ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
DIAGNOSTIC SERVICES			
D0120	PERIODIC ORAL EVALUATION EST PT	$0	$25
D0140	LTD ORAL EVALUATION - PROBLEM FOCUS	$0	$30
D0145	ORAL EVAL PT<3 AND COUNSEL	$0	$30
D0150	COMP ORAL EVALUATION - NEW/EST PT	$0	$30
D0160	DTL & EXT ORAL EVAL - PROBLEM FOCUS REPORT	$0	$25
D0170	RE-EVALUATION - LTD PROBLEM FOCUSED	$0	$25
D0171	RE-EVALUATION - POST-OPERATIVE OFFICE VISIT	$5	$19
D0180	COMP PERIODONTAL EVAL - NEW/EST PT	$0	$30
D0210	INTRAORAL - COMPLETE SERIES RADIOGRAPHIC IMAGES	$0	$60
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$0	$60
D0220	INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$0	$10
D0230	INTRAORL PERIAPICAL EACH ADD RADIOGRAPHIC IMAGE	$0	$5
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$0	$12
D0250	EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$0	$20
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$0	$12
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	$0	$8
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$0	$10
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	$0	$14
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	$0	$18
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	$0	$18
D0290	POSTERIOR - ANTERIOR OR LATERAL SKULL AND FACIAL SURVEY RADIOGRAPHIC IMAGE	$0	$20
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL SURVEY RADIOGRAPHIC IMAGE	$0	$20
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$0	$25
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$0	$0
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$60	
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$60	
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$60	
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$60	
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$60	
D0414	LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$0	
D0415	COLLECT MICROORGANISMS CULT & SENS	$0	$24
D0416	VIRAL CULTURE	$0	$24
D0422	COLLECTION AND PREPARATION OF GENETIC SAMPLE MATERIAL FOR LABORATORY ANALYSIS AND REPORT	$0	$24
D0423	GENETIC TEST FOR SUSCEPTIBILITY TO DISEASES - SPECIMEN ANALYSIS	$0	$24
D0425	CARIES SUSCEPTIBILITY TESTS	$0	$24
D0431	ADJUNCT PREDX TST NO CYTOL/BX PROC	$20	$45
D0460	PULP VITALITY TESTS	$0	$10
D0470	DIAGNOSTIC CASTS	$0	$5
D0472	ACCESS TISS-GROSS EXAM-PREP & REPRT	$0	$25
D0472	ACCESS TISSUE, GROSS EXAM - PREP & REPORT	$0	$25
D0473	ACCESS TISS-GROSS/MICRO-PREP/REPRT	$0	$60

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D0473	ACCESS TISSUE, GROSS & MICROSCOPIC - PREP/REPORT	$0	$60
D0474	ACCESS TISSUE, GROSS & MICROSCOPIC SURG MARG PREP/REPORT	$0	$65
D0474	ACSS TISS GR&MIC SURG MARG PREP/RPT	$0	$65
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$0	$25
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$0	$25
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$0	$25
D0999	OFFICE VISIT FEE - PER VISIT	$0	$0
PREVENTIVE SERVICES			
D1110[1]	PROPHYLAXIS - ADULT	$0	$40
D1110[1]	- PROPHYLAXIS - ADULT 1 ADD. PROPHY WITHIN 6 MONTHS	$25	$0
D1120[1]	PROPHYLAXIS - CHILD	$0	$25
D1120[1]	- PROPHYLAXIS - CHILD 1 ADD. PROPHY WITHIN 6 MONTHS	$25	$0
D1203	TOPICAL FLUORIDE - CHILD	$0	$13
D1204	TOPICAL FLUORIDE - ADULT	$0	$13
D1206	TOPICALFLUORIDE VARNISH	$0	$15
D1310	NUTRIT CNSL CONTROL DENTAL DISEASE	$0	$0
D1320	TOBACCO CNSL CNTRL&PREVION ORL DZ	$0	$0
D1330	ORAL HYGIENE INSTRUCTIONS	$0	$0
D1351	SEALANT - PER TOOTH	$8	$10
D1352	PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$10	$10
D1353	SEALANT REPAIR – PER TOOTH	$8	$10
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	$25	$160
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	$25	$160
D1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL	$40	$100
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	$40	$140
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	$40	$140
D1550	RECEMENT OR RE-BOND SPACE MAINTAINER	$15	$12
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$15	$10
D1575	DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL	$25	
D1999	UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT		
RESTORATIVE SERVICES			
D2140	AMALGAM - ONE SURFACE PRIMARY/PERMANENT	$8	$40
D2140	AMALGAM-ONE SURFACE PRIMARY/PERM	$8	$40
D2150	AMALGAM - TWO SURFACES PRIMARY/PERMANENT	$15	$60
D2150	AMALGAM-TWO SURFACES PRIMARY/PERM	$15	$60
D2160	AMALGAM - 3 SURFACES PRIMARY/PERMAMENT	$22	$75
D2160	AMALGAM-3 SURFACES PRIMARY/PERM	$22	$75
D2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	$28	$90
D2161	AMALGAM-FOUR/MORE SURF PRIM/PERM	$28	$90
D2330	RESIN COMPOS - ONE SURFACE ANTERIOR	$10	$40
D2330	RESIN COMPOSITE - ONE SURFACE ANTERIOR	$10	$40
D2331	RESIN COMPOS - 2 SURFACES ANTERIOR	$20	$60
D2331	RESIN COMPOSITE - 2 SURFACES ANTERIOR	$20	$60
D2332	RESIN COMPOS - 3 SURFACES ANTERIOR	$30	$70
D2332	RESIN COMPOSITE - 3 SURFACES ANTERIOR	$30	$70
D2335	RESIN COMPOS-4/> SURF/W/INCISAL ANG	$38	$80
D2335	RESIN COMPOSITE - 4/> SURF/W/INCISAL ANG	$38	$80
D2390	RESIN COMPOS CROWN ANTERIOR	$45	$85
D2390	RESIN COMPOSITE CROWN ANTERIOR	$45	$85
D2391	RESIN COMPOS - 1 SURFACE POSTERIOR	$50	$40
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$50	$40

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D2392	RESIN COMPOS - 2 SURFACES POSTERIOR	$55	$60
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$55	$60
D2393	RESIN COMPOS - 3 SURFACES POSTERIOR	$85	$75
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$85	$75
D2394	RESIN COMPOS - 4/MORE SURFACES POST	$95	$90
D2394	RESIN COMPOSITE - 4/MORE SURFACES POST	$95	$90
D2510	INLAY - METALLIC - ONE SURFACE	$185	$125
D2520	INLAY - METALLIC - TWO SURFACES	$185	$150
D2530	INLAY - METALLIC - 3/MORE SURFACES	$185	$175
D2542	ONLAY - METALLIC - TWO SURFACES	$225	$175
D2543	ONLAY - METALLIC THREE SURFACES	$225	$205
D2544	ONLAY - METALLIC FOUR OR MORE SURF	$225	$205
D2544	ONLAY - METALLIC FOUR OR MORE SURFACES	$225	$205
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$250	$125
D2610	INLAY - PORCELN/CERAMIC - 1 SURFACE	$250	$125
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$250	$150
D2620	INLAY - PORCELN/CERAMIC - 2 SURF	$250	$150
D2630	INLAY - PORCELAIN/CERAMIC - 3/MORE SURFACES	$250	$175
D2630	INLAY - PORCELN/CERAM - 3/MORE SURF	$250	$175
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$250	$205
D2642	ONLAY - PORCELN/CERAMIC - 2 SURF	$250	$205
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$250	$205
D2643	ONLAY - PORCELN/CERAMIC - 3 SURF	$250	$205
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$250	$205
D2644	ONLAY - PORCELN/CERAM - 4/MORE SURF	$250	$205
D2650	INLAY - RESIN BASED COMPOSITE - 1 SURFACE	$250	$110
D2650	INLAY-RSN COMPOS COMPOS/RSN-1 SURF	$250	$110
D2651	INLAY - RESIN BASED COMPOSITE - 2 SURFACES	$250	$125
D2651	INLAY-RSN COMPOS COMPOS/RSN-2 SURF	$250	$125
D2652	INLAY - RESIN BASED COMPOSITE - 3 />SURFACES	$250	$145
D2652	INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	$250	$145
D2662	ONLAY - RESIN - BASED COMPOSITE - 2 SURFACES	$250	$115
D2662	ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	$250	$115
D2663	ONLAY - RESIN - BASED COMPOSITE - 3 SURFACES	$250	$150
D2663	ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	$250	$150
D2664	ONLAY - RESIN - BASED COMPOSITE - 4/> SURFACES	$250	$175
D2664	ONLAY-RSN COMPOS COMPOS/RSN-4/>	$250	$175
D2710	CROWN - RESIN - BASED COMPOSITE INDIRECT	$150	$160
D2710	CROWN RESINBASED COMPOSITE INDIRECT	$150	$160
D2712	CROWN - 3/4 RESIN - BASED COMPOSITE INDIRECT	$150	$160
D2712	CROWN 3/4 RESNBASED COMPOS INDIRECT	$150	$160
D2720*	CROWN - RESIN WITH HIGH NOBLE METAL	$250	$320
D2721	CROWN - RESIN W/PREDOM BASE METAL	$250	$240
D2722*	CROWN - RESIN WITH NOBLE METAL	$250	$275
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$300	$320
D2750*	CROWN - PORCELAIN FUSED HI NOBLE METAL	$250	$350
D2750*	CROWN - PORCELAIN FUSED HI NOBLE METL	$250	$350
D2751	CROWN - PORCELAIN FUSED PREDOM BASE METAL	$250	$250
D2751	CROWN - PORCELAIN FUSED PREDOM BASE METL	$250	$250
D2752*	CROWN - PORCELAIN FUSED NOBLE METAL	$250	$290
D2780*	CROWN - 3/4 CAST HIGH NOBLE METAL	$250	$325
D2781	CROWN - 3/4 CAST PREDOM BASE METAL	$250	$290

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D2781	CROWN - 3/4 CAST PREDOM BASE METL	$250	$290
D2782*	CROWN - 3/4 CAST NOBLE METAL	$250	$290
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$250	$350
D2790*	CROWN - FULL CAST HIGH NOBLE METAL	$250	$300
D2791	CROWN - FULL CAST PREDOM BASE METAL	$250	$240
D2791	CROWN - FULL CAST PREDOM BASE METL	$250	$240
D2792*	CROWN - FULL CAST NOBLE METAL	$250	$250
D2794*	CROWN TITANIUM	$250	$300
D2910	RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$0	$20
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFAB POST & CORE	$0	$20
D2915	RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFABRICATED POST & CORE	$0	$20
D2920	RECEMENT OR RE-BOND CROWN	$0	$20
D2921	REATTACHMENT OF TOOTH FRAGMENT	$55	
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY	$25	$60
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIM	$25	$60
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT	$25	$90
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERM	$25	$90
D2932	PREFABRICATED RESIN CROWN	$40	$48
D2933	PREFABRICATED STAINLESS STEEL CROWN RESIN WINDOW	$40	$60
D2933	PREFABRICATED STNLSS STEEL CROWN RSN WNDOW	$40	$60
D2934	PREFABRICATED ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$45	$64
D2940	SEDATIVE FILLING	$0	$25
D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$0	
D2950	CORE BUILDUP INCLUDING ANY PINS	$50	$96
D2951	PIN RETENTION - PER TOOTH ADDITION REST	$10	$16
D2951	PIN RETN - PER TOOTH ADDITION REST	$10	$16
D2952	POST & CORE ADD CROWN INDIRECT FAB	$50	$115
D2953	EA ADD INDIRECT FAB POST SAME TOOTH	$50	$45
D2953	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$50	$45
D2954	PREFABR POST&CORE ADDITION CROWN	$30	$80
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$30	$80
D2955	POST REMOVAL	$10	$80
D2957	EA ADD PREFABR POST - SAME TOOTH	$30	$40
D2957	EACH ADD PREFABR POST - SAME TOOTH	$30	$40
D2960	LABIAL VENEER (LAMINATE) - CHAIRSIDE	$300	$0
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$450	$0
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$550	$0
D2971	ADD PROC NEW CROWN XST PART DENTURE	$50	$40
D2971	ADD PROCEDURE NEW CROWN XST PART DENTURE	$50	$40
D2980	CROWN REPAIR	$55	$0
ENDODONTIC SERVICES			
D3110	PULP CAP - DIRECT	$5	$20
D3120	PULP CAP - INDIRECT	$5	$16
D3220	TX PULPOTOMY - CORONAL DENTNOCEMENTL JUNC	$5	$48
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMAMENT TEETH	$30	$48
D3222	PARTIAL PULPOTOMY	$30	$48
D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$40	$55
D3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	$40	$55
D3310	ANTERIOR	$125	$325
D3320	BICUSPID	$175	$350
D3330	MOLAR	$325	$400

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D3331	TX RC OBSTRUCTION; NON-SURG ACCESS	$85	$50
D3332	INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$85	$150
D3333	INTRL ROOT REPAIR PERFORATION DEFEC	$85	$50
D3346	RETX PREVIOUS RC THERAPY - ANTERIOR	$145	$325
D3347	RETX PREVIOUS RC THERAPY - BICUSPID	$195	$350
D3348	RETX PREVIOUS RC THERAPY - MOLAR	$345	$450
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VST	$70	$40
D3352	APEXIFICATION/RECALCIFICATION - INTERIM	$70	$40
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$70	$175
D3355	PULPAL REGENERATION - INITIAL VISIT	$70	$40
D3356	PULPAL REGENERATION - INTERIM MEDICAMENT REPLACEMENT	$70	$40
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	$70	$175
D3410	APICOECTOMY SURG - ANT	$95	$112
D3421	APICOECTOMY SURG-BICUSPID	$95	$224
D3425	APICOECTOMY SURG - MOLAR	$95	$336
D3426	APICOECTOMY SURGERY	$55	$144
D3427	PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$55	$144
D3430	RETROGRADE FILLING - PER ROOT	$55	$134
D3450	ROOT AMPUTATION - PER ROOT	$95	$96
D3910	SURG PROC ISOLAT TOOTH W/RUBBER DAM	$15	$40
D3920	HEMISECTION NOT INCL RC THERAPY	$90	$96
D3950	CANAL PREP & FIT PREFORMED DOWEL/POST	$15	$50
PERIODONTIC SERVICES			
D4210	GINGIVECTOMY/GINGIVOPLASTY 4/>CNTIG TEETH QUAD	$130	$95
D4211	GINGIVECTOMY/GINGIVOPLASTY 1-3 CNTIG TEETH QUAD	$85	$50
D4240	GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$150	$100
D4241	GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$110	$64
D4245	APICALLY POSITIONED FLAP	$165	$100
D4249	CLIN CROWN LEN - HARD TISSUE	$150	$95
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$355	$320
D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$275	$211
D4263	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$205	$175
D4263	BONE REPLCMT GRAFT - 1 SITE QUAD	$205	$175
D4264	BN REPLCMT GRAFT - EA ADD SITE QUAD	$90	$175
D4264	BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – EACH ADDITIONAL SITE IN QUADRANT	$90	$175
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$235	$190
D4271	FREE SOFT TISSUE GRAFT PROCEDURE	$235	$190
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$90	$175
D4274	MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$90	$175
D4320	PROVISIONAL SPLINTING - INTRACORONAL	$95	$95
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	$75	$75
D4341	PERIODONTAL SCAL & ROOT PLAN 4/>TEETH-QUAD	$55	$60
D4342	PERIODONTAL SCAL & ROOT PLAN 1-3 TEETH	$50	$40
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$0	
D4355	FULL MOUTH DEBRID COMP ORAL EVAL & DX ON A SUBSEQUENT VISIT	$55	$60
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$65	$25
D4910	PERIODONTAL MAINTENANCE	$40	$55
D4920	UNSCHEDULED DRESSING CHANGE	$18	$18

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D4921	GINGIVAL IRRIGATION □ PER QUADRANT	$0	$0
REMOVABLE PROSTHODONTIC SERVICES			
D5110	COMPLETE DENTURE - MAXILLARY	$350	$500
D5120	COMPLETE DENTURE - MANDIBULAR	$350	$500
D5130	IMMEDIATE DENTURE - MAXILLARY	$400	$540
D5140	IMMEDIATE DENTURE - MANDIBULAR	$400	$540
D5211	MAX PARTIAL DENTURE - RESIN BASE	$325	$350
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$325	$350
D5212	MAND PARTIAL DENTUR - RESIN BASE	$325	$350
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$325	$350
D5213	MAX PART DENTUR-CAST METL W/RSN	$425	$400
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL W/RESIN	$425	$400
D5214	MAND PART DENTUR- CAST METL W/RSN	$425	$400
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL W/RESIN	$425	$400
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$20	$160
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$20	$160
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$20	$160
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$20	$160
D5225	MAXILLARY PARTIAL DENTURE FLEX BASE	$425	$350
D5226	MANDIBULAR PART DENTURE FLEX BASE	$425	$350
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE - 1 PC CAST METAL (INCLUDING CLASPS AND TEETH), MAXILLARY	$300	$125
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE - 1 PC CAST METAL (INCLUDING CLASPS AND TEETH), MANDIBULAR		
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$10	$16
D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	$10	$16
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$10	$16
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$10	$27
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$10	$27
D5511	REPAIR BROKEN COMPLETE DENTURE BASE	$35	
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$35	
D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	$35	$32
D5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	$35	$32
D5611	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$35	
D5612	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$35	
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$35	
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$35	
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$35	$96
D5640	REPLACE BROKEN TEETH - PER TOOTH	$35	$48
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$40	$48
D5660	ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$40	$80
D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	$150	$315
D5670	REPLACE ALL TEETH & ACRYLC FRMEWRK MAXILLARY	$150	$315
D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	$150	$315
D5671	REPLACE ALL TEETH & ACRYLC FRMEWRK MANDIBULAR	$150	$315
D5710	REBASE COMPLETE MAXILLARY DENTURE	$75	$160
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$75	$160
D5720	REBASE MAXILLARY PARTIAL DENTURE	$75	$128

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$75	$128
D5730	RELINE CMPL MAXIL DENTURE CHAIRSIDE	$55	$96
D5730	RELINE COMPLETE MAXILLARY DENTURE CHAIRSIDE	$55	$96
D5731	RELINE CMPL MAND DENTURE CHAIRSIDE	$55	$96
D5731	RELINE COMPLETE MANDIBULAR DENTURE CHAIRSIDE	$55	$96
D5740	RELINE MAXIL PART DENTURE CHAIRSIDE	$55	$80
D5740	RELINE MAXILLARY PARTIAL DENTURE CHAIRSIDE	$55	$80
D5741	RELINE MAND PART DENTURE CHAIRSIDE	$55	$80
D5741	RELINE MANDIBULAR PARTIAL DENTURE CHAIRSIDE	$55	$80
D5750	RELINE CMPL MAXIL DENTURE LAB	$75	$125
D5750	RELINE COMPLETE MAXILLARY DENTURE LAB	$75	$125
D5751	RELINE CMPL MAND DENTRUE LABORATORY	$75	$125
D5751	RELINE COMPLETE MANDIBULAR DENTURE LABORATORY	$75	$125
D5760	RELINE MAXIL PART DENTURE LAB	$75	$125
D5760	RELINE MAXILLARY PARTIAL DENTURE LAB	$75	$125
D5761	RELINE MAND PART DENTURE LABORATORY	$75	$125
D5761	RELINE MANDIBULAR PARTIAL DENTURE LABORATORY	$75	$125
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$145	$192
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$155	$192
D5820	INTERIM PARTIAL DENTURE MAXILLARY	$20	$160
D5821	INTERIM PARTIAL DENTURE MANDIBULAR	$20	$160
D5850	TISSUE CONDITIONING MAXILLARY	$0	$24
D5851	TISSUE CONDITIONING MANDIBULAR	$0	$24
D5863	OVERDENTURE - COMPLETE MAXILLARY	$350	$500
D5864	OVERDENTURE - COMPLETE MANDIBULAR	$350	$500
D5865	OVERDENTURE - PARTIAL MAXILLARY	$425	$400
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$425	$400
D5876	ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH)	$75	$160
IMPLANT SERVICES			
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$1,950	$0
D6013	SURGICAL PLACEMENT OF A MINI-IMPLANT	$1,950	$0
D6052	SEMI-PRECISION ATTACHMENT ABUTMENT	$368	
D6056	PREFABRICATED ABUTMENT - INCLUDES MOD AND PLACEMENT	$368	$0
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,050	$0
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINATELY BASE METAL)	$1,050	$0
D6061*	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	$946	$0
D6062*	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$981	$0
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINATELY BASE METAL)	$854	$0
D6064*	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$1,168	$0
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,144	$0
D6066*	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	$1,083	$0
D6067*	IMPLANT SUPPORTED METAL CROWN	$962	$0
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$1,026	$0
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	$1,050	$0
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINATELY BASE METAL)	$965	$0
D6071*	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$984	$0
D6072*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$997	$0

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINATELY BASE METAL)	$910	$0
D6074*	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$967	$0
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$1,018	$0
D6076*	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	$992	$0
D6077*	IMPLANT SUPPORTED RETAINER FOR CASE METAL FPD	$962	$0
D6092	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	$79	$0
D6093	RECEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	$124	$0
D6094*	ABUTMENT SUPPORTED CROWN - TITANIUM	$810	$0
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$10	
D6118	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	$155	
D6119	IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	$145	
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM	$835	$0
FIXED PROSTHODONTIC SERVICES			
D6205	PONTIC- INDIRECT RESIN BASED COMPOSITE	$150	$225
D6210*	PONTIC - CAST HIGH NOBLE METAL	$250	$320
D6211	PONTIC - CAST PREDOM BASE METAL	$250	$224
D6212*	PONTIC - CAST NOBLE METAL	$250	$256
D6214*	PONTIC TITANIUM	$250	$320
D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METAL	$250	$352
D6240*	PONTIC - PORCELAIN FUSED HI NOBLE METL	$250	$352
D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METAL	$250	$288
D6241	PONTIC - PORCELAIN FUSED PREDOM BASE METL	$250	$288
D6242*	PONTIC - PORCELAIN FUSED NOBLE METAL	$250	$304
D6245	PONTIC - PORCELAIN/CERAMIC	$300	$320
D6250*	PONTIC - RESIN W/HIGH NOBLE METAL	$250	$320
D6251	PONTIC RESIN W/PREDOM BASE METAL	$250	$224
D6252*	PONTIC RESIN W/NOBLE METAL	$250	$288
D6253	PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$95	$95
D6545	RETAINER - CASE METAL FOR RESIN FIXED PROSTHESIS	$115	$128
D6545	RETAINER- CASE MTL FOR RESIN FXD PROS	$115	$128
D6548	RETAINER - PORCELAIN CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	$350	$375
D6548	RET-PORC/CER FOR RESIN BONDED FIXED PROS	$350	$375
D6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$115	$128
D6600	RETAINER INLAY - PORCELAIN/CERAMIC 2 SURFACES	$270	$150
D6600	RETAINER INLAY-PORCELAIN/CERAMIC 2 SURFACES	$270	$150
D6601	RETAINER INLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$270	$175
D6601	RETAINER INLAY - PORCELN/CERAMIC 3/MORE SURF	$270	$175
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURF	$185	$150
D6602*	RETAINER INLAY - CAST HI NOBLE METAL 2 SURFACES	$185	$150
D6603*	RETAINER INLAY - CAST HI NOBLE METAL 3/> SURFACES	$185	$175
D6603*	RETAINER INLAY-CAST HI NOBLE METL 3/> SURF	$185	$175
D6604	RETAINER INLAY - CAST PREDOM BASE METAL 2 SURFACES	$185	$150
D6604	RETAINER INLAY-CAST PREDOM BASE METL 2 SURF	$185	$150
D6605	RETAINER INLAY - CAST PREDOM BASE METAL 3/>SURFACES	$185	$175
D6605	RETAINER INLAY-CAST PREDOM BASE METL 3/>SURF	$185	$175
D6606*	RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$185	$150
D6607*	RETAINER INLAY - CAST NOBLE METAL 3/MORE SURFACES	$185	$175
D6607*	RETAINER INLAY - CAST NOBLE METL 3/MORE SURF	$185	$175
D6608	RETAINER ONLAY - PORCELAIN/CERAMIC 2 SURFACES	$280	$175

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D6608	RETAINER ONLAY - PORCELN/CERAMIC 2 SURFACES	$280	$175
D6609	RETAINER ONLAY - PORCELAIN/CERAMIC 3/MORE SURFACES	$280	$185
D6609	RETAINER ONLAY - PORCELN/CERAMIC 3/MORE SURF	$280	$185
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURF	$185	$200
D6610*	RETAINER ONLAY - CAST HI NOBLE METAL 2 SURFACES	$185	$200
D6611*	RETAINER ONLAY - CAST HI NOBLE METAL 3/> SURFACES	$175	$225
D6611*	RETAINER ONLAY-CAST HI NOBLE METL 3/> SURF	$175	$225
D6612	RETAINER ONLAY - CAST PREDOM BASE METAL 2 SURFACES	$175	$185
D6612	RETAINER ONLAY-CAST PREDOM BASE METL 2 SURF	$175	$185
D6613	RETAINER ONLAY - CAST PREDOM BASE METAL 3/>SURFACES	$175	$200
D6613	RETAINER ONLAY-CAST PREDOM BASE METL 3/>SURF	$175	$200
D6614*	RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$175	$185
D6615*	RETAINER ONLAY - CAST NOBLE METAL 3/MORE SURFACES	$175	$195
D6615*	RETAINER ONLAY - CAST NOBLE METL 3/MORE SURF	$175	$195
D6624*	RETAINER INLAY - TITANIUM	$250	$175
D6634*	RETAINER ONLAY - TITANIUM	$250	$175
D6710	RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$150	$160
D6720*	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	$250	$320
D6721	RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$250	$240
D6722*	RETAINER CROWN - RESIN WITH NOBLE METAL	$250	$272
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$300	$350
D6750*	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$250	$350
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$250	$250
D6752*	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$250	$320
D6780*	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	$250	$300
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$250	$300
D6782*	RETAINER CROWN - 3/4 CAST NOBLE METAL	$250	$320
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$250	$350
D6790*	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	$250	$300
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$250	$240
D6792*	RETAINER CROWN - FULL CAST NOBLE METAL	$250	$275
D6794*	RETAINER CROWN - TITANIUM	$250	$300
D6930	RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$0	$32
D6940	STRESS BREAKER	$50	$80
D6970	POST&CORE ADD FIX PART DENTURE RET	$50	$90
D6972	PREFABRICATED POST & CORE ADD PART DENTURE RETN	$30	$80
D6972	PRFAB POST&COR ADD PART DENTUR RETN	$30	$80
D6973	CORE BUILD UP RETAIN INCL ANY PINS	$20	$90
D6976	EA ADD INDIRECT FAB POST SAME TOOTH	$50	$75
D6976	EACH ADD INDIRECT FABRICATED POST SAME TOOTH	$50	$75
D6977	EACH ADD PREFABRICATED POST SAME TOOTH	$50	$45
D6977	EACH ADD PRFAB POST SAME TOOTH	$50	$45
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$75	$0
ORAL SURGERY SERVICES			
D7111	XTRCT CORONAL REMNANTS PRIMARY TOOTH	$10	$21
D7111	XTRCT CORONL RMNNTS DECIDUOUS TOOTH	$10	$21
D7140	EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$10	$32
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$30	$64
D7220	REMOVAL IMPACT TOOTH - SOFT TISSUE	$65	$100
D7230	REMOVAL IMPACT TOOTH - PARTLY BONY	$85	$125

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D7240	REMOVAL IMPACTED TOOTH - CMPL BONY	$125	$160
D7240	REMOVAL IMPACTED TOOTH - COMPLETELY BONY	$125	$160
D7241	REMOVAL IMPACTED TOOTH - COMPLETELY BONY W/SURG COMP	$150	$175
D7241	REMV IMP TOOTH-CMPL BNY W/SURG COMP	$150	$175
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$40	$60
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$0	$105
D7270	TOOTH REIMPL&/STBL ACC DISPLCD	$50	$100
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION ACCIDENTLY DISPLACED	$50	$100
D7280	EXPOSURE OF AN UNERUPTED TOOTH	$85	$160
D7280	SURGICAL ACCESS AN UNERUPTED TOOTH	$85	$160
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$90	$55
D7282	MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	$90	$55
D7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD	$150	$80
D7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$60	$80
D7288	BRUSH BIOPSY	$0	$40
D7290	SURGICAL REPOSITIONING OF TEETH	$0	$115
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$40	$65
D7311	ALVEOLOPLASTY CONJNC XTRCT 1-3 TEETH	$15	$45
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$15	$45
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$60	$85
D7321	ALVEOLOPLASTY NOT W/XTRCT 1-3 TEETH	$25	$50
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$25	$50
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$175	$175
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$200	$275
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$185	$185
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$295	$295
D7471	REMOVAL OF LATERAL EXOSTOSIS	$85	$165
D7472	REMOVAL OF TORUS PALATINUS	$65	$325
D7473	REMOVAL OF TORUS MANDIBULARIS	$65	$165
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$65	$225
D7485	SURGICAL RDUC OSSEOUS TUBEROSITY	$65	$225
D7510	I & D ABSCESS - INTRAORAL SOFT TISSUE	$35	$60
D7510	I&D ABSCESS-INTRAORAL SOFT TISS	$35	$60
D7511	I & D ABSC INTRAORAL SOFT TISS COMP	$35	$60
D7511	I & D ABSCESS - INTRAORAL SOFT TISS COMPLICATED	$35	$60
D7530	REMO OF FORREIGN BODY - SKIN SUBCUTANEOUS	$80	$80
D7530	REMOVAL OF FOREIGN BODY - SKIN SUBCUTANEOUS	$80	$80
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	$10	
D7960	FRENULECTOMY SEPARATE PROCEDURE	$45	$60
D7963	FRENULOPLASTY	$45	$60
D7970	EXC HYPERPLASTIC TISSUE-PER ARCH	$55	$80
D7971	EXCISION OF PERICORONAL GINGIVA	$40	$70
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$100	$175
ADJUNCTIVE GENERAL SERVICES			
D9110	PALLIATVE TX DENTAL PAIN-MINOR PROC	$10	$26
D9120	FIXED PARTIAL DENTURE SECTIONING	$0	$39
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$0	$10
D9211	REGIONAL BLOCK ANESTHESIA	$0	$15
D9212	TRIGEMINAL DIVISION BLOCK ANES	$0	$20

ADA	DESCRIPTION	IN-NETWORK NO ANNUAL MAX NO DEDUCTIBLE MEMBER PAYS	OUT-OF-NETWORK NO ANNUAL MAX NO DEDUCTIBLE PLAN PAYS
D9215	LOCAL ANESTHESIA	$0	$0
D9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	$0	$48
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$310	
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$155	$0
D9230	ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$35	$0
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$310	
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$155	$70
D9248	NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$50	$50
D9310	CNSLT DX DENT/PHY NOT REQ DENT/PHY	$0	$48
D9430	OV OBS - NO OTH SERVICES PERFORMED	$5	$19
D9440	OV-AFTER REGULARLY SCHEDULED HRS	$35	$48
D9450	CASE PRSATION DTL & EXT TX PLANNING	$0	$0
D9450	CASE PRSATION DTL&EXT TX PLANNING	$0	$0
D9930	TREATMENT OF COMPLICATIONS - POST SURG.	$0	$19
D9943	OCCLUSAL GUARD ADJUSTMENT	$10	$16
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	$100	$50
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH	$100	$50
D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH	$100	$50
D9951	OCCLUSAL ADJUSTMENT - LIMITED	$35	$40
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	$90	$96
D9972	EXTERNAL BLEACHING - PER ARCH PERFORMED IN OFFICE	$125	$0
D9995	TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW	$0	
D9996	BROKEN APPOINTMENT	$0	
D9999	BROKEN APPOINTMENT	$20	$0
ORTHODONTIC SERVICES			
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$2,900	
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$2,900	
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$3,050	
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	$150	
D8999	a START-UP FEE (INCLUDING EXAM, BEGINNING RECORDS, X-RAYS,TRACING, PHOTOS, AND MODELS)	$250	

[1]Additional Prophy within 6 months will be based upon the necessity recommended by the provider.

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.

*If a noble, high noble or titanium metal is used, there will be an additional charge not to exceed $150 per unit. If a base metal is used, there are no additional charges from the provider.

UnitedHealthcare/Select Managed Care dental exclusions and limitations

LIMITATIONS OF BENEFITS

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	DENTAL PROPHYLAXIS	Limited to 1 time per 6 months
2.	FLUORIDE TREATMENTS	Limited to 1 time per calendar year.
3.	POST AND CORES	Covered only for teeth that have had root canal therapy.
4.	SCALING AND ROOT PLANING	Limited to 4 quadrants per calendar year.
5.	REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROTHESIS	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implant crowns, implant prostheses previously submitted for payment under the plan is limited to 1 time per tooth per 5 years from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable orthodontic appliances.
6.	INTRAORAL COMPLETE SERIES (INCLUDING BITEWINGS)	Limited to 1 time in any 2-year period.
7.	INTRAORAL BITEWING RADIOGRAPHS	Limited to 1 series of 4 films in any 6 month period.
8.	REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MAJOR RESTORATIVE SERVICES)	Replacement of complete dentures, and 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.
9.	CROWNS RETAINERS/ABUTMENTS	Retainers/Abutments - Limited to 1 time per tooth per 5 years.
10.	TEMPORARY CROWNS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
11.	INLAYS/ONLAYS RETAINERS/ABUTMENTS	Limited to 1 time per tooth per 5 years.
12.	INLAYS/ONLAYS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
13.	STAINLESS STEEL CROWNS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.
14.	ADJUSTMENTS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES OR CROWNS	Limited to repairs or adjustments performed more than 6 months after the initial insertion.
15.	INTRAVENOUS SEDATION OR GENERAL ANESTHESIA	Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions)
16.	PERIODONTAL MAINTENANCE PROCEDURES	Limited to once every 6 months, following active therapy, exclusive of gross debridement.
17.	REMOVABLE PROSTHETICS/FIXED PROSTHETICS/CROWNS, INLAYS AND ONLAYS (MINOR RESTORATIVE SERVICES)	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 5 years from initial or supplemental placement.
18.	CROWNS RESTORATIONS	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
19.	CROWNS, FIXED BRIDGES, AND IMPLANTS	The maximum benefit within a 12 month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12 month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Charges.
20.	ADJUNCTIVE	Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesion, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.
21.	SPECIALTY REFERRAL SERVICES MUST BE:	(A) Pre-Authorized by us; and (B) Coordinated by a Covered Person's Participating Dentist. Any Covered Person who elects specialist care without prior referral by his or her Participating Dentist and approval by us is responsible for all charges incurred • In order for specialty services to be Covered by this plan, the following referral process must be followed: • A Covered Person's Participating Dentist must coordinate all Dental Services. • When the care of a Network Specialist Dentist is required, the Covered Person's Participating Dentist must contact us and request authorization... • If the Participating Dentist request for specialist referral is denied, the Participating Dentist and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the Participating Dentist may be asked to perform the service. • Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not preauthorized by us to provide such services. • Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.
22.	CONE BEAM	Limited to 1 time per consecutive 60 months.

EXCLUSIONS OF BENEFITS

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits:

1.	Dental Services that are not Necessary.
2.	Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
3.	Any Dental Procedure not directly associated with dental disease.
4.	Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
5.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
6.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
7.	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.
8.	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.
9.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
10.	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.
11.	Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.
12.	Costs for non-dental services related to the provision of dental services in hospitals, extended care facilities, or Member's home are not covered. When deemed necessary by the Primary Care Dentist, the Member's physician, and authorized by the Plan, covered dental services that are delivered in an inpatient or outpatient hospital setting are covered as indicated in the Schedule of Benefits.
13.	Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
14.	Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates.
15.	Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the Covered Person must pay: (a) the Copayment for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal.
16.	Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
17.	Orthodontic Exclusions The following are not covered orthodontic benefits: • Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person • Treatment in progress prior to the effective date of this coverage • Extractions required for orthodontic purposes • Surgical orthodontics or jaw repositioning • Myofunctional therapy • Cleft palate • Micrognathia • Macroglossia • Hormonal imbalances • Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of treatment of accident • Palatal expansion appliances • Services performed by outside laboratories If a treatment plan is for less than 24 months, then a prorated portion of the full copayment shall apply. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a $50 consultation fee, plus any lab costs incurred by the orthodontist. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this Comprehensive Orthodontic Treatment. If comprehensive treatment is necessary, and is completed within a 24 month period, the Copayments listed will apply. If necessary and active treatment extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.
18.	Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by a Participating Dentist; or (b) treatment by a specialist without referral from a Participating Dentist and our approval.
19.	Any Dental Procedure not performed in a dental setting. This will not apply to Covered Emergency Dental Services.
20.	Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
21.	If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.
22.	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
23.	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. This exclusion does not apply to any services covered by Medicaid or Medicare
24.	Treatment which requires the services of a pediatric specialist, after the Covered Person's 6th birthday.

