form. Cigna Specialist Referral Forms can be located at the Cigna for Health Care Professionals website at CignaforHCP.com.

Endodontic coverage is NOT available for the following.

› Treatment of teeth exhibiting poor/hopeless periodontal prognosis
› Treatment of teeth exhibiting non-restorable caries
› Treatment of teeth that are currently non-functional and for which no future function is feasible or treatment planned, such as unopposed third molars
› Use of unacceptable materials: Paraformaldehyde containing pastes or silver point fillings
› Intentional endodontics in the absence of injury or disease to solely facilitate a restorative procedure
› Consultation (D9310) when you are providing definitive treatment for patient
› Bone grafting (D4263, D4264) and/or guided tissue regeneration (D4266, D4267) – When performed in conjunction with an apicoectomy
› Endodontic irrigants and/or specialized equipment used in endodontic therapy are considered to be part of the primary endodontic service. Therefore, neither the member nor Cigna may be charged separately for irrigants or equipment.
Administrative policies and procedures (continued)
State-specific guidelines

**Colorado**
Cigna will not take adverse action against a provider or provide financial incentives or subject the provider to financial disincentives based solely on a patient satisfaction survey or other method of obtaining patient feedback relating to the patient satisfaction with pain treatment. In case of an adverse pre-determination, you have the right to a peer-to-peer conversation with the reviewer that made the decision. To initiate a peer-to-peer conversation, please call the reviewing dentists, the name and phone number is listed on the EOB.

**Connecticut**
Upon leaving the Cigna network for any reason, Network Dentists shall provide Cigna a list of Cigna patients being treated on a regular basis no later than thirty (30) days after the Network Dentist sends Cigna the notice of termination.

**Maryland**
Maryland has a state-specific referral form. Please use this form when referring to a specialist. Please contact Customer Service at 800.Cigna24 (800.244.6224) for more information.

**Minnesota**
The term “Certification Number” in pre-authorization documents is synonymous with either Referral Number or Document Control Number.

**Missouri**
In rendering a case involving an initial determination, providers have an opportunity to request on behalf of the enrollee, a reconsideration of an adverse determination by the reviewer making the adverse determination.

**New Jersey**
- NGDs may receive a copy of the New Jersey State Health Benefits Program Dental Plan Organization Agreement by calling Customer Service at 800.Cigna24 (800.244.6224).
- Cigna may recover a refund for overpayment of a claim up to 18 months after the date the first payment on the claim was made. This timeframe does not apply to claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits. Cigna will provide written documentation that identifies the claim processing or payment error made that justifies the reimbursement request. NGDs may pursue reimbursement for underpayments for 18 months from the date the first payment on the claim was made, unless the claim is subject to an appeal.

- NGDs must initiate an appeal on or before: (1) the 90th calendar day following receipt of the adverse determination, or (2) the 90th calendar day of the missed due date for the claim determination (including a pended claim). The request for an appeal must be submitted on a form prescribed by the DOBI that is available for download on the Department’s website at http://www.state.nj.us/dobi/index.html or at the Cigna for Health Care Professionals website at CignaforHCP.com. A written decision of the appeal decision will be communicated to the NGD within 30 calendar days after receipt of the appeal on the standardized form. If not communicated within the required 30 days, the NGD may refer the dispute to arbitration.

**North Carolina**
NCGS 58-3-200(b) defines medical necessity as those covered services or supplies that are:
1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, not for experimental, investigational, or cosmetic purposes.
2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
3) Within generally accepted standards of medical care in the community.
4) Not solely for the convenience of the insured, the insured’s family, or the provider.

**Texas**
Upon written request, Cigna will provide Network Dentists with fee schedules and coding information.
Quality Management Program

The Cigna Quality Management Program was developed to reinforce our commitment to excellence, and our continuous drive to improve all phases of our business. The Quality Management Program is a set of principles and actions that facilitate the delivery of reliable dental care to our clients and members.

The quality of care and services is a key component in the satisfaction of our members. Through our Quality Management Program, we select dentists who not only meet our credentialing criteria, but also agree to comply with the program’s guidelines. They understand our compensation schedules and treat our members with the same care as their fee-for-service patients. The Quality Management Program includes all quality management activities.

Activities of the Quality Management Program include:

› Initial credentialing
› Recredentialing
› Health care provider accessibility monitoring
› Health promotion and preventive care
› Network Dentist performance monitoring
› Performance-monitoring focus studies
› Complaint and grievance review
› Member and health care provider satisfaction surveys
› Administrative standards for accuracy and response
› Reporting results and implementing corrective actions
› Quality review assessments of dental facilities, as applicable
› Review of patient records for appropriateness, as applicable
› Educational feedback to offices by Network Management and Dental directors

All Cigna Network Dentists are required to adhere to our Quality Management Program. This helps our members benefit by receiving reliable dental care, improved oral health and satisfaction from their dental plan.
Cigna Dental Oral Health Integration Program

Research shows that a person's oral health may have an impact on his or her overall health. This may be especially true for people who have certain medical conditions. That is why we offer reimbursement of copayments and coinsurance on certain dental procedures for customers with specific medical conditions. We also offer savings on certain prescription dental products, and guidance on behavioral issues that impact oral health.

Patients eligible to participate in the program

Most Cigna Dental customers are eligible for program participation, regardless of their medical carrier. The only requirement is that they must have one of the medical conditions listed below. Your patient can confirm eligibility by calling Customer Service at 800.Cigna24 (800.244.6224).

- Heart disease or stroke
- Diabetes
- Maternity
- Chronic kidney disease
- Organ transplant
- Head and neck cancer radiation

To determine the procedures for which your Cigna Dental insured patients may qualify for reimbursement of copayments or coinsurance from Cigna Dental, refer to the table below. Unless noted, normal age and frequency limitations apply.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Heart disease</th>
<th>Stroke</th>
<th>Diabetes</th>
<th>Maternity</th>
<th>Chronic kidney disease</th>
<th>Organ transplants</th>
<th>Head and neck cancer radiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodontal treatment and maintenance (D4341, D4342, D4910)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Periodontal evaluation (D0180)</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral evaluation° (D0120, D0140, D0150)</td>
<td></td>
<td>✓</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning° (D1110)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scaling in the presence of inflammation — full mouth° (D4346)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency palliative treatment° (D9110)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical application of fluoride varnish° (D1206)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical application of fluoride° (D1208)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Sealants° (D1351)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealant repair — per tooth° (D1353)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Eligibility, reimbursement and coverage for eligible services are subject to plan year maximums.
2. Four times per year.
3. One additional evaluation.
4. One additional cleaning.
5. No limitations.
6. Age limits removed, all other limitations apply.
Provider reimbursement

Follow the same procedure you normally would. Bill the patient according to his or her plan after performing the covered procedure. Bill DHMO plan participants for their copay and DPPO plan participants for their coinsurance. Provide your patient with an itemized receipt, as you usually do for any covered dental service you provide. Then submit your claim to Cigna Dental.

Member reimbursement

Your patient must complete the Cigna Dental Oral Health Integration Program “Registration Form”. The registration form is available on myCigna.com, Cigna.com or by calling the number on the ID card. Once registered, your patient simply visits your office and pays the usual copayment or coinsurance amount for the covered procedure. Cigna will automatically send the reimbursement to the member within 30 days.

Can I tell my patients about the program?

Yes, we encourage dentists to ask patients about their medical conditions to see if they are eligible for the program. Help your patients maintain a healthy mouth after they leave your office, and share all the benefit of the Oral Health Integration Program with them. If you are registered, you can also visit the Cigna for Health Care Professional website to view Oral Health Integration Program details. A link can be found under the Dental Health Connect section of Plan Details. Your awareness of this program and assistance with members who qualify will help them take full advantage of additional plan features. Together, we can make sure proper dental care is given to those who truly need it most.

Questions?

If you have any questions about the program, please reach out to your Cigna Dental Professional Relations Manager or call Customer Service at 800.Cigna24 (800.244.6224).
Clinical policies and guidelines

Clinical coverage determination guidelines

Information about the Cigna Dental Care® Clinical Coverage Determination Guidelines relied upon in making benefit determinations is available immediately at CignaforHCP.com > Resources > Reference Guides. You may also request this information by contacting Customer Service at 800.Cigna24 (800.244.6224). A copy will be provided to you or your authorized representative free of charge.

AIDS/HIV seropositive policy

Policy
The management of issues concerning AIDS is a constantly evolving process. Cigna urges Network Dentists, for the protection of their members, their personnel and themselves, to practice in accordance with the recommendations quoted below as set forth by:

› The ADA
› The CDC
› OSHA
› The Americans with Disabilities Act

NGDs and Network Specialists should access ADA guidelines on an ongoing basis for current information. It is advisable to consult with physicians and lawyers when AIDS/HIV seropositive issues arise in the dental office.

The ADA’s Council on Scientific Affairs can provide specific information on AIDS as it relates to dentistry, including questions on infection control, OSHA regulations and CDC recommendations. You can contact the ADA’s Division on Scientific Affairs at 312.440.2528.

Administrative guidelines

› Use Universal Precautions in the management of all members to reduce the risk of exposure to HIV infection and other bloodborne pathogens.
› Follow the ethical guidelines presented by the ADA.
› Abide by the Americans with Disabilities Act.
› Train and educate the dental staff about AIDS management and infection control.
› Observe, and train the dental staff to observe, the confidentiality laws in your state.

Clinical policies and guidelines (continued)

Infection control – Per visit

Policy
All NGDs and Network Specialists should follow CDC, ADA, OSHA, and any applicable state recommendations for sterilization and/or infection control. Cigna considers sterilization, personal protective equipment, infection control (including surface and/or air decontamination), tray/setup and the handling/disposal of biohazardous waste to be included as part of the delivery of dental services and patient care. Therefore, neither the member nor Cigna may be charged separately for these services. The member is responsible for paying only those patient charges indicated on the applicable Patient Charge Schedule for covered services.
Clinical policies and guidelines (continued)

Temporomandibular joint (TMJ) dysfunction

Policy and rationale
The Cigna Dental Care plan now covers certain specific dental services when performed for the treatment of TMJ dysfunction.

Procedure codes D0160 (Detailed and extensive oral evaluation - Problem focused, by report) and D7880 (Occlusal orthotic device, by report) and D7881 (Occlusal orthotic device adjustment) are now considered covered services, but only when performed in conjunction with the treatment of TMJ dysfunction.

Adjustments (D7881) within the first six months of insertion are considered inclusive to the delivery of the device. After six months, up to two adjustments per year are allowable. Please note that these procedure codes will only appear on the Cigna Dental Care 09, P and Q Series Patient Charge Schedules. However, they will also be covered in previously issued Patient Charge Schedules.

To find applicable patient copays and any plan limitations that may apply, please reference the applicable Patient Charge Schedule under the member’s record in CignaforHCP.com or by contacting Customer Service at 800.Cigna24 (800.244.6224).

Clinical policies and guidelines (continued)

Use of equipment

Policy and rationale
The Code on Dental Procedures and Nomenclature (CDT), published by the American Dental Association (ADA), has been designated as the national standard for reporting dental services by the federal government under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is recognized by third-party payers nationwide. According to the ADA's CDT 2021 Coding Companion: Training Guide for the Dental Team, the codes are “procedure based rather than instrument based.”*

Hence, Cigna members cannot be charged for the specific use of equipment or instruments (including, but not limited to, handpieces, air abrasion, lasers, CAD/CAM technology**) in the completion of a dental service. The use of equipment to complete a procedure is considered inclusive of the applicable CDT procedure codes. Members may only be charged the applicable Patient Charge for the dental procedure(s).

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**CAD/CAM Services: An upgrade charge not to exceed $150 per tooth may be applied to covered crowns, inlays, onlays, post and cores, and veneers if using same-day, in-office CAD/CAM (ceramic) services. This feature only applies to the Cigna Dental Care 09 Series, P Series, and Q Series as specified in the patient’s Patient Charge Schedule. For guidance, please refer to the member’s applicable Patient Charge Schedule under the member’s record in CignaforHCP.com or contact Customer Service at 800.Cigna24 (800.244.6224).
Dental procedure policies and guidelines
Endodontist – Evaluation, consultation

Procedure codes: D0140, D9310

Rationale
In this dental program, it is expected that the Network General Dentist (NGD)/Network Pediatric Dentist (NPD) will provide a specific diagnosis for intended treatment, as well as provide a diagnostic quality radiograph (periapical) to confirm his/her diagnosis. This policy will explain our position for reimbursement to the Network Endodontist.

CDT nomenclature and descriptor

D0140 – Limited oral evaluation – Problem-focused
An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same dates as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

D9310 – Consultation – Diagnostic service provided by dentist or physician other than requesting dentist or physician
A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services.

Policy
The Network Endodontist is reimbursed for a Limited oral evaluation – Problem focused (D0140) when the member is referred for definitive treatment and a preliminary oral evaluation is performed. This involves the actual transfer of care from the general dentist to the specialist for definitive treatment, in most cases root canal therapy.

The Network Endodontist is reimbursed for a Consultation (D9310) when the member is referred for a diagnostic opinion and/or advice regarding evaluation and/or management of a specific problem. A consultation would imply that a report is returned to the general dentist for his/her final determination of a treatment plan. This does not involve the actual transfer of care from the general dentist to the specialist for treatment.
Dental procedure policies and guidelines (continued)
Diagnostic radiographic imaging and records policy

Procedure codes: D0210–D0330, D0701–D0709

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Intraoral - Complete series of radiographic images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - Periapical first radiographic image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - Periapical each additional radiographic image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - Occlusal radiographic image</td>
</tr>
<tr>
<td>D0251</td>
<td>Extra-oral posterior dental radiographic image</td>
</tr>
<tr>
<td>D0270–D0274</td>
<td>Bitewings - 1 to 4 radiographic images</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings - 7 to 8 radiographic images</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
</tr>
<tr>
<td>D0701</td>
<td>Panoramic radiographic image - image capture only</td>
</tr>
<tr>
<td>D0702</td>
<td>2-D cephalometric radiographic image - image capture only</td>
</tr>
<tr>
<td>D0705</td>
<td>Extra-oral posterior dental radiographic image - image capture only</td>
</tr>
<tr>
<td>D0706</td>
<td>Intraoral - occlusal radiographic image - image capture only</td>
</tr>
<tr>
<td>D0707</td>
<td>Intraoral - periapical radiographic image - image capture only</td>
</tr>
<tr>
<td>D0708</td>
<td>Intraoral - bitewing radiographic image - image capture only</td>
</tr>
<tr>
<td>D0709</td>
<td>Intraoral - complete series of radiographic images - image capture only</td>
</tr>
</tbody>
</table>

Rationale
In a managed care benefit model, the NGD and/or NPD is contracted and responsible for providing all necessary and essential diagnostic radiographs for covered members. In the event of a referral, it is also the NGD/NPD’s responsibility to forward any necessary diagnostic-quality radiographs to the specialist. Please refer to the following pages for additional information. This is based on the following assumptions:

- Radiographs are primarily for clinical purposes, not administrative; they represent a critical diagnostic aid and supplement to the health history and clinical exam to identify dental needs of the member.
- Radiographs must be of diagnostic quality.
- The number and type of radiographs will vary according to the needs of the individual member.
- Exposure to radiation warrants the cautious and prudent use of radiographs.

Policy
Radiographic considerations
Decisions regarding the use of diagnostic radiography should be made only after the dentist has reviewed the health history and clinically evaluated the member. The changing patterns of dental disease, concerns of exposure to radiation and the development of guidelines have replaced the usual office routine of taking an automatic full-mouth series or set of bitewings before the member is ever seen by the dentist. See page 39 for Recommendations for prescribing dental radiographs (ADA/FDA).

A radiographic exam is a combination of periapical, bitewing, panoramic films or other views selected for an individual based on need. The following factors should be taken into consideration to determine the radiographic needs of an individual member.

- Age
- Growth and development status
- Dentition type
- Caries and periodontal disease risk factors
- History of dental treatment
Dental procedure policies and guidelines (continued)

Diagnostic radiographic imaging and records policy (continued)

Procedure codes: D0210–D0330, D0701–D0709 (continued)

Radiographs for adolescent and adult patients

For new members, an intraoral radiographic complete series is appropriate for adolescent and adult members who present with clinical evidence of generalized dental disease (e.g., periodontitis, caries) or a history of extensive dental treatment. Some dentists prefer a panoramic examination with posterior bitewings to an individualized set of selected periapical and bitewing films or a full-mouth intraoral series, although clinical research indicates superior visualization of proximal surfaces and of alveolar bone with intraoral radiographs.

For previously treated members, a new and complete radiographic examination may be required in the following situations:

- The member has been absent from the practice for a prolonged period.
- A child’s dentition has changed from deciduous to permanent.
- The member has had a medical experience that has changed his/her health status.

Panoramic radiographs

1. **Periodontal referrals** - For Cigna Dental Care members who require a referral to a periodontist, the NGD is ultimately responsible for providing a complete series of radiographic images (FMX) to the periodontist. These images are taken by the NGD on a pre-referral basis by assessing the radiographic needs of the member at the time of the initial evaluation. In the event a member who has been referred to a periodontist with a panoramic radiograph image requires an FMX to be taken by the periodontist, a backcharge to the NGD may occur. The backcharge will be the amount of the periodontist’s contracted fee for the FMX.

2. **Oral surgery referrals** - Radiographs for oral surgery referrals should be provided by the NGD/NPD; however, a panoramic radiograph may be required for certain clinical situations. For those referral situations when selective periapicals are inadequate and the NGD does not have a panoramic radiograph machine, Cigna will reimburse the oral surgeon for any necessary panoramic radiograph subject to any coverage limitations.

Quality of care

The delivery of quality care dictates that the dentist stay informed of current techniques and procedures including radiography. Dental radiographic coverage is available only for diagnostic-quality radiographs; a backcharge to the NGD in the amount of the specialist’s contracted fee for the radiographs taken by the specialist and paid for by Cigna may be applied for the following:

- Over- or under-exposed films
- Radiographs which do not visually demonstrate the anatomical area in question
- Films demonstrating incomplete processing
- Damaged or altered radiographs

Previous diagnostic records

Dentists should attempt to obtain previous radiographs of new members. An evaluation of these will help determine member risk factors and additional radiographic needs.

Documentation of radiographs

Radiographs, particularly FMXs and panoramic films, should be:

- Correctly mounted, with left and right clearly designated.
- Identified according to the member’s name and date of exposure.
- Documented specifically in the member’s chart by the number and type(s) of films.

Cigna Dental considers interpretation of diagnostic images to be part of the process of diagnosing and determining treatment plans that meet the needs of the patient’s condition. Therefore, Cigna Dental considers D0391 to be covered and inclusive to any associated evaluation, consultation, and/or definitive treatment. The member may not be charged for the D0391 in these situations.
Dental procedure policies and guidelines (continued)

Diagnostic radiographic imaging and records policy (continued)

Procedure codes: D0210–D0330, D0701–D0709 (continued)

Duplication of X-rays
Radiographs are an integral part of the dentist’s clinical records and are generally considered the property of the dentist. However, contractual provisions of the NGD and Network Specialist agreements require Network Dentists to make copies of records and radiographs available to Cigna Dental Care members or Cigna at no additional cost.

Written radiology report or interpretation
In those offices where the member is sent to a diagnostic-imaging center for the purpose of taking dental radiographs, the dentist must be responsible for that expense and should report the radiographs to Cigna as per the instructions in the dental contract. If requested by Cigna, a written radiology report is not to be reported or charged as a separate service or expense.

Administrative guidelines

Radiographs
When the allowance for a combination of X-rays (such as seven or more periapical X-rays or a panoramic X-ray with bitewings) on the same date of service meets or exceeds the allowance for intraoral complete series of X-rays, plan reimbursements will be based on an intraoral complete series.

• A panoramic radiograph and bitewings are often used as the diagnostic equivalent of an FMX. However, dental offices should not report this version of an FMX; rather, the individual procedure codes for each service should be reported.

• If an FMX is rendered as the radiographic examination of a new member, a subsequent panoramic radiograph is separately allowable for valid clinical reasons (e.g., periodontal referral) and is not subject to the frequency limitation of an FMX. Please note this applies only at the NGD’s office.

• Dental specialists are required to submit X-rays only on certain procedure codes as listed below. Please note that Cigna Dental Care Network General Dentists do not need to send X-rays or preauthorize services that they will perform.

Please submit duplicate X-rays
The duplicate radiographs must be diagnostic and clearly labeled with the member’s name, date of exposure, and left and right designations. If you wish to have X-rays returned to your office, please include a self-addressed, stamped envelope; X-rays submitted without a self-addressed, stamped envelope will not be returned.

Procedure codes that require submission of X-rays

Endodontic Therapy Services
D3310, D3320, D3331, D3332, D3333, D3346, D3347, D3348, D3351, D3352, D3353, D3355, D3356, D3357, D3410, D3421, D3425, D3426, D3428, D3429, D3430, D3431, D3432, D3471, D3472, 3473

Periodontic Services
D4249, D4260, D4261, D4341, D4342, D4346

Implant Services
D6010, D6013, D6101, D6102, D6103, D6104

Oral and Maxilofacial Surgery Services
D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7310, D7311, D7320, D7321, D7471, D7472, D7473, D7485, D7922

Cigna reserves the right to request additional X-rays on these and other procedures as deemed necessary for claims payment.
Dental procedure policies and guidelines (continued)
Diagnostic radiographic imaging and records policy (continued)

Procedure codes: D0210–D0330, D0701–D0709 (continued)

You can also submit X-rays electronically
You can submit X-rays and other attachments electronically through any of the following options:

› Standard EDI 275 attachment transactions through your clearinghouse
› DentalXChange Attachment Service available free of charge for DentalXChange Claim Connect™ subscribers
› NEA FastAttach® – Secure information exchange that is cost-effective and reliable. To learn more, visit the National Electronic Attachment (NEA) FastAttach website at nea-fast.com or call 800.782.5150. Discounts are available for Cigna Dental network dentists through the Cigna Network Rewards Program® (refer to page 9 of this guide for more program details).

Electronic submission eliminates the need for duplicate X-rays or self-addressed, stamped envelopes.
Dental procedure policies and guidelines (continued)
Diagnostic radiographic imaging and records policy (continued)

Recommendations for prescribing dental radiographs
These recommendations are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient’s health history and completing a clinical examination. Even though radiation exposure from dental radiographs is low, once a decision to obtain radiographs is made it is the dentist’s responsibility to follow the ALARA (as low as reasonably achievable) Principle to minimize the patient’s exposure.

<table>
<thead>
<tr>
<th>PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of encounter</strong></td>
</tr>
<tr>
<td><em><em>New patient</em> being evaluated for oral diseases</em>*</td>
</tr>
<tr>
<td><em><em>Recall patient</em> with clinical caries or at increased risk for caries</em>*</td>
</tr>
<tr>
<td><em><em>Recall patient</em> with no clinical caries and not at increased risk for caries</em>*</td>
</tr>
<tr>
<td><em><em>Recall patient</em> with periodontal disease</em>*</td>
</tr>
</tbody>
</table>

* See page 41. ** Factors increasing risk for caries may be assessed using the ADA Caries Risk Assessment forms (0–6 years of age and over 6 years of age).
# Recommendations for prescribing dental radiographs

**PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE**

<table>
<thead>
<tr>
<th>Type of encounter</th>
<th>Child with primary dentition (before eruption of first permanent tooth)</th>
<th>Child with transitional dentition (after eruption of first permanent tooth)</th>
<th>Adolescent with permanent dentition (before eruption of third molars)</th>
<th>Adult, dentate or partially edentulous</th>
<th>Adult, edentulous</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient (new and recall)</strong> for monitoring of dentofacial growth and development, and/or assessment of dental/skeletal relationships</td>
<td>Clinical judgment as to need for, and type of, radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships.</td>
<td>Clinical judgment as to need for, and type of, radiographic images for evaluation and/or or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars.</td>
<td>Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for, and type of, radiographic image for evaluation of dental and skeletal relationships.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/ endodontic needs, treated periodontal disease and caries, remineralization</strong></td>
<td>Clinical judgment as to need for, and type of, radiographic images for evaluation and/or monitoring of these conditions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dental procedure policies and guidelines (continued)
Diagnostic radiographic imaging and records policy (continued)

Recommendations for prescribing dental radiographs (continued)

* Clinical situations for which radiographs may be indicated include, but are not limited to:

A. Positive historical findings
   1. Previous periodontal or endodontic treatment
   2. History of pain or trauma
   3. Familial history of dental anomalies
   4. Postoperative evaluation of healing
   5. Remineralization monitoring
   6. Presence of implants, previous implant-related pathosis or evaluation for implant placement

B. Positive clinical signs/symptoms
   1. Clinical evidence of periodontal disease
   2. Large or deep restorations
   3. Deep carious lesions
   4. Malposed or clinically impacted teeth
   5. Swelling
   6. Evidence of dental/facial trauma
   7. Mobility of teeth
   8. Sinus tract (“fistula”)
   9. Clinically suspected sinus pathology
  10. Growth abnormalities
  11. Oral involvement in known or suspected systemic disease
  12. Positive neurologic findings in the head and neck
  13. Evidence of foreign objects
  14. Pain and/or dysfunction of the TMJ
  15. Facial asymmetry
  16. Abutment teeth for fixed or removable partial prosthesis
  17. Unexplained bleeding
  18. Unexplained sensitivity of teeth
  19. Unusual eruption, spacing or migration of teeth
  20. Unusual tooth morphology, calcification or color
  21. Unexplained absence of teeth
  22. Clinical tooth erosion
  23. Peri-implantitis

Dental procedure policies and guidelines (continued)

Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum

Procedure code: D0600

CDT nomenclature and descriptor

D0600 – Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum

Policy

Cigna Dental considers the use of any non-ionizing tools or instruments to be part of the process of diagnosing and determining treatment plans that meet the needs of the patient’s condition. Therefore, Cigna Dental considers D0600 to be covered and inclusive to any associated evaluation, consultation, and/or definitive treatment. The member may not be charged for the D0600 in these situations.
Dental procedure policies and guidelines (continued)

Pulpotomy and other endodontic procedures

Procedure codes: D3220-D3333

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement – Primary and permanent teeth</td>
</tr>
<tr>
<td>D3222</td>
<td>Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development</td>
</tr>
<tr>
<td>D3331</td>
<td>Treatment of root canal obstruction, nonsurgical access</td>
</tr>
<tr>
<td>D3332</td>
<td>Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth</td>
</tr>
<tr>
<td>D3333</td>
<td>Internal root repair of perforation defects</td>
</tr>
</tbody>
</table>

Rationale

Many procedures may become part of the patient treatment for pulpal diseases. As these are often subject to a misunderstanding, Cigna has specific criteria for coverage to be allowed in these circumstances.

Policies

Nomenclature and descriptor

**D3220 – Therapeutic pulpotomy (excluding final restoration) – Removal of pulp coronal to the dentinocemental junction and application of medicament**

Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary or permanent teeth, this is not to be construed as the first stage of root canal therapy.

This procedure is allowed when there is an intention to maintain the vitality of the remaining portion of the root tissue, and as additionally described in the above descriptor.

**D3221 – Pulpal debridement – Primary and permanent teeth**

Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.

This procedure is not covered under 02 and 03 Series Patient Charge Schedules. This procedure is allowed for the relief of acute pain prior to the start of conventional root canal treatment. Typically, this is allowed for the Network General Dentist prior to the referral to the Network Endodontist, when the services of a specialist are indicated. It is allowed for the Network Endodontist only on an emergency referral when time only allows for this emergency procedure and should not be reported as the first appointment of routine root canal therapy.

**D3222 – Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development**

Removal of a portion of the pulp and application of a medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root.

This procedure is not to be construed as the first stage of root canal therapy.

**Please note:** This procedure is not covered under 02 and 03 Series Patient Charge Schedules.
Dental procedure policies and guidelines (continued)
Pulpotomies and other endodontic procedures (continued)

**Procedure codes: D3220-D3333** (continued)

**D3331 Treatment of root canal obstruction, nonsurgical access**
In lieu of surgery, the formation of a pathway to achieve an apical seal without surgical intervention because of a non-negotiable root canal blocked by foreign bodies, including but not limited to, separated instruments, broken posts or calcification of 50% or more of the length of the tooth root.

This procedure is performed to achieve a pathway to an apical seal because of a non-negotiable canal blocked by a foreign body. When submitting for payment, include a brief narrative and radiograph to confirm the obstruction. Coverage for D3331 is allowed on a per-tooth basis.

**Please note:** This procedure is not covered under 02 and 03 Patient Charge Schedules.

**D3332 – Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth**
Considerable time is necessary to determine diagnosis and/or provide initial treatment before the fracture makes the tooth unretainable.

This procedure is allowed when considerable time is necessary to determine the diagnosis and/or provide the initial treatment, before the fracture makes the tooth unretainable. Cigna will also allow this procedure for other circumstances that give justification to not completing any root canal. When submitting for payment, include a brief narrative and radiograph to confirm the incomplete service.

**D3333 – Internal root repair of perforation defects**
Nonsurgical seal of perforation caused by resorption and/or decay but not iatrogenic by health care provider filing claim.

This procedure is allowed for the nonsurgical repair of a perforation. When submitting for payment, include a brief narrative and radiograph to confirm the perforation.

**Please note:** This procedure is not covered under 02 and 03 Patient Charge Schedules.
Dental procedure policies and guidelines (continued)

Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site

**Procedure code:** D7922

**CDT nomenclature and descriptor**

D7922 – Placement of intra‑socket biological dressing to aid in hemostasis or clot stabilization, per site

This procedure can be performed at the time of and/or after extraction to aid in hemostasis. The socket is packed with a hemostatic agent to aid in hemostasis and/or clot stabilization.

**Rationale and Policy**

Cigna Dental considers the placement of intra-socket biological dressings to aid in hemostasis or clot stabilization to be part of the global process of extracting a tooth or teeth. Therefore, Cigna Dental considers D7922 to be covered and inclusive to any associated extraction(s). The Cigna Dental member may not be charged for the D7922 in these situations.

Inclusive denials may be considered for coverage upon appeal with a narrative and any supportive clinical documentation that may be requested by Cigna, for example, documentation from the patient's medical physician indicating the need and rationale for this procedure, as defined.
Dental procedure policies and guidelines (continued)
Consultation with a medical health care professional

Procedure code: D9311

CDT nomenclature and descriptor

D9311– Consultation with a medical health care professional
Treating dentist consults with a medical health care professional concerning medical issues that may affect patient’s planned dental treatment.

Policy
Cigna Dental considers any consultation with a medical health care professional to be an integral part of the process by which a dentist provides overall dental management of their patients. Therefore, Cigna Dental considers D9311 to be inclusive to any associated evaluation and/or consultation. The member may not be charged for the D9311 in these situations.
Infiltration of sustained release therapeutic drug – single or multiple sites

Procedure code: D9613

CDT nomenclature and descriptor

D9613 – Infiltration of sustained release therapeutic drug – single or multiple sites

Infiltration of sustained release pharmacologic agent for long acting surgical site pain control. Not for local anesthesia purposes.

Policy and rationale

By definition of the CDT code, D9613 is reported when a sustained release therapeutic drug is administered for pain control. The descriptor specifically indicates that the agent used must not be “for local anesthesia purposes.” At this time, reporting of the D9613 service is limited to one approved FDA agent, Exparel™, which is a liposomal encapsulated form of bupivacaine. When injected into or near the oral surgical site immediately post operatively by the dentist, this agent is purported to avoid or reduce severity of resultant pain for an extended time period.

There is limited evidence-based research at this time to confirm that the cost and effectiveness of D9613 outweighs other modalities of pain control. Therefore, D9613 is covered on the Cigna Dental Care plan as outlined below.

Administrative guidelines

Note: The nomenclature for D9613 states that it includes single or multiple sites. Therefore, the infiltration of sustained release therapeutic drugs at multiple sites should be reported as a single D9613.

Cigna Dental Care members must be thoroughly informed of the risks and benefits of all available options for post-operative pain control so they can make an informed decision based upon their individual circumstances.

D9613 may be allowable under the following conditions:

› If performed in conjunction with covered surgical extraction(s) of one or more impacted teeth, once per date of service
› If the patient is 18 years of age or older

D9613 is not allowable under the following conditions:

› For local anesthesia purposes
› For any procedures other than the surgical extraction of impacted teeth
› For patients under the age of 18

Plan limitations:

Note: There may be specific plan exclusions and/or limitations for D9613. Please refer to the member’s applicable Patient Charge Schedule under the member’s record in CignaforHCP.com or contact Customer Service at 800.Cigna24 (800.244.6224).
Dental procedure policies and guidelines (continued)

Teledentistry

Procedure codes: D9995 and D9996

CDT nomenclature and descriptor

D9995 – teledentistry – synchronous; real-time encounter
Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

D9996 – teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

Policy and Rationale

Cigna’s policy is that the appropriate teledentistry procedure code (D9995 or D9996) should be reported by the dentist who provided the oversight of the teledentistry encounter, in accordance with any applicable state laws and/or regulations and/or licensure and/or state dental practice acts.

The appropriate dental procedure codes for the actual dental services provided in conjunction with the teledentistry service(s) should be reported by the dentist or other oral health care practitioner who performed the actual delivery of services (e.g., radiographs, prophylaxes and/or other preventive dental services), in accordance with any applicable state laws and/or regulations and/or licensure and/or state dental practice acts, including direct and/or indirect supervision requirements.

According to the D9995 and D9996 - ADA Guide to Understanding and Documenting Teledentistry Events document (Version 1 – July 17, 2017), “teledentistry provides the means for a patient to receive services when the patient is in one physical location and the dentist or other oral health or general health care practitioner overseeing the delivery of those services is in another location.”

The D9995 and D9996 ADA Guide describes synchronous teledentistry (D9995) as “delivery of patient care and education where there is live two-way interaction between a person or persons (e.g., patient; dental, medical or health caregiver) at one physical location, and an overseeing supervising or consulting dentist or dental provider at another location. The communication is real-time and continuous between all participants who are working together as a group. Use of audiovisual communications technology means that all involved persons are able to see what is happening and talk about it in a natural manner.” Based upon these ADA guidelines, a telephonic exchange without a real time visual component (real time video) would not constitute an appropriate use of this code. State exceptions may apply.

The D9995 and D9996 ADA Guide describes asynchronous teledentistry (D9996) as different from D9995 in that “there is no real-time, live, continuous interaction with anyone who is not at the same physical location as the patient. Also known as store-and-forward, asynchronous teledentistry involves transmission of recorded health information (e.g., radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to another practitioner for use at a later time.”

Note: The D9995 and D9996 ADA Guide describes how a teledentistry event is affected when the health care practitioners are in different states: “A teledentistry event is subject to applicable state law, regulation or licensure. All involved persons (the dentist or other oral health or general healthcare practitioner) must determine if a teledentistry event can occur when all participants are not in the same state.”

Note: The D9995 and D9996 ADA Guide contains examples of two Coding Scenarios. In both scenarios, information is transmitted “via a HIPAA compliant (Security and Privacy) connection that uses encryption and a secure “cloud” server.”
Cigna Dental considers post-operative services to be inclusive to the primary procedure(s) and the responsibility of the treating dentist. Therefore, neither the Cigna Dental member nor Cigna may be charged for the post-operative services or for the teledentistry procedures associated with the post-operative services.

All Cigna Dental network dentists and dental specialists are responsible to insure that teledentistry services provided to Cigna Dental members are in compliance with applicable state law, regulation or licensure.

**Administrative Guidelines**

Cigna Dental Care plans provide coverage for the use of teledentistry (D9995 and D9996) at no charge to the member.

When covered, only one D9995 or D9996 is allowable per date of service.

D9995 or D9996 are covered when reported in conjunction with one or more other dental procedures that are covered by the dental plan.

Benefits for covered dental services provided through teledentistry will be determined on the same basis as though the services had been delivered via traditional office setting without the use of teledentistry.

It is Cigna’s position that teledentistry services do not include audio only or video only communications, information sent via facsimile (fax) machine, instant messages and/or electronic mail, unless required by specific state mandates.
Exclusions and limitations
01, 02 and 03 Patient Charge Schedules

Services not covered under the dental plan
Listed below are the services or expenses that are not covered under the dental plan and that are the covered person's responsibility at the dentist's usual fees. Except as set forth below, preexisting conditions are not excluded. There is no coverage for:

› Services not listed on the Patient Charge Schedule.
› Services provided by a non-network dentist without Cigna’s prior approval (except emergencies).
› Services related to an injury or illness paid under workers’ compensation, occupational disease or similar laws. (Florida residents: This exclusion relates to services paid under such 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 relating to injuries that are intentionally self-inflicted. (Ohio and Texas residents: Not excluded.)
› 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. (Maryland residents: General anesthesia is covered when medically necessary and authorized by the member’s physician.)
› Prescription drugs.
› 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); or (b) Diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), except as specifically listed on the Patient Charge Schedule.
› The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the member’s Cigna coverage. (Texas and California residents: This exclusion does not apply if otherwise covered on the applicable Patient Charge Schedule.)
› Replacement of fixed and/or removable prosthodontic 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. (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.
› Services to the extent covered person is compensated for them under any group medical plan, no-fault auto insurance policy or insured motorist policy. (Arizona and Pennsylvania residents: This exclusion does not apply. Kentucky and North Carolina residents: Services compensated under no-fault auto or insured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)

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 (excluding evaluation) by a Network Specialty Dentist.

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.

Pediatric dentistry – Coverage provided by a pediatric dentist ends on an enrolled child’s 13th birthday; however, exceptions for medical reasons may be considered on an individual basis. The Network General Dentist (NGD) shall provide care after the child’s 13th birthday.
Exclusions and limitations (continued)

04 Patient Charge Schedules

Exclusions

Listed below are the services or expenses that are not covered under the Dental Plan and that are the covered person’s responsibility at the dentist’s usual fees. Except as set forth below, preexisting conditions are not excluded. There is no coverage for:

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-network dentist without Cigna’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 relating to injuries that are intentionally self-inflicted. (Ohio and Texas residents: Services relating to injuries that are intentionally self-inflicted are not excluded.)
- 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 the applicable Patient Charge Schedule. When listed on the 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 the member’s physician.)
- Prescription drugs.
- 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 abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on the member’s Patient Charge Schedule; or (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

(California residents: The word “attrition” is modified as follows: Except for medically necessary treatment where functionality of teeth has been impaired; restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction, and the primary purpose of the restoration is to: (a) Change the vertical dimension of the occlusion; (b) Diagnose or treat abnormal condition of the TMJ; or (c) For cosmetic purposes.)

- The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the member’s Cigna coverage. (Texas and California residents: Preexisting conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the member’s coverage, are not excluded, if otherwise covered under the Patient Charge Schedule.)
- 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. (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.
- Services to the extent the covered person is compensated for them under any group medical plan, no-fault auto insurance policy or insured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no-fault auto insurance policies or insured motorist policies is 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.)
- Crowns and bridges used solely for splinting.
- Resin-bonded retainers and associated pontics.
Exclusions

Listed below are the services or expenses that are not covered under the dental plan and that are the covered person’s responsibility at the dentist’s usual fees. Except as set forth below, preexisting conditions are not excluded. There is no coverage for:

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-network dentist without Cigna’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 the applicable Patient Charge Schedule. When listed on the 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 the member’s physician).
- Prescription drugs.
- 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 abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically on the Patient Charge Schedule, or if the member’s Patient Charge Schedule ends in “-04” or higher; (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

(California residents: The word “attrition” is modified as follows: Except for medically necessary treatment where functionality of teeth has been impaired; restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction, and the primary purpose of the restoration is to: (a) Change the vertical dimension of the occlusion; (b) Diagnose or treat abnormal condition of the TMJ; or (c) For cosmetic purposes.)

- Replacement of fixed and/or removable 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. (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 coverage determination.)
- Services to the extent the covered person is compensated under any group medical plan, no-fault auto insurance policy or insured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent 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.)
Exclusions and limitations (continued)

05 Patient Charge Schedules (continued)

Exclusions (continued)

- The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the Cigna member’s coverage. (Texas and California residents: Preexisting conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the member’s coverage are not excluded, if otherwise covered under the Patient Charge Schedule.)

- Crowns and bridges used solely for splinting.

- Resin-bonded retainers and associated pontics.

Preexisting conditions are not excluded if the procedures involved are otherwise covered under the Patient Charge Schedule.

The above exclusions and limitations are subject to change, pursuant to regulatory requirements. State exceptions may apply.
Exclusions and limitations (continued)

06 Patient Charge Schedules

Services not covered under the dental plan

Listed below are the services or expenses that are not covered under the dental plan and that are the member’s 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’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) unless specifically listed on the member’s Patient Charge Schedule.
› General anesthesia, sedation and nitrous oxide, unless specifically listed on the applicable Patient Charge Schedule. When listed on the 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 the member’s physician.)
› Prescription drugs.
› 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 abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on the member’s Patient Charge Schedule, or if the member’s Patient Charge Schedule ends in “-04” or higher; (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

(California residents: The word “attrition” is modified as follows: Except for medically necessary treatment where functionality of teeth has been impaired; restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction, and the primary purpose of the restoration is to (a) Change the vertical dimension of the occlusion; (b) Diagnose or treat abnormal condition of the TMJ; or (c) For cosmetic purposes.)
› Replacement of fixed and/or removable 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. (Coverage is 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 coverage determination.)
› Services to the extent the member or their 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.)
Exclusions and limitations (continued)
06 Patient Charge Schedules (continued)

Services not covered under the dental plan (continued)

› The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the Cigna member’s coverage. (Texas residents: Preexisting conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the member’s coverage, are not excluded, if otherwise covered under the Patient Charge Schedule.)

In addition to the above, if the member’s Patient Charge Schedule number ends in “-04” or a higher number, there is no coverage for the following.

› Crowns and bridges used solely for splinting
› Resin-bonded retainers and associated pontics

Preexisting conditions are not excluded if the procedures involved are otherwise covered under the Patient Charge Schedule.

Limitations on covered services

Listed below are limitations on services covered by the dental plan.

Frequency – The frequency of certain covered services, like cleanings, is limited. The Patient Charge Schedule lists any limitations on frequency.

Pediatric dentistry – Coverage for treatment by a pediatric dentist ends on an enrolled child’s 13th birthday; however, exceptions for medical reasons may be considered on an individual basis. The Network General Dentist (NGD) will provide care after the child’s 13th birthday.

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. The Patient Charge Schedule lists any limitations on oral surgery.
Exclusions and limitations (continued)

06 Patient Charge Schedule Value Plans – Alternate Benefit Provision

Services not covered under the dental plan
Listed below are the services or expenses that are not covered under the dental plan and that are the covered person’s 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’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 the applicable Patient Charge Schedule. When listed on the 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 the member’s physician.)
- Prescription drugs.
- 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 abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on the covered person’s Patient Charge Schedule; or (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction. (California residents: The word “attrition” is modified as follows: Except for medically necessary treatment where functionality of teeth has been impaired; restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction, and the primary purpose of the restoration is to: (a) Change the vertical dimension of the occlusion; (b) Diagnose or treat abnormal condition of the TMJ; or (c) For cosmetic purposes.)
- Replacement of fixed and/or removable 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 coverage determination.)
- Services to the extent the member or their enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy or insured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no-fault auto insurance policies or insured motorist policies is 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.)
Exclusions and limitations (continued)

06 Patient Charge Schedule Value Plans – Alternate Benefit Provision (continued)

Services not covered under the dental plan (continued)

› The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the Cigna member’s coverage. (Texas residents: Preexisting conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the member’s coverage, are not excluded, if otherwise covered under the Patient Charge Schedule.)

› Crowns and bridges used solely for splinting.

› Resin-bonded retainers and associated pontics.

Preexisting conditions are not excluded if the procedures involved are otherwise covered under the member’s Patient Charge Schedule.

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.

Alternate benefit provision – If more than one service may be used to treat a dental condition, coverage will be limited to the less costly covered service provided it is a professionally accepted, necessary and appropriate method of treatment.

If treatment is provided by a Network Dentist, and the patient requests or accepts a more costly covered service, the specific Patient Charge for such service is equal to:

1. The Patient Charge for the less costly service, plus
2. The difference in cost between the usual fee for the more costly service and usual fee for the less costly service.

Limitations on covered services

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

Frequency – The frequency of certain covered services, like cleanings, is limited. The Patient Charge Schedule lists any limitations on frequency.

Pediatric dentistry – Coverage for referral to a pediatric dentist ends on an enrolled child’s 13th birthday; however, exceptions for medical reasons may be considered on an individual basis. The Network General Dentist (NGD) will provide care after the child’s 13th birthday.
Exclusions and limitations (continued)

06 Patient Charge Schedule Specialty Discount Plan – No Alternate Benefit Provision

Services not covered under the dental plan

Listed below are the services or expenses that are not covered under the dental plan and that are the covered person’s 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’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) unless specifically listed on the Patient Charge Schedule.
› General anesthesia, sedation and nitrous oxide, unless specifically listed on the applicable Patient Charge Schedule. When listed on the 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 the member’s physician.)
› Prescription drugs.
› 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 abnormal conditions of the joint (TMJ), unless TMJ therapy is specifically listed on the member’s Patient Charge Schedule; or (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

(California residents: The word “attrition” is modified as follows: Except for medically necessary treatment where functionality of teeth has been impaired; restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction, and the primary purpose of the restoration is to: (a) Change the vertical dimension of the occlusion; (b) Diagnose or treat abnormal condition of the TMJ; or (c) For cosmetic purposes.)

› Replacement of fixed and/or removable 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 coverage determination.)
› Services to the extent the member or their enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy or insured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plans, no-fault auto insurance policies or insured motorist policies is 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.)
Exclusions and limitations (continued)

06 Patient Charge Schedule Specialty Discount Plan – No Alternate Benefit Provision (continued)

Services not covered under the dental plan (continued)

› The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the Cigna member’s coverage. (Texas residents: Preexisting conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the member’s coverage, are not excluded, if otherwise covered under the Patient Charge Schedule.)

› Crowns and bridges used solely for splinting.

› Resin-bonded retainers and associated pontics.

› Specialty care services performed by a Network Specialty Dentist. For specialty care services listed on the Patient Charge Schedule and performed by a Network Specialty Dentist, the member will be responsible for paying total contract fees, which are a discount from the dentist’s usual fees, to the Network Specialty Dentist. Preexisting conditions are not excluded if the procedures involved are otherwise covered under the member’s Patient Charge Schedule.

Limitations on covered services

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

Frequency – The frequency of certain covered services, like cleanings, is limited. The member’s Patient Charge Schedule lists any limitations on frequency.

Covered services – Procedures are only covered at the fees listed on the member’s Patient Charge Schedule when they are performed by a Network General Dentist (NGD).

Oral surgery – Contract fees for the surgical removal of an impacted wisdom tooth may not be available if the tooth is not diseased or the removal is only for orthodontic reasons. The member’s Patient Charge Schedule lists any limitations on oral surgery.
Exclusions and limitations (continued)

06 Patient Charge Schedule Specialty Discount Plan – Alternate Benefit Provision

**Services not covered under the dental plan**

Listed below are the services or expenses that are not covered under the dental plan and that are the covered person’s 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’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) unless specifically listed on the member’s Patient Charge Schedule.
- General anesthesia, sedation and nitrous oxide, unless specifically listed on the applicable Patient Charge Schedule. When listed on the 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 the member’s physician.)
- Prescription drugs.
- 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 abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on the member’s Patient Charge Schedule; or (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction. (California residents: The word “attrition” is modified as follows: except for medically necessary treatment where functionality of teeth has been impaired; restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction, and the primary purpose of the restoration is to: (a) Change the vertical dimension of the occlusion; (b) Diagnose or treat abnormal condition of the TMJ; or (c) For cosmetic purposes.)
- Replacement of fixed and/or removable 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 coverage determination.)
- Services to the extent the member or their enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy or insured motorist policy. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no-fault auto insurance policies or insured motorist policies is 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.)
Exclusions and limitations (continued)

06 Patient Charge Schedule Specialty Discount Plan – Alternate Benefit Provision (continued)

Services not covered under the dental plan (continued)

› The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the Cigna member’s coverage. (Texas residents: Preexisting conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your coverage, are not excluded, if otherwise covered under the member’s Patient Charge Schedule.)

› Crowns and bridges used solely for splinting.

› Resin-bonded retainers and associated pontics.

› Specialty care services performed by a Network Specialty Dentist. For specialty care services listed on the Patient Charge Schedule and performed by a Network Specialty Dentist, the member will be responsible for paying total contract fees, which are a discount from the dentist’s usual fees, to the Network Specialty Dentist.

Preexisting conditions are not excluded if the procedures involved are otherwise covered under the member’s Patient Charge Schedule.

Limitations on covered services

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

Frequency – The frequency of certain covered services, like cleanings, is limited. The member’s Patient Charge Schedule lists any limitations on frequency.

Covered services – Procedures are only covered at the fees listed on the member’s Patient Charge Schedule when they are performed by a Network General Dentist (NGD).

Oral surgery – Contract fees for the surgical removal of an impacted wisdom tooth may not be available if the tooth is not diseased or the removal is only for orthodontic reasons. The Patient Charge Schedule lists any limitations on oral surgery.

Alternate benefit provision – If more than one service may be used to treat a dental condition, coverage will be limited to the less costly covered service provided it is a professionally accepted, necessary and appropriate method of treatment.

If treatment is provided by a Network Dentist, and the patient requests or accepts a more costly covered service, the specific Patient Charge for such service is equal to:

1. The Patient Charge for the less costly service, plus
2. The difference in cost between the usual fee for the more costly service and usual fee for the less costly service
Exclusions and limitations (continued)
07 Patient Charge Schedules

**Services not covered under the dental plan**

Listed below are the services or expenses that are not covered under the dental plan and that are the responsibility of the member 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’s prior approval (except emergencies).
- Services related to an injury or illness paid under workers’ compensation, occupational disease or similar laws. (North Carolina residents: Services or supplies for the treatment of an occupational injury or sickness that are paid under the North Carolina Workers’ Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers’ compensation insurance carrier, according to a final adjudication under the North Carolina Workers’ Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ Compensation Act.)
- 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) unless specifically listed on the member’s Patient Charge Schedule. If bleaching (tooth whitening) is listed on the member’s Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- General anesthesia, sedation and nitrous oxide, unless specifically listed on the applicable Patient Charge Schedule. When listed on the 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 a physician.) There is no coverage for general anesthesia or IV sedation when used for the purposes of anxiety control or patient management.
- Prescription drugs.
- 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 the member’s Patient Charge Schedule, or if the Patient Charge Schedule ends in “-04” or higher; (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or (d) Restore the occlusion. (Connecticut residents: Part (b) reads as follows: Diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on the Patient Charge Schedule. California residents: The word “attrition” is modified as follows: Except for medically necessary treatment where functionality of teeth has been impaired; restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction, and the primary purpose of the restoration is to: (a) Change the vertical dimension of the occlusion; (b) Diagnose or treat abnormal condition of the TMJ; or (c) For cosmetic purposes.)
- 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.
- Services associated with the placement, repair, removal or prosthodontic restoration of a dental implant, or any other services related to implants.
- Services considered to be unnecessary or experimental in nature, or do not meet commonly accepted dental standards.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- 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 coverage determination.)
Exclusions and limitations (continued)

Services not covered under the dental plan (continued)

› Services to the extent the member or their 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.)

› The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the Cigna member’s coverage. (California and Texas residents: Preexisting conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the member’s coverage, are not excluded if otherwise covered under the Patient Charge Schedule.)

› Consultations and/or evaluations associated with services that are not covered.

› Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis. (Connecticut residents: Exclusion does not apply if dentally necessary.)

› 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.

› Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

› Services performed by a prosthodontist.

› Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

› Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service.

› Infection control and/or sterilization. Cigna considers this to be incidental to, and part of, the charges for services provided and not separately chargeable.

› The recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement. Cigna considers recementation within this time frame to be incidental to, and part of, the charges for the initial restoration.

› Services to correct congenital malformations, including the replacement of congenitally missing teeth. (North Carolina residents: This exclusion does not apply.)

› The replacement of an occlusal guard (night guard) beyond one per any 24-consecutive-month period. In addition to the above, if the member’s Patient Charge Schedule number ends in “-04” or a higher number, there is no coverage for the following.

› Crowns and bridges used solely for splinting

› Resin-bonded retainers and associated pontics

Preexisting conditions are not excluded if the procedures involved are otherwise covered under the member’s 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.

Limitations on covered services

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

Frequency - The frequency of certain covered services, like cleanings, is limited. The member’s Patient Charge Schedule lists any limitations on frequency. (Texas residents: If the Network General Dentist (NGD) certifies to Cigna that, due to medical necessity, the member requires certain covered services more frequently than the limitation allows, Cigna may waive the applicable limitation.)
Exclusions and limitations (continued)

07 Patient Charge Schedules (continued)

Limitations on covered services (continued)

**Pediatric dentistry** – Coverage for treatment by a pediatric dentist ends on an enrolled child’s 13th birthday. Effective on the child’s 13th birthday, dental services must be obtained from an NGD; however, exceptions for medical reasons may be considered on an individual basis.

**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. The member’s Patient Charge Schedule lists any limitations on oral surgery.

**Periodontal services** (gum tissue and supporting bone) – 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.

**Clinical oral evaluations** – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations and oral evaluations for patients under 3 years of age are limited to a total of four evaluations during a 12-consecutive-month period.

General limitations – Dental benefits

No payment will be made for expense 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 that would not have been made in any facility other than a hospital or a correctional institution owned or operated by the U.S. 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 charges the person is not legally required to pay.

› For charges that would not have been made if the person had no insurance.

› Due to injuries which are intentionally self-inflicted.
Services not covered under the dental plan

Listed below are the services or expenses that are not covered under the dental plan and that are the member’s 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’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), unless listed on the member’s Patient Charge Schedule. If bleaching (tooth whitening) is listed on the Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
› General anesthesia, sedation and nitrous oxide, unless specifically listed on the applicable Patient Charge Schedule. When listed on the 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 the member’s physician.) There is no coverage for general anesthesia or IV sedation when used for the purposes of anxiety control or patient management.
› Prescription drugs.
› 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 or disorders of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on the member’s Patient Charge Schedule or, if the Patient Charge Schedule ends in “-04” or higher; (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or (d) Restore the occlusion. (Connecticut residents: Part (b) reads as follows: Diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on the Patient Charge Schedule. California residents: The word “attrition” is modified as follows: Except for medically necessary treatment where functionality of teeth has been impaired; restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction, and the primary purpose of the restoration is to: (a) Change the vertical dimension of the occlusion; (b) Diagnose or treat abnormal condition of the TMJ; or (c) For cosmetic purposes.)
› 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.
› Services associated with the placement, repair, removal or prosthodontic restoration of a dental implant, or any other services related to implants.
› Services considered to be unnecessary or experimental in nature or that do not meet commonly accepted dental standards.
› 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 General 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 the member or their 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.)
Exclusions and limitations (continued)

07 Patient Charge Schedules – Specialty Discount Plans (continued)

Services not covered under the dental plan (continued)

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.

The completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the Cigna member’s coverage. (California and Texas residents: Preexisting conditions, including the completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of the member’s coverage, are not excluded, if otherwise covered under the Patient Charge Schedule.)

Consultations and/or evaluations associated with services that are not covered.

Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.

Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, or when performed in conjunction with an apicoectomy or periapical surgery.

Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

Services performed by a prosthodontist.

Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service.

Infection control and/or sterilization. Cigna considers this to be incidental to, and part of, the charges for services provided and not separately chargeable.

The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna considers recementation within this time frame to be incidental to, and part of, the charges for the initial restoration.

Services to correct congenital malformations, including the replacement of congenitally missing teeth.

The replacement of an occlusal guard (night guard) beyond one per any 24-consecutive-month period.

In addition to the above, if the member’s Patient Charge Schedule number ends in “-04” or a higher number, there is no coverage for the following.

Crowns and bridges used solely for splinting

Resin-bonded retainers and associated pontics

Preexisting conditions are not excluded if the procedures involved are otherwise covered under the member’s 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.

Limitations on covered services

Listed below are limitations on services covered by the dental plan:

Frequency – The frequency of certain covered services, like cleanings, is limited. The Patient Charge Schedule lists any limitations on frequency.

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. The Patient Charge Schedule lists any limitations on oral surgery.

Periodontal services (gum tissue and supporting bone) – 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.

Clinical oral evaluations – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations and oral evaluations for patients under 3 years of age are limited to a total of four evaluations during a 12-consecutive-month period.

Specialty care – Payment for care received from a Network Specialty Dentist is not provided by this plan. The member will be responsible for contract fees for care received from a Network Specialty Dentist.
Exclusions and limitations (continued)
07 Patient Charge Schedules – Specialty Discount Plans (continued)

General limitations – Dental benefits
No payment will be made for expense 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 U.S. 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 charges which the person is not legally required to pay.
› For charges which would not have been made if the person had no insurance.
› For injuries that are intentionally self-inflicted.
Services not covered under the 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:

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-network dentist without Cigna Dental’s prior approval (except emergencies, as described in Section IV.F).
- 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) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- 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 IV sedation when used for the purposes of anxiety control or patient management.
- Prescription drugs.
- 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; or (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen or damaged due to patient abuse, misuse or neglect.
- 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.
- Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network General 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 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.)
- 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:...
Exclusions and limitations (continued)

08 Patient Charge Schedules (continued)

Services not covered under the dental plan (continued)

- Preexisting 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.
- Consultations and/or evaluations associated with services that are not covered.
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, or when performed in conjunction with an apicoectomy or periradicular surgery.
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- Services performed by a prosthodontist.
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service.
- Infection control and/or sterilization. Cigna Dental considers this to be incidental to, and part of, the charges for services provided and not separately chargeable.
- 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 time frame to be incidental to, and part of, the charges for the initial restoration.
- Services to correct congenital malformations, including the replacement of congenitally missing teeth.
- The replacement of an occlusal guard (night guard) beyond one per any 24-consecutive-month period.
- Crowns, bridges and/or implant-supported prosthesis used solely for splinting.
- Resin-bonded retainers and associated pontics.
- Preexisting 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.

Limitations on covered services

Listed below are limitations on services covered by the dental plan.

Frequency – The frequency of certain covered services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

Pediatric dentistry – Coverage for treatment by a Pediatric Dentist ends on your child’s 13th birthday. Effective on your child’s 13th birthday, dental services must be obtained from a Network General Dentist. However, exceptions for medical reasons may be considered on an individual basis.

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.

Periodontal services (gum tissue and supporting bone) – 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.

Clinical oral evaluations – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations and oral evaluations for patients under 3 years of age are limited to a total of four evaluations during a 12-consecutive-month period.
General limitations – Dental benefits

No payment will be made for expense 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 U.S. 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 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.
Exclusions and limitations (continued)

08 Patient Charge Schedules – Specialty Discount Plans

**Services not covered under the 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:

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-network dentist without Cigna Dental’s prior approval (except emergencies, as described in Section IV.F).
- 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), unless listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- 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 IV sedation when used for the purposes of anxiety control or patient management.
- Prescription drugs.
- 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 or disorders 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; or (c) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction. (California residents: 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 appliances (including fixed and removable orthodontic appliances) that have been lost, stolen or damaged due to patient abuse, misuse or neglect.
- 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.
- Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network General 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 enrolled dependent are compensated under any group medical plan. (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.)
Exclusions and limitations (continued)

08 Patient Charge Schedules – Specialty Discount Plans (continued)

Services not covered under the dental plan (continued)

› 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: Preexisting 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.)

› Consultations and/or evaluations associated with services that are not covered.

› Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.

› Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery.

› Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

› Services performed by a prosthodontist.

› Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.

› Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service.

› Infection control and/or sterilization. Cigna Dental considers this to be incidental to, and part of, the charges for services provided and not separately chargeable.

› 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 time frame to be incidental to, and part of, the charges for the initial restoration.

› Services to correct congenital malformations, including the replacement of congenitally missing teeth.

› The replacement of an occlusal guard (night guard) beyond one per any 24-consecutive-month period.

› Crowns, bridges and/or implant-supported prosthesis used solely for splinting.

› Resin-bonded retainers and associated pontics. Preexisting 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.

Limitations on covered services

Listed below are limitations on services covered by your dental plan.

Frequency – The frequency of certain covered services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

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.

Periodontal services (gum tissue and supporting bone) – 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.

Clinical oral evaluations – Periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations and oral evaluations for patients under 3 years of age are limited to a total of four evaluations during a 12-consecutive-month period.
Exclusions and limitations (continued)

08 Patient Charge Schedules – Specialty Discount Plans (continued)

Limitations on covered services (continued)

Specialty care – Payment for care received from a Network Specialty Dentist is not provided by this plan. You will be responsible for contract fees for care received from a Network Specialty Dentist.

General limitations – Dental benefits

No payment will be made for expense 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 run by the U.S. 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 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.
Services not covered under the 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:

› Services not listed on the Patient Charge Schedule.
› Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in Section IV.F).
› 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) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
› 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 IV sedation when used for the purposes of anxiety control or patient management.
› Prescription medications.
› Procedures, appliances or restorations if the main purpose is to: (a) Change vertical dimension (degree of separation of the jaw when teeth are in contact); or (b) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
› Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen or damaged due to patient abuse, misuse or neglect.
› 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, unless specifically listed on your Patient Charge Schedule.
› Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
› Procedures or appliances for minor tooth guidance or to control harmful habits.
› Hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network General 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 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.)
› The completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
› The completion of implant-supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
Exclusions and limitations (continued)
09 Patient Charge Schedules (continued)

Services not covered under the dental plan (continued)

- Consultations and/or evaluations associated with services that are not covered.
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- Services performed by a prosthodontist.
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service.
- Infection control and/or sterilization. Cigna Dental considers this to be incidental to, and part of, the charges for services provided and not separately chargeable.
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this time frame to be incidental to, and part of, the charges for the initial restoration.
- The recementation of any implant-supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this time frame to be incidental to, and part of, the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- Services to correct congenital malformations, including the replacement of congenitally missing teeth.

- The replacement of an occlusal guard (night guard) beyond one per any 24-consecutive-month period, when this limitation is noted on the Patient Charge Schedule.
- Crowns, bridges and/or implant-supported prosthesis used solely for splinting.
- Resin-bonded retainers and associated pontics. Preexisting 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.

Limitations on covered services

Listed below are limitations on services when covered by your dental plan.

Frequency – The frequency of certain covered services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

Pediatric dentistry – Coverage for treatment by a Pediatric Dentist ends on your child’s 13th birthday. Effective on your child’s 13th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.

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.

Periodontal services (gum tissue and supporting bone) – 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.
Limitations on covered services (continued)

Clinical oral evaluations - When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations and oral evaluations for patients under 3 years of age are limited to a combined total of four evaluations during a 12-consecutive-month period.

Surgical placement of implant services - When covered on the Patient Charge Schedule, 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 are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

Prosthesis over implant - When covered on the Patient Charge Schedule, a prosthetic device supported by an implant or implant abutment, is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least five calendar years old, is not serviceable and cannot be repaired.

General limitations - Dental benefits

No payment will be made for expense 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 U.S. 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 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.
Exclusions and limitations (continued)

09 Patient Charge Schedules – Specialty Discount Plans

Services not covered under the 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:

› Services not listed on the Patient Charge Schedule.
› Services provided by a non-network dentist without Cigna Dental’s prior approval (except emergencies, as described in Section IV.F).
› 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), unless listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
› 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 IV sedation when used for the purposes of anxiety control or patient management.
› Prescription medications.
› Procedures, appliances or restorations if the main purpose is to: (a) Change vertical dimension (degree of separation of the jaw when teeth are in contact); or (b) Restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.
› Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen or damaged due to patient abuse, misuse or neglect.
› 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, unless specifically listed on your Patient Charge Schedule.
› Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
› Procedures or appliances for minor tooth guidance or to control harmful habits.
› Hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network General 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 enrolled dependent are compensated under any group medical plan. (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.)
› The completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.
› The completion of implant-supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.
› Consultations and/or evaluations associated with services that are not covered.
Services not covered under the dental plan (continued)

- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your Patient Charge Schedule.
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- Services performed by a prosthodontist.
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service.
- Infection control and/or sterilization. Cigna Dental considers this to be incidental to, and part of, the charges for services provided and not separately chargeable.
- The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this time frame to be incidental to, and part of, the charges for the initial restoration.
- The recementation of any implant-supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this time frame to be incidental to, and part of, the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.
- Services to correct congenital malformations, including the replacement of congenitally missing teeth.

- The replacement of an occlusal guard (night guard) beyond one per any 24-consecutive-month period, when this limitation is noted on the Patient Charge Schedule.
- Crowns, bridges and/or implant-supported prosthesis used solely for splinting.
- Resin-bonded retainers and associated pontics.

Preexisting 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.

Limitations on covered services

Listed below are limitations on services when covered by your dental plan.

Frequency - The frequency of certain covered services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

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.

Periodontal services (gum tissue and supporting bone) - 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.

Clinical oral evaluations - When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations and oral evaluations for patients under 3 years of age are limited to a combined total of four evaluations during a 12-consecutive-month period.
Exclusions and limitations (continued)

09 Patient Charge Schedules – Specialty Discount Plans (continued)

Limitations on covered services (continued)

Specialty care – Payment for care received from a Network Specialty Dentist is not provided by this plan. You will be responsible for contract fees for care received from a Network Specialty Dentist.

Surgical placement of implant services – When covered on the Patient Charge Schedule, 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 are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

Prosthesis over implant – When covered on the Patient Charge Schedule, a prosthetic device supported by an implant or implant abutment, is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least five calendar years old, is not serviceable and cannot be repaired.

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 U.S. 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 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.
Contact information

All of the phone numbers and addresses that you may need to contact Cigna Dental are listed below.* Please note that, based on the patient’s ID card, call, claim, and service channels may differ.

<table>
<thead>
<tr>
<th>If you want to:</th>
<th>Use the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit your claims:</td>
<td>Submit patient encounters/claims electronically using Cigna payer ID <strong>62308</strong>.</td>
</tr>
<tr>
<td></td>
<td><strong>Submit paper patient encounters/claims to:</strong></td>
</tr>
<tr>
<td></td>
<td>General Practitioners: Cigna</td>
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<tr>
<td></td>
<td>PO Box 188046</td>
</tr>
<tr>
<td></td>
<td>Chattanooga, TN 37422-8046</td>
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<tr>
<td></td>
<td>Attn: Claims</td>
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<tr>
<td></td>
<td>Specialists: Cigna</td>
</tr>
<tr>
<td></td>
<td>PO Box 188045</td>
</tr>
<tr>
<td></td>
<td>Chattanooga, TN 37422-8045</td>
</tr>
<tr>
<td></td>
<td>Attn: Claims</td>
</tr>
<tr>
<td><strong>Access Cigna for Health Care Professionals website for online transactions</strong>**</td>
<td>Cigna for Health Care Professionals website at <a href="CignaforHCP.com">CignaforHCP.com</a></td>
</tr>
<tr>
<td>› Verify patient eligibility</td>
<td><strong>Dental Office Change Forms available online:</strong></td>
</tr>
<tr>
<td>› Check patient coverage and covered services</td>
<td><strong>Dentist Change Form:</strong> Use this form to change your office or mailing address, Taxpayer Identification Number (TIN) or “Payable to” name. (This form should only be used to report dental office changes, <strong>not</strong> to add a new location.)</td>
</tr>
<tr>
<td>› Get copies of the applicable Patient Charge Schedule under the member’s record</td>
<td><strong>W-9:</strong> Complete this form if you change your TIN or “payable to” name, and accompany it with a <strong>Dentist Change Form</strong>.</td>
</tr>
<tr>
<td>› View claim details and payment information</td>
<td><strong>New/Additional Location Form:</strong> Use this form to add a new/additional location to your existing contract with Cigna.</td>
</tr>
<tr>
<td>› Download/print explanation of payments</td>
<td><strong>Direct Deposit Authorization Form:</strong> If you change your TIN, address, or “payable to” name, and receive electronic funds transfer (EFT) payments from Cigna, you will need to complete this form with the new information.</td>
</tr>
<tr>
<td>› View payment guidelines</td>
<td>Refer to <a href="Cigna.com/EDIvendors">Cigna.com/EDIvendors</a> for a list of directly connected Cigna vendors.</td>
</tr>
<tr>
<td>› Obtain a Cigna Dental Care Dental Office Reference Guide according to your specialty</td>
<td></td>
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<tr>
<td>› Download and print Cigna Dental Care office management and financial reports</td>
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<tr>
<td>› Get forms for dental office changes</td>
<td></td>
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<tr>
<td>› Enroll for or make changes to EFT</td>
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<tr>
<td>› View the Cigna Network Rewards Program* vendors and discounts</td>
<td></td>
</tr>
<tr>
<td>› Other information resources</td>
<td></td>
</tr>
<tr>
<td><strong>Make Electronic Data Interchange (EDI) transactions using a multi-payer website or vendor</strong>**</td>
<td></td>
</tr>
<tr>
<td>› Verify patient eligibility</td>
<td></td>
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<tr>
<td>› Check patient coverage and covered services</td>
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<tr>
<td>› Submit claims electronically</td>
<td></td>
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<tr>
<td>› Check the status of a claim</td>
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<tr>
<td>› Receive electronic remittance advices</td>
<td></td>
</tr>
<tr>
<td>› View list of EDI vendors</td>
<td></td>
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</tbody>
</table>
## Contact information (continued)

<table>
<thead>
<tr>
<th>If you want to:</th>
<th>Use the following:</th>
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</thead>
<tbody>
<tr>
<td><strong>If you want to:</strong></td>
<td><strong>Use the following:</strong></td>
</tr>
<tr>
<td>Make telephone inquiries through the Cigna Customer Service Center**</td>
<td>Call the Customer Service Center toll-free at <strong>800.Cigna24 (800.244.6224)</strong> or the number on the patient's ID card to speak to a Customer Service Associate.</td>
</tr>
<tr>
<td>› Verify patient eligibility and coverage</td>
<td></td>
</tr>
<tr>
<td>› Check the status of a claim</td>
<td></td>
</tr>
<tr>
<td>Obtain assistance specifically tailored to the needs of a health care provider if escalation of an issue is necessary or if there are any network participation issues**</td>
<td>Contact the Cigna Dental Provider Services Unit (PSU) at: <strong>800.Cigna24 (800.244.6224)</strong></td>
</tr>
<tr>
<td>› Dental office changes</td>
<td>Through the voice prompts, identify yourself as a health care professional, enter your tax identification number, request contracting, and identify yourself as a dental caller.</td>
</tr>
<tr>
<td>› Direct deposit/EFT</td>
<td>Or send an email to: <a href="mailto:ProviderServiceUnitDental@Cigna.com">ProviderServiceUnitDental@Cigna.com</a></td>
</tr>
<tr>
<td>› Copies of contracts</td>
<td></td>
</tr>
<tr>
<td>› Copies of Patient Charge Schedules and/or other reimbursement arrangements</td>
<td></td>
</tr>
<tr>
<td>› Missing Cigna Dental Care checks</td>
<td></td>
</tr>
<tr>
<td>› Status of applications</td>
<td></td>
</tr>
<tr>
<td>› Office not listed in directory</td>
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<tr>
<td>› Other consultations</td>
<td></td>
</tr>
<tr>
<td>Join a Cigna Dental network or add a new health care provider to your office:</td>
<td>Send an email to: <a href="mailto:DentistEnrollment@Cigna.com">DentistEnrollment@Cigna.com</a></td>
</tr>
</tbody>
</table>
| Recredentialing applications and inquiries:                                 | **Phone:** 1.855.629.8584  
**Fax:** 1.860.263.3938  
dental.recredentialing@cigna.com                                      |
| Escalate claims only (not for initial claim submission):                    | **Send an email to:** DentalHCPInquiry@Cigna.com                                   |
| Appeal/Complaints                                                            | **Send a written request to:**                                                    |
|                                                                            | Cigna  
National Appeal Unit  
PO Box 188047  
Chattanooga, TN 37422-8047                                                    |
| Further escalate the following transactions:                                | **Contact your designated Provider Relations Manager.**                          |
| › Claims                                                                    | For territory assignments, log in to **CignaforHCP.com > Resources > Dental Resources > Doing Business with Cigna > Provider Relations Team** |
| › Other consultations                                                       |                                                                                   |
| Advanced assistance with the administration of the DPPO and Cigna Dental Care* products within your office | **Professional Relations Manager**                                                |
|                                                                            | Contracted dental providers have access to a dedicated Professional Relations Manager. To find yours, log in to **CignaforHCP.com > Resources > Dental Resources > Doing Business with Cigna > Professional Relations Team** |

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*Excluding customers with third party administrator plans.  
**Not all transactions are available for all Cigna plans.
Notes
“Cigna Dental Care” is a brand name 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 (including Dental HMO plans), and plans with open access features. The Cigna Dental Care plan may not be available in all states.

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