**UnitedHealthcare Insurance Company (30100)®** Dental Plan

**Contributory Options PPO 20 / covered dental services** New Standard/5P745/MAC - FS74

| | NON-ORTHODONTICS | | ORTHODONTICS | |
|---|---|---|---|---|
| | NETWORK | NON-NETWORK | NETWORK | NON-NETWORK |
| **Individual Annual Deductible** | $50 | $50 | $0 | $0 |
| **Family Annual Deductible** | $150 | $150 | $0 | $0 |
| Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum) | $1,000 per person per Calendar Year | $1,000 per person per Calendar Year | $1,000 per person per Lifetime | $1,000 per person per Lifetime |
| New enrollee's waiting period | None | | | |
| **Annual deductible applies to preventive and diagnostic services** | | | No (In Network | No (Out Network) |
| **Annual Deductible Applies to Orthodontic Services** | | | No | |
| **Orthodontic Eligibility Requirement** | | | Child Only (Up to Age 19) | |
| **CMM-Annual Roll-Over** | | | Yes | |

| **COVERED SERVICES *** | **NETWORK PLAN PAYS**** | **NON-NETWORK PLAN PAYS***** | **BENEFIT GUIDELINES** |
|---|---|---|---|
| **DIAGNOSTIC SERVICES** | | | |
| Periodic Oral Evaluation | 100% | See Fee Schedule | See Exclusions and Limitations section for benefit guidelines. |
| Radiographs | 100% | | |
| Lab and Other Diagnostic Tests | 100% | | |
| **PREVENTIVE SERVICES** | | | |
| Prophylaxis (Cleaning) | 100% | See Fee Schedule | See Exclusions and Limitations section for benefit guidelines. |
| Fluoride Treatment (Preventive) | 100% | | |
| Sealants | 100% | | |
| Space Maintainers | 100% | | |
| **BASIC SERVICES** | | | |
| Restorations (Amalgams or Composite) | 50% | See Fee Schedule | See Exclusions and Limitations section for benefit guidelines. |
| Emergency Treatment/General Services | 50% | | |
| Simple Extractions | 50% | | |
| Oral Surgery (incl. surgical extractions) | 50% | | |
| Periodontics | 50% | | |
| Endodontics | 50% | | |
| **MAJOR SERVICES** | | | |
| Inlays/Onlays/Crowns | 50% | See Fee Schedule | See Exclusions and Limitations section for benefit guidelines. |
| Dentures and Removable Prosthetics | 50% | | |
| Fixed Partial Dentures (Bridges) | 50% | | |
| Implants | 50% | | |
| **ORTHODONTIC SERVICES** | | | |
| Diagnose or correct misalignment of the teeth or bite | 50% | See Fee Schedule | |

# This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.
***The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider. For a complete list of amounts, please refer to your Certificate of Coverage.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

*The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.*

*UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.*

## UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

A. Necessary;

B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment, and

D. Not excluded as described in the Section entitled. General Exclusions.

**GENERAL LIMITATIONS**

1 PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

5 DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.

10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

11 INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

12 CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

13 POST AND CORES Covered only for teeth that have had root canal therapy.

14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.

23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.

24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

25 GENERAL ANESTHESIA Covered only when clinically necessary.

26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

29 CONE BEAM Limited to 1 time per consecutive 60 months.

**GENERAL EXCLUSIONS**

The following are not covered:

1 Dental Services that are not Necessary.

2 Hospitalization or other facility charges.

3 Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

4 Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

5 Any Dental Procedure not directly associated with dental disease.

6 Any Dental Procedure not performed in a dental setting.

7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

8 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

9 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

10 Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

11 Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

12 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

13 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

14 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

15 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

16 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

17 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

18 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

19 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

20 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situsued in the state of Arizona, in order to comply with state regulations.

21 Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

22 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

23 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

24 Foreign Services are not Covered unless required as an Emergency.

25 Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

26 Services for injuries or conditions covered by Worker’s Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

**UnitedHealthcare®**

**Dental Services**
**NJ 5P745 / FS74**

| ADA CODE AND DESCRIPTION | PLAN PAYS |
|---|---|
| D0120 PERIODIC ORAL EVALUATION EST PT | $20.00 |
| D0140 LTD ORAL EVALUATION - PROBLEM FOCUS | $32.00 |
| D0145 ORAL EVAL PT<3 AND COUNSEL | $24.80 |
| D0150 COMP ORAL EVALUATION - NEW/EST PT | $28.80 |
| D0160 DTL & EXT ORAL EVAL - PROBLEM FOCUS REPORT | $56.80 |
| D0170 RE-EVALUATION - LTD PROBLEM FOCUSED | $25.60 |
| D0171 RE-EVALUATION – POST-OPERATIVE OFFICE VISIT | $30.40 |
| D0180 COMP PERIODONTAL EVAL - NEW/EST PT | $26.40 |
| D0190 SCREENING OF A PATIENT | $30.40 |
| D0191 ASSESMENT OF A PATIENT | $30.40 |
| D0210 INTRAORAL - COMPLETE SERIES RADIOGRAPHIC IMAGES | $60.00 |
| D0220 INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE | $10.40 |
| D0230 INTRAORAL PERIAPICAL EACH ADD RADIOGRAPHIC IMAGE | $8.00 |
| D0240 INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE | $15.20 |
| D0250 EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE | $24.00 |
| D0251 EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE | $24.00 |
| D0260 EXTRAORAL - EACH ADDITIONAL RADIOGRAPHIC IMAGE | $20.00 |
| D0270 BITEWING - SINGLE RADIOGRAPHIC IMAGE | $8.80 |
| D0272 BITEWINGS - TWO RADIOGRAPHIC IMAGE | $16.80 |
| D0273 BITEWINGS - THREE RADIOGRAPHIC IMAGE | $21.60 |
| D0274 BITEWINGS - FOUR RADIOGRAPHIC IMAGE | $25.60 |
| D0277 VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGE | $36.80 |
| D0330 PANORAMIC RADIOGRAPHIC IMAGE | $47.20 |
| D0340 2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS | $35.50 |
| D0350 2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY | $28.00 |
| D0351 3D PHOTOGRAPHIC IMAGE | $28.00 |
| D0364 CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW | $64.20 |
| D0365 CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE | $64.20 |
| D0366 CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA | $64.20 |
| D0367 CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS | $64.20 |
| D0380 CONE BEAM CT IMAGE CAPTURE WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW | $64.20 |
| D0381 CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE | $64.20 |
| D0382 CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA | $36.30 |
| D0383 CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS | $64.20 |
| D0414 LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT | $57.60 |
| D0415 COLLECT MICROORGANISMS CULT & SENS | $57.60 |
| D0416 VIRAL CULTURE | $57.60 |
| D0421 GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASE | $57.60 |
| D0431 ADJUNCT PREDX TST NO CYTOL/BX PROC | $36.80 |
| D0460 PULP VITALITY TESTS | $20.00 |
| D0470 DIAGNOSTIC CASTS | $44.00 |
| D0601 CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW | $24.80 |
| D0602 CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE | $24.80 |
| D0603 CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH | $24.80 |
| D1110 PROPHYLAXIS - ADULT 1 | $41.60 |
| D1120 PROPHYLAXIS - CHILD 1 | $31.20 |
| D1206 TOPICALFLUORIDE VARNISH | $24.80 |
| D1208 TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH | $20.00 |
| D1351 SEALANT - PER TOOTH | $21.60 |
| D1352 PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH | $21.60 |
| D1353 SEALANT REPAIR – PER TOOTH | $10.80 |
| D1510 SPACE MAINTAINER - FIXED, UNILATERAL/QUAD | $169.60 |
| D1516 SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY | $257.60 |
| D1517 SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR | $257.60 |
| D1520 SPACE MAINTAINER - REMOVABLE-UNILATERAL/QUAD | $211.20 |
| D1526 SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY | $278.40 |
| D1527 SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR | $278.40 |
| D1551 RECEM/REBOND BILATERAL SPACE MAINTAINER – MAXIL | $26.40 |
| D1552 RECEM/REBOND BILATERAL SPACE MAINTAINER – MANDIB | $26.40 |
| D1553 RECEM/REBOND UNILATERAL SPACE MAINTAINER/QUAD | $26.40 |
| D1556 REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER/QUAD | $26.40 |
| D1557 REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXIL | $26.40 |
| D1558 REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIB | $26.40 |
| D1575 DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL/QUAD | $169.60 |
| D2140 AMALGAM - ONE SURFACE PRIMARY/PERM | $17.70 |
| D2150 AMALGAM - TWO SURFACES PRIMARY/PERM | $23.10 |
| D2160 AMALGAM - 3 SURFACES PRIMARY/PERM | $28.80 |
| D2161 AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT | $34.50 |
| D2330 RESIN COMPOSITE - ONE SURFACE ANTERIOR | $22.80 |
| D2331 RESIN COMPOSITE - 2 SURFACES ANTERIOR | $28.50 |
| D2332 RESIN COMPOSITE - 3 SURFACES ANTERIOR | $36.00 |
| D2335 RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG | $39.60 |
| D2390 RESIN COMPOSITE CROWN ANTERIOR | $33.00 |
| D2410 GOLD FOIL - ONE SURFACE | $89.70 |
| D2420 GOLD FOIL - TWO SURFACES | $110.10 |
| D2430 GOLD FOIL - THREE SURFACES | $156.00 |

| ADA CODE AND DESCRIPTION | PLAN PAYS |
|---|---|
| D2510 INLAY - METALLIC - ONE SURFACE | $116.70 |
| D2520 INLAY - METALLIC - TWO SURFACES | $132.30 |
| D2530 INLAY - METALLIC - 3/MORE SURFACES | $159.90 |
| D2542 ONLAY - METALLIC - TWO SURFACES | $162.90 |
| D2543 ONLAY - METALLIC THREE SURFACES | $170.70 |
| D2544 ONLAY - METALLIC FOUR OR MORE SURFACES | $184.20 |
| D2610 INLAY - PORCELAIN/CERAMIC - 1 SURFACE | $137.70 |
| D2620 INLAY - PORCELAIN/CERAMIC - 2 SURFACES | $141.30 |
| D2630 INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES | $159.30 |
| D2642 ONLAY - PORCELAIN/CERAMIC - 2 SURFACES | $169.80 |
| D2643 ONLAY - PORCELAIN/CERAMIC - 3 SURFACES | $184.20 |
| D2644 ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES | $211.20 |
| D2650 INLAY - RESIN BASED COMPOSITE - 1 SURFACE | $120.00 |
| D2651 INLAY - RESIN BASED COMPOSITE - 2 SURFACES | $122.40 |
| D2652 INLAY - RESIN BASED COMPOSITE - 3 />SURFACES | $136.50 |
| D2662 ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES | $128.10 |
| D2663 ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES | $145.50 |
| D2664 ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES | $163.80 |
| D2710 CROWN - RESIN - BASED COMPOSITE INDIRECT | $62.10 |
| D2712 CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT | $62.10 |
| D2720 CROWN - RESIN WITH HIGH NOBLE METAL* | $179.10 |
| D2721 CROWN - RESIN W/PREDOM BASE METAL | $162.90 |
| D2722 CROWN - RESIN WITH NOBLE METAL* | $172.80 |
| D2740 CROWN - PORCELAIN/CERAMIC SUBSTRATE | $204.00 |
| D2750 CROWN - PORCELAIN FUSED HI NOBLE METAL* | $201.00 |
| D2751 CROWN - PORCELAIN FUSED PREDOM BASE METAL | $179.10 |
| D2752 CROWN - PORCELAIN FUSED NOBLE METAL* | $186.90 |
| D2753 CROWN PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS | $186.90 |
| D2780 CROWN - 3/4 CAST HIGH NOBLE METAL* | $181.50 |
| D2781 CROWN - 3/4 CAST PREDOM BASE METAL | $173.40 |
| D2782 CROWN - 3/4 CAST NOBLE METAL* | $177.30 |
| D2783 CROWN - 3/4 PORCELAIN/CERAMIC | $187.50 |
| D2790 CROWN - FULL CAST HIGH NOBLE METAL* | $191.70 |
| D2791 CROWN - FULL CAST PREDOM BASE METAL | $176.10 |
| D2792 CROWN - FULL CAST NOBLE METAL* | $180.60 |
| D2794 CROWN - TITANIUM AND TITANIUM ALLOYS* | $191.70 |
| D2799 PROVISIONAL CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION | $54.00 |
| D2910 RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST | $14.70 |
| D2915 RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE | $14.70 |
| D2920 RECEMENT OR RE-BOND CROWN | $14.70 |
| D2921 REATTACHMENT OF TOOTH FRAGMENT | $22.80 |
| D2930 PREFABRICATED STAINLESS STEEL CROWN - PRIMARY | $39.30 |
| D2931 PREFABRICATED STAINLESS STEEL CROWN - PERMANENT | $39.60 |
| D2932 PREFABRICATED RESIN CROWN | $42.30 |
| D2933 PREFABRICATED STAINLSS STEEL CROWN RESIN WNDOW | $60.30 |
| D2934 PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY | $39.30 |
| D2940 SEDATIVE FILLING | $14.10 |
| D2941 INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION | $14.10 |
| D2950 CORE BUILDUP INCLUDING ANY PINS | $36.90 |
| D2951 PIN RETENTION - PER TOOTH ADDITION REST | $8.40 |
| D2952 POST & CORE ADD CROWN INDIRECT FAB | $59.10 |
| D2953 EACH ADD INDIRECT FABRICATED POST SAME TOOTH | $45.90 |
| D2954 PREFABRICATED POST & CORE ADDITION CROWN | $50.10 |
| D2957 EACH ADD PREFABR POST - SAME TOOTH | $18.90 |
| D2960 LABIAL VENEER (LAMINATE) - CHAIRSIDE | $83.10 |
| D2961 LABIAL VENEER (RESIN LAMINATE) - LABORATORY | $111.60 |
| D2962 LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY | $143.70 |
| D2970 TEMPORARY CROWN | $54.00 |
| D2971 ADD PROCEDURE NEW CROWN XST PART DENTURE | $46.80 |
| D2975 COPING | $118.80 |
| D2980 CROWN REPAIR | $30.30 |
| D2981 INLAY REPAIR | $30.30 |
| D2982 ONLAY REPAIR | $30.30 |
| D2983 VENEER REPAIR | $30.30 |
| D3110 PULP CAP - DIRECT | $10.80 |
| D3120 PULP CAP - INDIRECT | $9.30 |
| D3220 TX PULPOT-CORONAL DENTNOCEMENTL JUNC | $25.50 |
| D3221 PULPAL DEBRIDEMENT PRIMARY & PERMAMENT TEETH | $31.50 |
| D3222 PARTIAL PULPOTOMY | $25.50 |
| D3230 PULPAL THERAPY - ANTERIOR PRIMARY TOOTH | $41.70 |
| D3240 PULPAL THERAPY - POSTERIOR PRIMARY TOOTH | $48.60 |
| D3310 ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION) | $114.90 |
| D3320 ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATIONS) | $136.80 |
| D3330 ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION) | $194.40 |
| D3331 TX RC OBSTRUCTION; NON-SURG ACCESS | $52.50 |
| D3332 INCMPL ENDO TX;INOP UNRSTR/FX TOOTH | $60.30 |
| D3333 INTRL ROOT REPAIR PERFORATION DEFEC | $35.10 |
| D3346 RETX PREVIOUS RC THERAPY - ANTERIOR | $138.00 |
| D3347 RETX PREVIOUS RC THERAPY - BICUSPID | $161.70 |

| ADA CODE AND DESCRIPTION | PLAN PAYS |
|---|---|
| D3348 RETX PREVIOUS RC THERAPY - MOLAR | $205.80 |
| D3351 APEXIFICATION/RECALCIFICATION - INITIAL VST | $57.00 |
| D3352 APEXIFICATION/RECALCIFICATION -INTERIM | $40.20 |
| D3353 APEXIFICATION/RECALCIFICATION - FINAL VISIT | $74.40 |
| D3354 PULPAL REGENERATION | $57.00 |
| D3355 PULPAL REGENERATION - INITIAL VISIT | $57.00 |
| D3356 PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT | $40.20 |
| D3357 PULPAL REGENERATION - COMPLETION OF TREATMENT | $74.40 |
| D3410 APICOECTOMY - ANTERIOR | $119.10 |
| D3421 APICOECTOMY - PREMOLAR (FIRST ROOT) | $135.00 |
| D3425 APICOECTOMY - MOLAR (FIRST ROOT) | $144.60 |
| D3426 APICOECTOMY - (EACH ADDITIONAL ROOT) | $53.40 |
| D3427 PERIRADICULAR SURGERY WITHOUT APICOECTOMY | $53.40 |
| D3430 RETROGRADE FILLING - PER ROOT | $32.70 |
| D3450 ROOT AMPUTATION - PER ROOT | $78.60 |
| D3470 INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING) | $135.60 |
| D3920 HEMISECTION NOT INCL RC THERAPY | $65.40 |
| D4210 GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD | $84.60 |
| D4211 GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD | $23.70 |
| D4230 ANOTOMICAL CROWN EXPOSURE - 4 OR MORE CONTIG TEETH OR BONDED TOOTH SPACES | $158.70 |
| D4231 ANOTOMICAL CROWN EXPOSURE - 1 TO 3 TEETH OR BONDED TOOTH SPACES PER QUAD | $42.30 |
| D4240 GINGL FLP 4/>CNTIG/BOUND TEETH QUAD | $89.10 |
| D4241 GINGL FLP 1-3 CNTIG/BND TEETH QUAD | $44.70 |
| D4245 APICALLY POSITIONED FLAP | $138.90 |
| D4249 CLIN CROWN LEN - HARD TISSUE | $122.10 |
| D4260 OSSEOUS SURG 4/> CNTIG TEETH QUAD | $194.40 |
| D4261 OSSEOUS SURG 1-3 CNTIG TEETH QUAD | $97.20 |
| D4263 BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT | $108.30 |
| D4264 BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – EACH ADDITIONAL SITE IN QUADRANT | $81.30 |
| D4265 BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION | $54.30 |
| D4266 GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE | $150.60 |
| D4267 GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL) | $175.50 |
| D4268 SURGICAL REVISION PROCEDURE, PER TOOTH | $94.80 |
| D4270 PEDICLE SOFT TISSUE GRAFT PROCEDURE | $120.00 |
| D4271 FREE SOFT TISSUE GRAFT PROCEDURE | $130.20 |
| D4273 AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH | $95.40 |
| D4274 MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA) | $110.70 |
| D4275 NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH | $130.20 |
| D4276 COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH | $95.40 |
| D4277 FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH | $130.20 |
| D4283 AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN S | $47.70 |
| D4285 NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITIOI | $65.10 |
| D4320 PROVISIONAL SPLINTING - INTRACORONAL | $35.10 |
| D4321 PROVISIONAL SPLINTING - EXTRACORONAL | $31.50 |
| D4341 PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD | $33.90 |
| D4342 PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH | $17.10 |
| D4346 SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION | $16.80 |
| D4355 FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT | $20.10 |
| D4381 LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH | $27.30 |
| D4910 PERIODONTAL MAINTENANCE | $21.00 |
| D4920 UNSCHEDULED DRESSING CHANGE | $17.40 |
| D5110 COMPLETE DENTURE - MAXILLARY | $249.60 |
| D5120 COMPLETE DENTURE - MANDIBULAR | $249.60 |
| D5130 IMMEDIATE DENTURE - MAXILLARY | $268.80 |
| D5140 IMMEDIATE DENTURE - MANDIBULAR | $268.80 |
| D5211 MAXILLARY PARTIAL DENTURE - RESIN BASE | $175.50 |
| D5212 MANDIBULAR PARTIAL DENTUR - RESIN BASE | $175.50 |
| D5213 MAX PART DENTUR-CAST METL W/RSN | $290.70 |
| D5214 MAND PART DENTUR- CAST METL W/RSN | $290.70 |
| D5221 IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | $86.10 |
| D5222 IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | $86.10 |
| D5223 IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | $107.63 |
| D5224 IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | $107.63 |
| D5225 MAXILLARY PARTIAL DENTURE FLEX BASE | $290.70 |
| D5226 MANDIBULAR PART DENTURE FLEX BASE | $290.70 |
| D5282 REMV UNILATERAL PART DENTURE-1 PC CAST METL (INCLUDING CLASPS AND TEETH), MANDIBULAR | $139.80 |
| D5283 REMV UNILATERAL PART DENTURE-1 PC CAST METL (INCLUDING CLASPS AND TEETH), MAXILLARY | $139.80 |
| D5284 REMOVABLE UNILATERAL PARTIAL DENTURE – FLEX BASE/QUAD | $290.70 |
| D5286 REMOVABLE UNILATERAL PARTIAL DENTURE-RESIN/QUAD | $290.70 |
| D5410 ADJUST COMPLETE DENTURE - MAXILLARY | $12.60 |
| D5411 ADJUST COMPLETE DENTURE - MANDIBULAR | $12.60 |
| D5421 ADJUST PARTIAL DENTURE - MAXILLARY | $12.60 |
| D5422 ADJUST PARTIAL DENTURE - MANDIBULAR | $12.60 |
| D5511 REPAIR BROKEN COMPLETE DENTURE BASE - MANDIBULAR | $24.30 |
| D5512 REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY | $24.30 |
| D5520 REPLACE MISSING/BROKEN TEETH-COMPLETE DENTURE | $20.40 |
| D5611 REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR | $24.30 |
| D5612 REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY | $24.30 |
| D5621 REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR | $27.60 |

| ADA CODE AND DESCRIPTION | PLAN PAYS |
|---|---|
| D5622 REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY | $27.60 |
| D5630 REPAIR OR REPLACE BROKEN CLASP - PER TOOTH | $29.70 |
| D5640 REPLACE BROKEN TEETH - PER TOOTH | $21.30 |
| D5650 ADD TOOTH EXISTING PARTIAL DENTURE | $27.60 |
| D5660 ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH | $33.60 |
| D5670 REPLACE ALL TEETH & ACRYLC FRMEWRK MAX | $105.30 |
| D5671 REPLACE ALL TEETH&ACRYLC FRMEWRK MAND | $105.30 |
| D5710 REBASE COMPLETE MAXILLARY DENTURE | $80.70 |
| D5711 REBASE COMPLETE MANDIBULAR DENTURE | $80.70 |
| D5720 REBASE MAXILLARY PARTIAL DENTURE | $80.70 |
| D5721 REBASE MANDIBULAR PARTIAL DENTURE | $49.50 |
| D5730 RELINE COMPLETE MAXILLARY DENTURE CHAIRSIDE | $49.50 |
| D5731 RELINE COMPLETE MANDIBULAR DENTURE CHAIRSIDE | $49.50 |
| D5740 RELINE MAXILLARY PARTIAL DENTURE CHAIRSIDE | $49.50 |
| D5741 RELINE MANDIBULAR PARTIAL DENTURE CHAIRSIDE | $49.50 |
| D5750 RELINE COMPLETE MAXILLARY DENTURE LAB | $70.20 |
| D5751 RELINE COMPLETE MANDIBULAR DENTRUE LABORATORY | $70.20 |
| D5760 RELINE MAXILLARY PARTIAL DENTURE LAB | $70.20 |
| D5761 RELINE MANDIBULAR PARTIALDENTURE LABORATORY | $70.20 |
| D5810 INTERIM COMPLETE DENTURE (MAXILLARY) | $107.70 |
| D5811 INTERIM COMPLETE DENTURE (MANDIBULAR) | $107.70 |
| D5820 INTERIM PARTIAL DENTURE MAXILLARY | $86.10 |
| D5821 INTERIM PARTIAL DENTURE MANDIBULAR | $86.10 |
| D5850 TISSUE CONDITIONING MAXILLARY | $23.40 |
| D5851 TISSUE CONDITIONING MANDIBULAR | $23.40 |
| D5863 OVERDENTURE - COMPLETE MAXILLARY | $249.60 |
| D5864 OVERDENTURE - COMPLETE MANDIBULAR | $249.60 |
| D5865 OVERDENTURE - PARTIAL MAXILLARY | $290.70 |
| D5866 OVERDENTURE - PARTIAL MANDIBULAR | $290.70 |
| D5876 ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH) | $80.70 |
| D6010 SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT | $357.30 |
| D6013 SURGICAL PLACEMENT OF A MINI-IMPLANT | $357.30 |
| D6052 SEMI-PRECISION ATTACHMENT ABUTMENT | $100.20 |
| D6053 IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS | $325.50 |
| D6054 IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS | $317.70 |
| D6056 PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT | $100.20 |
| D6057 CUSTOM FAB ABUTMENT - INCLUDES PLACEMENT | $150.30 |
| D6058 ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN | $222.30 |
| D6059 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL) | $215.70 |
| D6060 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL) | $187.20 |
| D6061 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL) | $200.70 |
| D6062 ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL) | $206.70 |
| D6063 ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL) | $188.10 |
| D6064 ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL) | $200.70 |
| D6065 IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN | $242.70 |
| D6066 IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS | $244.80 |
| D6067 IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS | $237.00 |
| D6068 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD | $213.00 |
| D6069 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL) | $209.70 |
| D6070 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL) | $190.20 |
| D6071 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL) | $198.30 |
| D6072 ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL) | $203.10 |
| D6073 ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL) | $190.20 |
| D6074 ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL) | $194.70 |
| D6075 IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD | $230.40 |
| D6076 IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS | $225.30 |
| D6077 IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS | $235.80 |
| D6080 IMPLANT MAINTENANCE PROCEDURES, WHEN PROSTHESIS ARE REMOVED AND REINSERTED INCLUDING: CLEANSING OF PROSTHESIES | $43.80 |
| D6081 SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE | $33.53 |
| D6082 IMPLANT SUPPT CROWN-PORCELAIN FUSED TO PREDOM. BASE ALLOYS | $244.80 |
| D6083 IMPLANT SUPPT CROWN-PORCELAIN FUSED TO NOBLE ALLOYS | $244.80 |
| D6084 IMPLANT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS | $244.80 |
| D6085 PROVISIONAL IMPLANT CROWN | $54.00 |
| D6086 IMPLANT SUPPT CROWN-PREDOM. BASE ALLOYS | $237.00 |
| D6087 IMPLANT SUPPT CROWN-NOBLE ALLOYS | $237.00 |
| D6088 IMPLANT SUPPT CROWN-TITANIUM/TITANIUM ALLOYS | $237.00 |
| D6090 REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT | $123.30 |
| D6091 REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT(MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS | $104.40 |
| D6092 RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN | $20.10 |
| D6093 RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE | $29.70 |
| D6094 ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS | $206.70 |
| D6095 REPAIR IMPLANT ABUTMENT, BY REPORT | $127.50 |
| D6096 REMOVE BROKEN IMPLANT RETAINING SCREW | $45.00 |
| D6097 ABUTMENT SUPPT CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS | $215.70 |
| D6098 IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO PREDOM. BASE ALLOYS | $225.30 |
| D6099 IMPLANT SUPPT RETAINER FOR FPD-PORCELAIN FUSED TO NOBLE ALLOYS | $225.30 |
| D6101 DEBRIDEMENT PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT | $44.70 |
| D6102 DEBRIDEMENT & OSSEOUS PERI IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT | $44.70 |
| D6103 BONE GRAFT FOR REPAIR OF PERI IMPLANT DEFECT | $81.30 |

| ADA CODE AND DESCRIPTION | PLAN PAYS |
|---|---|
| D6110 IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY | $325.50 |
| D6111 IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR | $325.50 |
| D6112 IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY | $317.70 |
| D6113 IMPLANT /ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR | $317.70 |
| D6114 IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY | $633.90 |
| D6115 IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR | $633.90 |
| D6116 IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY | $413.40 |
| D6117 IMPLANT /ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR | $413.40 |
| D6118 IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR | $107.70 |
| D6119 IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY | $107.70 |
| D6120 IMPLANT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS | $225.30 |
| D6121 IMPLANT SUPPT RETAINER FOR METAL FPD-PREDOM. BASE ALLOYS | $235.80 |
| D6122 IMPLANT SUPPT RETAINER FOR METAL FPD-NOBLE ALLOYS | $235.80 |
| D6123 IMPLANT SUPPT RETAINER FOR METAL FPD-TITANIUM/TITANIUM ALLOYS | $235.80 |
| D6190 RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT | $37.50 |
| D6194 ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS | $203.10 |
| D6195 ABUTMENT SUPPT RETAINER-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS | $209.70 |
| D6205 PONTIC- INDIRECT RESIN BASED COMPOSITE | $62.10 |
| D6210 PONTIC - CAST HIGH NOBLE METAL* | $191.70 |
| D6211 PONTIC - CAST PREDOM BASE METAL | $176.10 |
| D6212 PONTIC - CAST NOBLE METAL * | $180.60 |
| D6214 PONTIC - TITANIUM AND TITANIUM ALLOYS* | $191.70 |
| D6240 PONTIC - PORCELAIN FUSED HI NOBLE METAL * | $201.00 |
| D6241 PONTIC - PORCELAIN FUSED PREDOM BASE METAL | $179.10 |
| D6242 PONTIC - PORCELAIN FUSED NOBLE METAL * | $186.90 |
| D6243 PONTIC-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS | $201.00 |
| D6245 PONTIC - PORCELAIN/CERAMIC | $187.80 |
| D6250 PONTIC - RESIN W/HIGH NOBLE METAL * | $182.40 |
| D6251 PONTIC RESIN W/PREDOM BASE METAL | $169.20 |
| D6252 PONTIC RESIN W/NOBLE METAL * | $175.50 |
| D6253 PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION | $71.40 |
| D6545 RETAINER - CASE METAL FOR RESIN FXD PROS | $77.70 |
| D6548 RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROS | $147.90 |
| D6549 RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS | $77.70 |
| D6600 RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES | $138.00 |
| D6601 RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES | $152.10 |
| D6602 RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES | $145.50 |
| D6603 RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES | $176.10 |
| D6604 RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES | $145.50 |
| D6605 RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES | $151.80 |
| D6606 RETAINER INLAY - CAST NOBLE METAL 2 SURFACES | $132.30 |
| D6607 RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES | $159.90 |
| D6608 RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES | $138.00 |
| D6609 RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES | $152.10 |
| D6610 RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES | $183.00 |
| D6611 RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES | $200.10 |
| D6612 RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURF | $157.20 |
| D6613 RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURF | $174.30 |
| D6614 RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES | $165.90 |
| D6615 RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURF | $183.00 |
| D6624 RETAINER INLAY - TITANIUM | $176.10 |
| D6634 RETAINER ONLAY - TITANIUM | $200.10 |
| D6710 RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE | $62.10 |
| D6720 RETAINER CROWN - RESIN WITH HIGH NOBLE METAL * | $185.40 |
| D6721 RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL | $170.40 |
| D6722 RETAINER CROWN - RESIN WITH NOBLE METAL * | $179.70 |
| D6740 RETAINER CROWN - PORCELAIN/CERAMIC | $188.10 |
| D6750 RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL * | $201.00 |
| D6751 RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | $179.10 |
| D6752 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL * | $186.90 |
| D6753 RETAINER CROWN-PORCELAIN FUSED TO TITANIUM/TITANIUM ALLOYS | $201.00 |
| D6780 RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL * | $167.70 |
| D6781 RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL | $180.00 |
| D6782 RETAINER CROWN - 3/4 CAST NOBLE METAL * | $184.20 |
| D6783 RETAINER CROWN - 3/4 PORCELAIN/CERAMIC | $187.80 |
| D6784 RETAINER CROWN - 3/4 TITANIUM/TITANIUM ALLOYS | $167.70 |
| D6790 RETAINER CROWN - FULL CAST HIGH NOBLE METAL * | $191.70 |
| D6791 RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL | $176.10 |
| D6792 RETAINER CROWN - FULL CAST NOBLE METAL * | $180.60 |
| D6793 PROVISIONAL RETAINER CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION | $53.70 |
| D6794 RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS * | $191.70 |
| D6930 RECEMENT OR RE-BOND FIXED PARTIAL DENTURE | $20.40 |
| D6972 PREFABRICATED POST & CORE ADD PART DENTURE RETN | $54.60 |
| D6973 CORE BUILD UP RETAIN INCL ANY PINS | $45.90 |
| D6975 COPING | $118.80 |
| D6976 EACH ADD INDIRECT FAB POST SAME TOOTH | $47.40 |
| D6977 EACH ADD PREFABRICATED POST SAME TOOTH | $21.90 |
| D6980 FIXED PARTIAL DENTURE REPAIR | $62.70 |
| D7111 XTRCT CORONAL REMNANTS PRIMARY TOOTH | $11.10 |

| ADA CODE AND DESCRIPTION | PLAN PAYS |
|---|---|
| D7140 EXTRAC ERUPTED TOOTH/EXPOSED ROOT | $21.90 |
| D7210 EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED | $39.60 |
| D7220 REMOVAL IMPACT TOOTH - SOFT TISSUE | $54.90 |
| D7230 REMOVAL IMPACT TOOTH - PARTLY BONY | $68.70 |
| D7240 REMOVAL IMPACTED TOOTH - COMPLETELY BONY | $87.60 |
| D7241 REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP | $96.90 |
| D7250 REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) | $40.50 |
| D7260 OROANTRAL FISTULA CLOSURE | $140.70 |
| D7261 PRIMARY CLOSURE OF A SINUS PERFORATION | $140.70 |
| D7270 TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED | $65.40 |
| D7272 TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION) | $110.70 |
| D7280 EXPOSURE OF AN UNERUPTED TOOTH | $87.30 |
| D7282 MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION | $61.80 |
| D7283 PLACEMENT DEVICE FACILITATE ERUPT IMPACTED TOOTH | $43.80 |
| D7285 INCISIONAL BIOPSY OF ORAL TISSUE HARD | $47.10 |
| D7286 INCISIONAL BIOPSY OF ORAL TISSUE SOFT | $42.90 |
| D7287 EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION | $21.30 |
| D7288 BRUSH BIOPSY | $21.30 |
| D7291 TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT | $12.90 |
| D7310 ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE | $38.40 |
| D7311 ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH | $19.20 |
| D7320 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC | $52.20 |
| D7321 ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH | $26.10 |
| D7340 VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) | $126.00 |
| D7350 VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT | $269.10 |
| D7410 EXCISION OF BENIGN LESION UP TO 1.25 CM | $51.00 |
| D7450 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM | $55.80 |
| D7451 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM | $164.40 |
| D7460 REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM | $64.20 |
| D7461 REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM | $111.60 |
| D7472 REMOVAL OF TORUS PALATINUS | $51.30 |
| D7473 REMOVAL OF TORUS MANDIBULARIS | $51.30 |
| D7510 I & D ABSCESS - INTRAORAL SOFT TISSUE | $24.90 |
| D7511 I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED | $31.20 |
| D7520 I & D OF ABSCESS EXTRAORAL SOFT TISSUE | $50.10 |
| D7521 I & D OF ABSCESS EXTRAORAL COMPLICATED | $62.40 |
| D7530 REMOVAL OF FOREIGN BODY - SKIN SUBCUTANEOUS | $26.70 |
| D7540 REMOVAL OF REACTION - PRODUCING FOREIGN BODIES - MUSCULOSKELETAL SYSTEM | $81.90 |
| D7550 PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE | $87.30 |
| D7560 MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY | $162.90 |
| D7960 FRENULECTOMY SEPARATE PROCEDURE | $61.50 |
| D7963 FRENULOPLASTY | $61.50 |
| D7970 EXC HYPERPLASTIC TISSUE-PER ARCH | $55.80 |
| D7971 EXCISION OF PERICORONAL GINGIVA | $28.20 |
| D7972 SURGICAL RDUC FIBROUS TUBEROSITY | $55.80 |
| D7997 APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCHBAR | $28.80 |
| D8010 LTD ORTHO TREAT OF THE PRIM DENTITION | UP TO PLAN MAXIMUM |
| D8020 LTD ORTHO TREAT OF THE TRANS DENTITION | UP TO PLAN MAXIMUM |
| D8030 LTD ORTHO TREAT OF THE ADOLESC DENTITION | UP TO PLAN MAXIMUM |
| D8040 LTD ORTHO TREAT OF THE ADULT DENTITION | UP TO PLAN MAXIMUM |
| D8050 INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION | UP TO PLAN MAXIMUM |
| D8060 INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION | UP TO PLAN MAXIMUM |
| D8070 COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION) | $1,862.00 |
| D8080 COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION | UP TO PLAN MAXIMUM |
| D8090 COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION | $1,953.00 |
| D8210 REMOVABLE APPLIANCE THERAPY | UP TO PLAN MAXIMUM |
| D8220 FIXED APPLIANCE THERAPY | UP TO PLAN MAXIMUM |
| D8660 PRE-ORTHODONTIC TREATMENT EXAM TO MONITOR GROWTH AND DEVELOPMENT | UP TO PLAN MAXIMUM |
| D8670 PERIODIC ORTHODONTIC TREATMENT VISIT | UP TO PLAN MAXIMUM |
| D8680 ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS) | UP TO PLAN MAXIMUM |
| D8681 REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT | $8.25 |
| D8690 ORTHODONTIC TREATMENT, (ALTERNATIVE BILLING TO A CONTRACT FEE) | UP TO PLAN MAXIMUM |
| D8695 REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF TREATMENT | UP TO PLAN MAXIMUM |
| D8696 REPAIR OF ORTHODONTIC APPLIANCE-MAXIL | UP TO PLAN MAXIMUM |
| D8697 REPAIR OF ORTHODONTIC APPLIANCE-MANDIB | UP TO PLAN MAXIMUM |
| D8698 RECEM/REBOND FIXED RETAINER-MAXIL | UP TO PLAN MAXIMUM |
| D8699 RECEM/REBOND FIXED RETAINER-MANDIB | UP TO PLAN MAXIMUM |
| D8701 REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT-MAXIL | UP TO PLAN MAXIMUM |
| D8702 REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT-MANDIB | UP TO PLAN MAXIMUM |
| D9110 PALLIATVE TX DENTAL PAIN-MINOR PROC | $14.10 |
| D9120 FIXED PARTIAL DENTURE SECTIONING | $41.10 |
| D9210 LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES | $11.10 |
| D9219 EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA | $16.20 |
| D9220 DP SEDATION/GEN ANES - 1ST 30 MIN | $56.10 |
| D9221 DP SEDAT/GEN ANES - EACH ADD 15 MIN | $21.00 |
| D9222 DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES | $26.25 |
| D9223 DEEP SEDATION/GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT | $26.25 |
| D9230 ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE | $7.50 |
| D9239 INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES | $61.50 |

| ADA CODE AND DESCRIPTION | PLAN PAYS |
|---|---|
| D9241 IV CONSC SEDAT/ANALG -1ST 30 MIN | $61.50 |
| D9242 IV MODERATE CONSC SEDAT/ANALG-EA ADD 15 MIN | $23.70 |
| D9243 INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT | $29.63 |
| D9248 NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION | $40.20 |
| D9310 CNSLT DX DENT/PHY NOT REQ DENT/PHY | $16.20 |
| D9311 CONSULTATION WITH A MEDICAL HEALTH CARE PROFESSIONAL | $11.40 |
| D9610 THERAPEUTIC DRUG INJECTION, BY REPORT | $15.00 |
| D9630 DRUGS OR MEDICAMENTS DISPENSED IN THE OFFICE FOR HOME USE | $7.50 |
| D9910 APPLICATION OF DESENSITIZING MEDICAMENT | $7.50 |
| D9911 APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH | $11.40 |
| D9931 CLEANING AND INSPECTION OF A REMOVABLE APPLIANCE | $43.80 |
| D9942 REPAIR AND/OR RELINE OCCCLUSAL GUARDS | $26.10 |
| D9943 OCCLUSAL GUARD ADJUSTMENT | $12.60 |
| D9944 OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH | $86.70 |
| D9945 OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH | $86.70 |
| D9946 OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH | $86.70 |
| D9951 OCCLUSAL ADJUSTMENT - LIMITED | $16.50 |
| D9952 OCCLUSAL ADJUSTMENT - COMPLETE | $75.60 |