The **Guardian** Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10004

SCHEDULE OF BENEFITS

This Policy includes pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

The Schedule of Benefits refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule of Benefits summarizes benefit information and the date these benefits take effect. You selected some of these benefits when You applied for this Policy. All Covered Persons less than age 19 are eligible for pediatric dental services. When You or Your Dependent Spouse, Dependent Child, or Domestic Partner no longer qualify for pediatric dental services due to age, You will then be eligible for non-pediatric dental services. When a Dependent child no longer qualifies for coverage under this Policy, as described in the Who May Enroll section of this Policy, that Dependent child's coverage will terminate.

Please read the entire Policy, along with this Schedule of Benefits, to fully understand all terms, conditions, limitations and exclusions that apply.

POLICYOWNER	Refer to Your ID Card
POLICY NUMBER	Refer to Your ID Card
EFFECTIVE DATE	The Effective Date Approved by Us
POLICY ANNIVERSARIES:	The Anniversary of the Effective Date, Each Year.

NON-PEDIATRIC (ADULT) SCHEDULE FOR COVERED PERSONS AGE 19 AND OVER

Cash Deductible Information

Deductible per Covered Person per Benefit Year
(When 3 Insureds meet the Deductible, no additional Deductibles will be required to be met for that Benefit Year.)

Preferred Provider Benefit Year Cash Deductible:
Group I and Group II Services $60.00

Non-Preferred Provider Benefit Year Cash Deductible:
Group I and Group II Services $120.00

Non-Pediatric Dental Services Covered Percentages

Preferred Provider Covered Percentage for services provided by a DentalGuard Preferred Provider and Non-Preferred Provider.

Preferred Provider Covered Percentages for:
Group I Services 100%
Group II Services 60%

Non-Preferred Provider Covered Percentages for:
Group I Services 100%
Group II Services 60%

Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximum
Annual Maximum per Covered Person $1,500.00

Preferred Provider and Non-Preferred Provider Waiting Periods
Group I Services ..... None
Group II Services ..... 6 Months

PEDIATRIC DENTAL SCHEDULE FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons under the age of 19 who are eligible for the Pediatric Dental Services explained below.

Pediatric Dental Services Cash Deductible Information

Deductible per Covered Person per Benefit Year

Preferred Provider Benefit Year Cash Deductible:
Group I, Group II and Group III Services $60.00
Group IV (Orthodontic) Services ..... None

Non-Preferred Provider Benefit Year Cash Deductible:
Group I, Group II and Group III Services $120.00

Pediatric Dental Services Covered Percentages

Preferred Provider Covered Percentage for services provided by a DentalGuard Preferred Provider and Non-Preferred Provider.

Preferred Provider Covered Percentages:
Group I Services 100%
Group II Services 50%
Group III Services 50%
Group IV (Orthodontic) Services 50%

Non-Preferred Provider Covered Percentages:
Group I Services 100%
Group II Services 50%
Group III Services 50%

Pediatric Dental Services Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximums:
Group I, Group II, Group III and Group IV (Orthodontic) Services ..... None

Preferred Provider and Non-Preferred Provider Orthodontics Lifetime Maximum ..... None

Preferred Provider Out of Pocket Annual Maximum Per Covered Person $450.00
Preferred Provider Out of Pocket Annual Maximum For Two or More Covered Persons $900.00
(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the

out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

Non-Preferred Provider Out of Pocket Annual Maximum ..... None

Preferred Provider and Non-Preferred Provider Waiting Periods:
Group I, Group II, Group III, and Group IV (Orthodontic) Services ..... None

How It Works

This Policy is designed to provide high quality dental care coverage while controlling the cost of such care. To do this, this Policy encourages a Covered Person to seek dental care from Dentists and dental care facilities that are under contract with Guardian's dental preferred provider organizations (PPOs), which is called DentalGuard Preferred.

DentalGuard Preferred is made up of Preferred Providers in a Covered Person's geographic area. Use of a Preferred Provider is voluntary. A Covered Person may receive dental treatment from any Dentist he or she chooses. And he or she is free to change Dentists at any time. When You enroll in this Policy, You and Your covered dependents receive: (1) a dental insurance ID card; and (2) information about current Preferred Providers.

This Policy usually pays a higher level of benefits for covered treatment furnished by a Preferred Provider. Conversely, it usually pays less for covered treatment furnished by a Non-Preferred Provider.

A Covered Person must present his or her ID card when he or she use a Preferred Provider. The Preferred Provider or Non Preferred Provider will prepare necessary claim forms, and submit the forms to Us. We send the Covered Person an explanation of this Policy's benefit payments. But, any benefit payable by Us is sent directly to the Preferred Provider.

What We pay is based on all of the terms of this Policy. Please read this Policy carefully.

A Covered Person may call Guardian at the number shown on his or her ID card should he or she have any questions about this Policy.

Please review the coverage, exclusions and limitations. Some services require prior authorization.

The Maximum Allowed Charges are the lesser of the amount charged by the Dentist or the maximum amount which the Preferred Provider has agreed with Guardian to accept as payment in full, for the dental services included in the List of Covered Dental Services below.

Covered Services performed by a Non-Preferred Provider will be based on a Covered Percentage of the fee schedule. A Covered Person will usually be left with less out-of-pocket expense when a Preferred Provider is used because Non-Preferred Providers may charge more than the charge listed in the fee schedule. The Covered Person will be responsible for paying the Deductible and any other part of the charge listed in the fee schedule for which Guardian does not pay benefits.

A dental service received through the use of audio-visual communication, sometimes called teledentistry, will be considered for benefits just like an in-person service. Teledentistry is provided to you at a different physical location than the dentist, or health professional acting under the delegation and supervision of a dentist, using telecommunications or information technology.

How to Reach Us

Claim Dept.	Customer Care Team	On the Web
P O Box 981587 El Paso, TX 79998-1587	(844) 561-5600	dentalexchange.guardiandirect.com

NON-PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS AGE 19 AND OLDER

List Of Covered Non-Pediatric Dental Services

The services covered by this Plan are named in this list. In order to be covered, the service must be furnished by, or under the direct supervision of, a Dentist. And, it must be Dentally Necessary.

Group I Services (Diagnostic & Preventive)

Prophylaxis And Fluorides

Prophylaxis: Limited to a total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group II Services.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Office Visits, Evaluations And Examination

Comprehensive oral evaluation – limited to once every 36 consecutive months.

Office visits, oral evaluations, limited oral evaluations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

After-hours office visit or emergency palliative treatment: Limited to a total of one in any six consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

Radiographs

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any twelve consecutive month period.

Intraoral periapical or occlusal images- single images.

Group II Services (Basic)

Restorative Services

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 36 months have passed since the previous restoration was placed.

Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 24 consecutive month period. Prefabricated stainless steel crowns, prefabricated

resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth: Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

Diagnostic Services

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment, limited to one consultation for each Covered Dental Specialty in any 12 consecutive month period. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic casts when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping: Limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

- Pulp capping, direct.
- Pulp capping, indirect: Includes sedative filling.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

Root canal treatment

Root canal retreatment: Limited to once per tooth, per lifetime.

Treatment of root canal obstruction, no surgical access.

Incomplete endodontic therapy, inoperable or fractured tooth.

Internal root repair of perforation defects.

Apexification: Limited to a maximum of three visits.

Apicoectomy: Limited to once per root, per lifetime.

Root amputation: Limited to once per root, per lifetime.

Retrograde filling: Limited to once per root, per lifetime.

Hemisection, including any root removal: Once per tooth.

Periodontal Services

Periodontal maintenance: Limited to a total of one periodontal maintenance or prophylaxis in any six consecutive month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis under Prophylaxis And Fluorides in Group I Services.

Periodontal Services**:** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once in any 36 consecutive month period. Considered only when no diagnostic preventive , periodontal maintenance procedure, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

The treatment listed below is limited to a total of one of following, once per tooth in any 12 consecutive month period.

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

The treatment listed below is limited to a total of one of the following, once per quadrant, in any 36 consecutive month period.

- Gingivectomy or gingivoplasty, per quadrant.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant.
- Gingival flap procedure, including scaling and root planing, per quadrant.
- Distal or proximal wedge procedure, not in conjunction with osseous surgery.
- Surgical revision procedure, per tooth.

The treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

The treatment listed below is limited to a total of one of the following, once per area or tooth, per lifetime, when the tooth is present.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

Periodontal Surgery Related

Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period after covered scaling and root planing or osseous surgery.

Occlusal guards: Covered only when done within a six consecutive month period after osseous surgery, and limited to one per lifetime.

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

- Uncomplicated extraction, one or more teeth.
- Root removal, non-surgical extraction of exposed roots.

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your medical plan**.

- Surgical removal of erupted teeth, involving tissue flap and bone removal.
- Surgical removal of residual tooth roots.
- Surgical removal of impacted teeth.

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your medical plan.**

- Alveoloplasty, per quadrant.
- Removal of exostosis, per site.
- Incision and drainage of abscess.
- Frenulectomy, frenectomy, frenotomy.
- Biopsy and examination of tooth related oral tissue.
- Brush biopsy
- Surgical exposure of impacted or unerupted tooth to aid eruption.
- Excision of tooth related tumors, cysts and neoplasms.
- Excision or destruction of tooth related lesion(s).
- Excision of hyperplastic tissue.
- Excision of pericoronal gingiva, per tooth.
- Oroantral fistula closure.
- Sialolithotomy.
- Sialodochoplasty.
- Closure of salivary fistula. Excision of salivary gland.
- Maxillary sinusotomy for removal of tooth fragment or foreign body.
- Vestibuloplasty.

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under Other Surgical Procedures.

Injectable antibiotics needed solely for treatment of a dental condition.

Waiting Periods For Certain Services

The following services when furnished by a Preferred Provider or Non-Preferred Provider are not considered covered charges during the waiting period shown in the Schedule of Benefits:

Group II Services

The services shown above are not covered charges under this Policy, and cannot be used to meet this Policy's Deductibles.

Limitations

Teeth Lost , Extracted or Missing Before A Covered Person Becomes Covered By This Plan: A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Plan.

Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) a facility owned or run by any governmental body; and (2) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons, unless this Plan provides benefits for a specific cosmetic services. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- Any endodontic or periodontal procedure performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
- Tooth transplants.
- Evaluations and consultations for non-covered services, or detailed and extensive oral evaluations.
- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.

- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.

PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS UNDER AGE 19

List Of Covered Pediatric Dental Services

The list below provides the Pediatric Dental Services based upon the NJ CHIP plan and selected as NJ's benchmark plan.

Group I Services (Diagnostic & Preventive)

Prophylaxis And Fluorides

- Dental prophylaxis once every 6 months*
- Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*. Fluoride varnish once every 3 months for children under the age of 6.

* Preventive services that can be considered every 3 months for individuals with special healthcare needs.

Office Visits, Evaluations And Examination

Clinical oral evaluations once every 6 months *

- Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
- Periodic oral evaluation – subsequent thorough evaluation of an established patient*
- Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
- Limited oral evaluations that are problem focused
- Detailed oral evaluations that are problem focused

* Preventive services that can be considered every 3 months for individuals with special healthcare needs.

Space Maintainers

Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal.

- fixed – unilateral and bilateral
- removable – bilateral only
- recementation of fixed space maintainer
- removal of fixed space maintainer – considered for provider that did not place appliance

Diagnostic Imaging with Interpretation

- A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
- An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
- Additional films/views needed for diagnosing can be provided as needed.

- Bitewings, periapicals, panoramic and cephlometric radiographic images
- Intraoral and extraoral radiographic images
- Oral/facial photographic images
- Maxillofacial MRI, ultrasound
- Cone beam image capture
- Tests and Examinations
- Viral culture
- Collection and preparation of saliva sample for laboratory diagnostic testing
- Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
- Oral pathology laboratory
- Accession/collection of tissue, examination – gross and microscopic, preparation and
- transmission of written report
- Accession/collection of exfoliative cytologic smears, microscopic examination,
- preparation and transmission of a written report
- Other oral pathology procedures, by report

Dental Sealants

Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of a sealant will be considered with prior authorization.

Group II Services (Basic)

Restorative Services

There are no frequency limits on replacing restorations (fillings). Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause. Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia. The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service. Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.

- Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, polishing and adjusting occlusion.
- Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
- Pin retention.
- Protective restoration/sedative filling.

Group III Services (Major)

Group III Restorative Services

There are no frequency limits on replacing restorations or crowns. Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause. Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.

- Gold foil - Service includes local anesthesia, polishing and adjusting occlusion.

- Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion.
- Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion. Provisional crowns are not covered.
- Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown.
- Core buildup including pins.
- Indirectly fabricated (custom fabricated/cast) and prefabricated post and core.
- Additional fabricated (custom fabricated/cast) and prefabricated post.
- Post removal.
- Temporary crown (fractured tooth).
- Additional procedures to construct new crown under existing partial denture.
- Coping.
- Crown repair.

Prosthodontic Services

All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.

- Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis.
- Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
- Provisional crowns are not covered.

New dentures or replacement dentures may be considered every 7 years unless dentures become obsolete due to additional extractions or are damaged beyond repair. All needed dental treatment must be completed prior to denture fabrication. Insertion of dentures includes adjustments for 6 months post insertion. Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

- Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
- Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
- Resin base and cast frame dentures including any conventional clasps, rests and teeth
- Flexible base denture including any clasps, rests and teeth
- Removable unilateral partial dentures or dentures without clasps are not considered
- Overdenture – complete and partial
- Denture adjustments –6 months after insertion or repair
- Denture repairs – includes adjustments for first 6 months following service

- Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
- Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
- Precision attachment, by report

Maxillofacial prosthetics - includes adjustments for first 6 months following service:

- Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
- Obturator prosthesis: surgical, definitive and modifications
- Mandibular resection prosthesis with and without guide flange
- Feeding aid
- Surgical stents
- Radiation carrier
- Fluoride gel carrier
- Commissure splint
- Surgical splint
- Topical medicament carrier
- Adjustments, modification and repair to a maxillofacial prosthesis
- Maintenance and cleaning of maxillofacial prosthesis

Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.

- Covered services include: implant body, abutment and crown.

Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.

- Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
- Abutment teeth must be periodontally sound and have a good long term prognosis
- Repair and recementation
- Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Endodontic Services

Service requires prior authorization Service includes all necessary radiographs or views needed for endodontic treatment. Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis. Emergency services for pain do not require prior authorization.

- Therapeutic pulpotomy for primary and permanent teeth

- Pulpal debridement for primary and permanent teeth
- Partial pulpotomy for apexogensis
- Pulpal therapy for anterior and posterior primary teeth
- Endodontic therapy and retreatment
- Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
- Apexification: initial, interim and final visits
- Pulpal regeneration
- Apicoectomy/Periradicular Surgery
- Retrograde filling
- Root amputation
- Surgical procedure for isolation of tooth with rubber dam
- Hemisection
- Canal preparation and fitting of preformed dowel or post
- Post removal

Periodontal Services

- Gingivectomy and gingivoplasty
- Gingival flap including root planning
- Apically positioned flap
- Clinical crown lengthening
- Osseous surgery
- Bone replacement graft – first site and additional sites
- Biologic materials to aid soft and osseous tissue regeneration
- Guided tissue regeneration
- Surgical revision
- Pedicle and free soft tissue graft
- Subepithelial connective tissue graft
- Distal or proximal wedge
- Soft tissue allograft
- Combined connective tissue and double pedicle graft

Non-Surgical Periodontal Service

- Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
- Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
- Full mouth debridement to enable comprehensive evaluation
- Localized delivery of antimicrobial agents

- Periodontal maintenance

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

- Extraction of coronal remnants – deciduous tooth
- Extraction, erupted tooth or exposed root
- Surgical removal of erupted tooth or residual root
- Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
- Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved
- Oroantral fistula
- Primary closure of sinus perforation and sinus repairs
- Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
- Surgical access of an unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to aid eruption
- Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
- Surgical repositioning of tooth/teeth
- Transseptal fiberotomy/supra crestal fiberotomy
- Surgical placement of anchorage device with or without flap
- Harvesting bone for use in graft(s)
- Alveoloplasty in conjunction or not in conjunction with extractions
- Vestibuloplasty
- Excision of benign and malignant tumors/lesions
- Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
- Destruction of lesions by electrosurgery
- Removal of lateral exostosis, torus palatinus or torus madibularis
- Surgical reduction of osseous tuberosity
- Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider
- Surgical Incision
- Incision and drainage of abcess - intraoral and extraoral
- Removal of foreign body
- Partial ostectomy/sequestrectomy
- Maxillary sinusotomy

- Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
- Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
- Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
- Manipulation under anesthesia
- Condylectomy, discectomy, synovectomy
- Joint reconstruction
- Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
- Arthroscopy
- Occlusal orthotic device – includes placement and removal to same provider
- Surgical and other repairs
- Repair of traumatic wounds – small and complicated
- Skin and bone graft and synthetic graft
- Collection and application of autologous blood concentrate
- Osteoplasty and osteotomy
- LeFort I, II, III with or without bone graft
- Graft of the mandible or maxilla – autogenous or nonautogenous
- Sinus augmentations
- Repair of maxillofacial soft and hard tissue defects
- Frenectomy and frenoplasty
- Excision of hyperplastic tissue and pericoronal gingiva
- Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
- Emergency tracheotomy
- Coronoidectomy
- Implant – mandibular augmentation purposes

Adjunctive General Services

- Palliative treatment for emergency treatment – per visit

Anesthesia

- Local anesthesia NOT in conjunction with operative or surgical procedures.
- Regional block
- Trigeminal division block.
- Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time

- Intravenous conscious sedation/analgesia – 2 hour maximum time
- Nitrous oxide/analgesia
- Non-intravenous conscious sedation – to include oral medications
- Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.

Consultation by specialist or non-primary care provider

Professional visits

- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
- For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
- General anesthesia and outpatient facility charges for dental services are covered
- Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

Drugs

- Therapeutic parenteral drug, Single administration
- Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report
- Application of desensitizing medicament – per visit

Occlusal guard – for treatment of bruxism, clenching or grinding

Athletic mouthguard covered once per year

Occlusal adjustment

- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

Odontoplasty

Internal bleaching

Group IV Services (Orthodontics)

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.

- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

- Limited treatment for the primary, transitional and adult dentition
- Interceptive treatment for the primary and transitional dentition
- Minor treatment to control harmful habits
- Continuation of transfer cases or cases started outside of the program
- Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the
- HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
- Orthognathic Surgical Cases with comprehensive orthodontic treatment
- Repairs to orthodontic appliances
- Replacement of lost or broken retainer
- Rebonding or recementing of brackets and/or bands
- Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.
- Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

How We Pay Benefits for Orthodontic Services For Covered Persons Under Age 19

Using the Covered Person's original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the active orthodontic appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the Covered Person must remain covered by this Plan.

We don't pay for orthodontic charges incurred by a Covered Person prior to being covered by this plan. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this plan to charges determined to be incurred by the Covered Person while covered by this Plan. Based on the original treatment Plan, We determine the portion of charges incurred by the Covered Person prior to being covered by this Plan, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the Orthodontic Treatment started.

The negotiated discounted fees for orthodontics performed by a Preferred Provider include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fix and removable appliances and related visits; and (c) limited, interceptive and comprehensive orthodontic treatment, with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for Orthodontic Treatment which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a Preferred Provider does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in Orthodontic Treatment necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; and (e) orthodontic treatment started before the member was eligible for orthodontic benefits under this Plan.

Exclusions

The Exclusions listed here apply to Covered Persons under the age of 19.

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) a facility owned or run by any governmental body; and (2) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges, charges for broken appointments. A Covered Person may seek the services of a new provider through which additional services are available.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis. This exclusion does not apply to Orthodontic retainers.
- The replacement of extracted or missing third molars/wisdom teeth.

- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Orthodontic Treatment that is not medically necessary.
- Prescription medication.

Schedule of Dental Fee Amounts
For Informational Purposes Only

The following schedule, which is provided for informational purposes only, illustrates the fee amounts used to determine covered charges for the specified code from the Current Dental Terminology © American Dental Association for dental plans in New Jersey. Covered charges are based on the schedule when You use the services of a Non-Preferred Provider.

This schedule does not guarantee that We will pay the amounts listed. What We pay is subject to all the terms of this plan, including Deductibles, Coinsurance rates, payment limits, plan frequencies, exclusions and other limitations.

Your plan may not include all of the listed codes as Covered Services. See the List of Covered Dental Services in the Schedule of Benefits.

The CDT codes, descriptions and fee amounts are subject to change.

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D0120	Periodic Oral Evaluation	$30	$31
D0140	Limited Oral Evaluation-Problem Focused	$46	$46
D0145	Oral Evaluation For A Patient Under Three Years Of Age	$47	$47
D0150	Comprehensive Oral Evaluation	$47	$47
D0160	Detailed And Extensive Oral Evaluation	$71	$71
D0170	Re-evaluation-Limited;Problem Focus;Not Postop	$41	$41
D0171	Re-Evaluation - Post-Operative Office Visit	$41	$41
D0180	Comprehensive Periodontal Evaluation	$47	$47
D0210	Intraoral Xrays-Complete Series W/ Bitewings	$88	$90
D0220	Intraoral Xrays - Periapical, First Film	$18	$20
D0230	Intraoral Xrays - Periapical, Each Extra Film	$11	$11
D0240	Intraoral Xrays - Occlusal Film	$25	$26
D0250	Extraoral Xrays - First Film	$25	$25
D0270	Bitewing Xrays - Single Film	$22	$23
D0272	Bitewing Xrays - Two Films	$27	$28
D0273	Bitewing Xrays - Three Films	$30	$31
D0274	Bitewing Xrays - Four Films	$41	$42
D0277	Vertical Bitewing Xrays - 7 To 8 Films	$55	$57
D0290	Post-Ant Or Lat Skull And Facial Bone Image	$87	$87
D0310	Sialography	$264	$264
D0320	Temporomandibular Joint Arthrogram with Injection	$308	$308
D0321	Other Temporomandibular Joint Films, By Report	$176	$176
D0322	Tomographic Survey	$264	$264
D0330	Panoramic Film	$76	$77
D0340	2d Cephalometric Radiographic Image	$62	$62
D0350	Oral/Facial Photo Images (Intra & Extraoral)	$32	$32
D0364	Cone Beam Capt & Interpret, Less Than One Jaw	$251	$251
D0365	Cone Beam Capt & Interpret, Full Arch-Mand	$213	$213
D0366	Cone Beam Capt & Interpret, Full Arch-Max	$205	$205
D0367	Cone Beam Capt & Interpret, Both Jaws	$274	$274
D0368	Cone Beam Capt & Interpret, Tmj, 2 Or More Images	$205	$205
D0380	Cone Beam Capture Only, Less Than One Jaw	$76	$76

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D0381	Cone Beam Capture Only, Full Arch-Mand	$213	$213
D0382	Cone Beam Capture Only, Full Arch-Max	$175	$175
D0383	Cone Beam Capture Only, Both Jaws	$152	$152
D0384	Cone Beam Capture Only, Tmj, 2 Or More Images	$198	$198
D0391	Interpret Image, Diff Prov Than Image Capture	$71	$71
D0431	Pre-Diagnostic Test To Detect Mucosal Abnormalities	$44	$44
D0460	Pulp Vitality Tests	$20	$20
D0470	Diagnostic Casts	$67	$67
D0601	Caries Risk Assessment - Low	$0	$0
D0602	Caries Risk Assessment - Moderate	$0	$0
D0603	Caries Risk Assessment - High	$0	$0
D1110	Prophylaxis - Adult	$55	$55
D1120	Prophylaxis - Child	$41	$41
D1206	Topical Fluoride Varnish; Therapeutic	$22	$22
D1208	Topical App Fluoride, Exc Varnish	$22	$22
D1351	Sealant - Per Tooth	$31	$31
D1352	Prev Resin Rest - Mod/High Caries-Perm Tooth	$31	$31
D1353	Sealant Repair-Per Tooth	$25	$25
D1510	Space Maintainer - Fixed - Unilateral	$210	$210
D1515	Space Maintainer - Fixed - Bilateral	$304	$304
D1520	Space Maintainer - Removable - Unilateral	$210	$210
D1525	Space Maintainer - Removable - Bilateral	$304	$304
D1550	Re-Cement Or Rebond Space Maintainer	$39	$39
D1555	Removal Of Fixed Space Maintainer	$27	$27
D2140	Amalgam - 1 Surface (Primary Or Permanent)	$70	$70
D2150	Amalgam - 2 Surfaces (Primary Or Permanent)	$88	$88
D2160	Amalgam - 3 Surfaces (Primary Or Permanent)	$108	$108
D2161	Amalgam - 4+ Surfaces (Primary Or Permanent)	$128	$128
D2330	Composite - 1 Surface, Anterior	$94	$94
D2331	Composite - 2 Surfaces, Anterior	$122	$122
D2332	Composite - 3 Surfaces, Anterior	$137	$137
D2335	Composite - 4 Or More Surfaces Or Incisal Angle, Anterior	$141	$141
D2390	Composite Crown, Anterior	$141	$141
D2391	Composite - 1 Surface, Posterior	$106	$106
D2392	Composite - 2 Surfaces, Posterior	$134	$134
D2393	Composite - 3 Surfaces, Posterior	$162	$162
D2394	Composite - 4 Or More Surfaces, Posterior	$170	$170
D2510	Inlay - Metal - 1 Surface	$478	$478
D2520	Inlay - Metal - 2 Surfaces	$569	$569
D2530	Inlay - Metal - 3 Or More Surfaces	$612	$612
D2542	Onlay - Metal - 2 Surfaces	$586	$586
D2543	Onlay - Metal - 3 Surfaces	$689	$689
D2544	Onlay - Metal - 4 Or More Surfaces	$718	$718
D2610	Inlay - Porcelain/Ceramic - 1 Surface	$515	$515
D2620	Inlay - Porcelain/Ceramic - 2 Surfaces	$572	$572
D2630	Inlay - Porcelain/Ceramic - 3 Or More Surfaces	$620	$620
D2642	Onlay - Porcelain/Ceramic - 2 Surfaces	$599	$599
D2643	Onlay - Porcelain/Ceramic - 3 Surfaces	$693	$693
D2644	Onlay - Porcelain/Ceramic - 4 Or More Surfaces	$722	$722

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D2650	Inlay - Composite - 1 Surface	$448	$448
D2651	Inlay - Composite - 2 Surfaces	$498	$498
D2652	Inlay - Composite - 3 Or More Surfaces	$539	$539
D2662	Onlay - Composite - 2 Surfaces	$520	$520
D2663	Onlay - Composite - 3 Surfaces	$602	$602
D2664	Onlay - Composite - 4 Or More Surfaces	$630	$630
D2710	Crown - Indirect Resin-Based Composite	$269	$269
D2712	Crown - Indirect 3/4 Resin-Based Composite	$269	$269
D2720	Crown - Resin With High Noble Metal	$404	$404
D2721	Crown - Resin With Predominantly Base Metal	$404	$404
D2722	Crown - Resin With Noble Metal	$404	$404
D2740	Crown - Porcelain/Ceramic Substrate	$789	$789
D2750	Crown - Porcelain On High Noble Metal	$774	$774
D2751	Crown - Porcelain On Predominantly Base Metal	$683	$683
D2752	Crown - Porcelain On Noble Metal	$728	$728
D2780	Crown - 3/4 Cast High Noble Metal	$735	$735
D2781	Crown - 3/4 Cast Predominantly Base Metal	$623	$623
D2782	Crown - 3/4 Cast Noble Metal	$692	$692
D2783	Crown - 3/4 Porcelain/Ceramic	$789	$789
D2790	Crown - Full Cast High Noble Metal	$735	$735
D2791	Crown - Full Cast Predominantly Base Metal	$623	$623
D2792	Crown - Full Cast Noble Metal	$692	$692
D2794	Crown - Titanium	$735	$735
D2799	Provisional Crown	$197	$197
D2910	Re-cement Inlay, Onlay, Veneer, Part Cov Rest	$54	$54
D2915	Re-cement Indirectly Fabricated Post & Core	$54	$54
D2920	Re-cement, Rebond Crown	$54	$54
D2929	Prefabricated Porcelain / Ceramic Crown - Primary Tooth	$197	$197
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$173	$173
D2931	Prefabricated Stainless Steel Crown-Permanent Tooth	$188	$188
D2932	Prefabricated Resin Crown	$197	$197
D2933	Prefabricated Stainless Steel Crown W/ Resin Window	$197	$197
D2934	Prefabricated Esthetic Stainless Steel Crown-Primary	$197	$197
D2940	Protective Restoration - Temporary	$55	$55
D2941	Interim Therapeutic Restoration - Primary	$39	$39
D2949	Restorative Foundation - Indirect Restoration	$0	$0
D2950	Core Buildup, Including Pins When Required	$121	$121
D2951	Pin Retention - Per Tooth	$32	$32
D2952	Indirectly Fabricated Post & Core	$270	$270
D2953	Each Additional Post, Indirect - Same Tooth	$20	$20
D2954	Prefabricated Post & Core	$170	$170
D2955	Post Removal (Not With Endo)	$141	$141
D2957	Each Additional Prefabricated Post - Same Tooth	$15	$15
D2960	Labial Veneer (Resin) - Chairside	$262	$262
D2961	Labial Veneer (Resin) - Lab	$389	$389
D2962	Labial Veneer (Porcelain) - Lab	$542	$542
D2971	Additional Procedure - Crown Under Part Dent Frame	$125	$125
D2980	Crown Repair, By Report	$141	$141
D2981	Inlay Repair Due To Rest Material Failure	$99	$99

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D2982	Onlay Repair Due To Rest Material Failure	$120	$120
D2983	Veneer Repair Due To Rest Material Failure	$99	$99
D3110	Pulp Cap -Direct (Excludes Final Restoration)	$39	$39
D3120	Pulp Cap-Indirect(Excludes Final Restoration)	$39	$39
D3220	Therapeutic Pulpotomy	$118	$126
D3221	Pulpal Debridement (Any Tooth)	$71	$76
D3222	Partial Pulpotomy - Apexogenesis (Perm Tooth)	$118	$126
D3230	Pulpal Therapy(Resorbable), Anterior, Primary	$124	$132
D3240	Pulpal Therapy(Resorbable), Posterior,Primary	$136	$145
D3310	Endodontic - Anterior (Exclude Final Restoration)	$487	$522
D3320	Endodontic - Bicuspid (Exclude Final Restoration)	$573	$615
D3330	Endodontic - Molar (Exclude Final Restoration)	$746	$802
D3331	Treatment Of Root Canal Obstruction (Non-Surgery)	$146	$157
D3332	Incomplete Rct - Inoperable, Unrestorable, Fx	$244	$261
D3333	Internal Root Repair Of Perforation	$146	$157
D3346	Endodontic - Retreatment - Anterior	$636	$683
D3347	Endodontic - Retreatment - Bicuspid	$731	$787
D3348	Endodontic - Retreatment - Molar	$887	$954
D3351	Apexification/Recalcification - Initial Visit	$146	$157
D3352	Apexification/Recalcification - Interim Meds	$97	$104
D3353	Apexification/Recalcification - Final Visit	$341	$365
D3355	Pulpal Regeneration - Initial Visit	$146	$157
D3356	Pulpal Regeneration - Interim Visit	$97	$104
D3357	Pulpal Regeneration - Tx Complete	$97	$104
D3410	Apicoectomy - Anterior	$447	$479
D3421	Apicoectomy - Bicuspid (First Root)	$539	$579
D3425	Apicoectomy - Molar (First Root)	$556	$597
D3426	Apicoectomy - (Additional Root)	$200	$216
D3427	Periradicular Surgery Without Apicoectomy	$485	$521
D3428	Bone Graft W/ Periradicular Surg - Tooth	$232	$249
D3429	Bone Graft W/ Periradicular Surg - Add Tooth	$178	$190
D3430	Retrograde Filling - Per Root	$98	$106
D3432	Gtr Per Site, W/ Periradicular Surg	$284	$305
D3450	Root Amputation - Per Root	$290	$313
D3920	Hemisection (W/Root Removal)	$246	$263
D3950	Canal Prep & Fit Of Preformed Dowel/Post	$73	$73
D4210	Gingivectomy - 4 Or More Teeth/Quad	$347	$374
D4211	Gingivectomy - 1 To 3 Teeth/Quad	$143	$153
D4212	Gingivectomy-Access For Rest Proc, Per Tooth	$100	$107
D4230	Crown Exposure - Four Or More Teeth, Per Quad	$514	$550
D4231	Crown Exposure - One To Three Teeth, Per Quad	$360	$385
D4240	Gingival Flap, W/ Root Planing-4 Or More Teeth/Quad	$407	$437
D4241	Gingival Flap, W/ Root Planing-1-3 Teeth/Quad	$285	$306
D4249	Clinical Crown Lengthening - Hard Tissue	$514	$550
D4260	Osseous Surgery - 4 Or More Teeth/Quad	$770	$829
D4261	Osseous Surgery - 1 To 3 Teeth/Quad	$539	$580
D4263	Bone Graft - First Site In Quadrant	$232	$249
D4264	Bone Graft - Additional Site In Quad	$178	$190
D4266	Guided Tissue Regen -Resorb Barrier/Site	$284	$305

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D4267	Guided Tissue Regen -Non-Resorb Barrier/Site	$334	$358
D4268	Surgical Revision, Per Tooth	$143	$143
D4270	Pedicle Soft Tissue Graft Procedure	$547	$588
D4273	Autogenous Connective Tissue Grft First Tooth	$671	$722
D4274	Distal Or Proximal Wedge Procedure	$178	$190
D4275	Non-Autogenous Tissue Graft First Tooth	$690	$743
D4276	Connective Tissue & Double Pedicle Graft	$705	$758
D4277	Free Soft Tissue Graft Proc, First Tooth	$575	$619
D4278	Free Soft Tissue Graft Proc, Additional Tooth	$345	$371
D4283	Autogenous Connective Tissue Graft, Additional Tooth	$403	$433
D4285	Nonautogenous Tissue Graft First, Additional Tooth	$414	$446
D4341	Scaling And Root Planing - 4 Or More Teeth/Quad	$148	$157
D4342	Scaling And Root Planing - 1-3 Teeth/Quad	$104	$110
D4355	Full Mouth Debridement	$78	$82
D4381	Local Delivery Antimicrobial Agents-Per Tooth	$65	$65
D4910	Periodontal Maintenance	$83	$87
D4921	Gingival Irrigation - Per Quadrant	$52	$52
D5110	Complete Denture - Maxillary	$942	$942
D5120	Complete Denture - Mandibular	$942	$942
D5130	Immediate Denture - Maxillary	$995	$995
D5140	Immediate Denture - Mandibular	$995	$995
D5211	Maxillary Partial Denture - Resin Base	$699	$699
D5212	Mandibular Partial Denture - Resin Base	$699	$699
D5213	Maxillary Partial Denture - Cast Frame	$1,033	$1,033
D5214	Mandibular Partial Denture - Cast Frame	$1,033	$1,033
D5221	Immediate Maxillary Partial Denture - Resin	$734	$734
D5222	Immediate Mandibular Partial Denture -Resin	$734	$734
D5223	Immediate Maxillary Partial Denture - Metal	$1,085	$1,085
D5224	Immediate Mandibular Partial Denture - Metal	$1,085	$1,085
D5225	Maxillary Partial Denture - Flexible Base	$1,033	$1,033
D5226	Mandibular Partial Denture - Flexible Base	$1,033	$1,033
D5281	Removable Unilateral Partial Denture-Metal	$408	$408
D5410	Adjust Complete Denture - Maxillary	$47	$47
D5411	Adjust Complete Denture - Mandibular	$47	$47
D5421	Adjust Partial Denture - Maxillary	$47	$47
D5422	Adjust Partial Denture - Mandibular	$47	$47
D5510	Repair Broken Complete Denture Base	$144	$144
D5520	Replace Missing/Broken Denture Tooth	$114	$114
D5610	Repair Resin Denture Base	$98	$98
D5620	Repair Cast Framework	$108	$108
D5630	Repair / Replace Broken Clasp	$92	$92
D5640	Replace Broken Teeth (Per Tooth)	$86	$86
D5650	Add Tooth To Existing Partial Denture	$115	$115
D5660	Add Clasp To Existing Partial Denture	$149	$149
D5670	Replace All Teeth & Acrylic - Maxillary	$388	$388
D5671	Replace All Teeth & Acrylic - Mandibular	$388	$388
D5710	Rebase Complete Maxillary Denture	$335	$335
D5711	Rebase Complete Mandibular Denture	$335	$335
D5720	Rebase Maxillary Partial Denture	$310	$310

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D5721	Rebase Mandibular Partial Denture	$310	$310
D5730	Reline Complete Max Denture (Chairside)	$164	$164
D5731	Reline Complete Mand Denture (Chairside)	$164	$164
D5740	Reline Max Partial Denture (Chairside)	$131	$131
D5741	Reline Mand Partial Denture (Chairside)	$131	$131
D5750	Reline Complete Max Denture (Lab)	$281	$281
D5751	Reline Complete Mand Denture (Lab)	$281	$281
D5760	Reline Max Partial Denture (Lab)	$243	$243
D5761	Reline Mand Partial Denture (Lab)	$243	$243
D5810	Interim Complete Denture (Maxillary)	$846	$846
D5811	Interim Complete Denture (Mandibular)	$846	$846
D5820	Interim Partial Denture (Maxillary)	$334	$334
D5821	Interim Partial Denture (Mandibular)	$334	$334
D5850	Tissue Conditioning, Maxillary	$91	$91
D5851	Tissue Conditioning, Mandibular	$91	$91
D5911	Facial Moulage (Sectional)	$143	$153
D5912	Facial Moulage (Complete)	$143	$153
D5913	Nasal Prosthesis	$3,027	$3,247
D5914	Auricular Prosthesis	$3,027	$3,247
D5915	Orbital Prosthesis	$4,089	$4,386
D5916	Ocular Prosthesis	$1,094	$1,173
D5919	Facial Prosthesis	$396	$425
D5922	Nasal Septal Prosthesis	$263	$282
D5924	Cranial Prosthesis	$523	$561
D5931	Obturator Prosthesis, Surgical	$1,633	$1,751
D5932	Obturator Prosthesis, Definitive	$1,141	$1,224
D5933	Obturator Prosthesis, Modification	$165	$177
D5934	Mand Resection Prosthesis With Guide Flange	$2,774	$2,975
D5935	Mand Resection Prosthesis Without Guide Flange	$2,409	$2,584
D5951	Feeding Aid	$444	$476
D5952	Speech Aid Prosthesis, Pediatric	$1,442	$1,547
D5954	Palatal Augmentation Prosthesis	$365	$391
D5955	Palatal Lift Prosthesis, Definitive	$2,346	$2,516
D5958	Palatal Lift Prosthesis, Interim	$793	$850
D5959	Palatal Lift Prosthesis, Modification	$165	$177
D5982	Surgical Stent	$159	$170
D5983	Radiation Carrier	$523	$561
D5986	Fluoride Gel Carrier	$89	$95
D5987	Commissure Splint	$238	$255
D5988	Surgical Splint	$238	$255
D5991	Topical Medicament Carrier	$89	$95
D5992	Adjust Max Prosthetic Appliance, By Report	$60	$65
D6010	Surgical Placement Of Implant Body: Endosteal	$1,386	$1,492
D6011	Second Stage Implant Surgery	$154	$166
D6012	Surgical Placement Of Interim Implant Body	$1,540	$1,658
D6013	Surgical Placement Of Mini Implant	$1,386	$1,492
D6040	Surgical Placement: Eposteal Implant	$2,464	$2,653
D6050	Surgical Placement: Transosteal Implant	$1,540	$1,658
D6051	Interim Abutment	$197	$197

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D6056	Prefabricated Abutment	$430	$430
D6057	Custom Abutment	$595	$595
D6058	Abutment Supported Porcelain/Ceramic Crown	$1,184	$1,184
D6059	Abutment Supported Pfm/High Noble Crown	$1,161	$1,161
D6060	Abutment Supported Pfm/Base Metal Crown	$1,025	$1,025
D6061	Abutment Supported Pfm/Noble Crown	$1,092	$1,092
D6062	Abutment Supported Cast/High Noble Crown	$1,103	$1,103
D6063	Abutment Supported Cast/Base Metal Crown	$935	$935
D6064	Abutment Supported Cast/Noble Metal Crown	$1,038	$1,038
D6065	Implant Supported Porcelain/Ceramic Crown	$1,184	$1,184
D6066	Implant Supported Pfm/High Noble Crown	$1,161	$1,161
D6067	Implant Supported Metal Crown/High Noble	$1,103	$1,103
D6068	Abutment Supported Retainer For Ceramic Fpd	$1,184	$1,184
D6069	Abutment Supported Retainer For Porcelain Fused To Metal (High Noble Metal) Fpd	$1,161	$1,161
D6070	Abutment Supported Retainer For Porcelain Fused To Metal (Base Metal) Fpd	$1,025	$1,025
D6071	Abutment Supported Retainer For Porcelain Fused To Metal Noble Fpd	$1,092	$1,092
D6072	Abutment Supported Retainer For High Noble Cast Fpd	$1,103	$1,103
D6073	Abutment Supported Retainer For Base Cast Fpd	$935	$935
D6074	Abutment Supported Retainer For Noble Cast Fpd	$1,038	$1,038
D6075	Implant Supported Retainer For Ceramic Fpd	$1,184	$1,184
D6076	Implant Supported Retainer - High Noble Pfm Fpd	$1,161	$1,161
D6077	Implant Supported Retainer - Cast High Noble Fpd	$1,103	$1,103
D6092	Re-cement, Rebond Imp/Abutment Supported Crown	$54	$54
D6093	Re-cement, Rebond Imp/Abutment Supp Fix Part Dent	$78	$78
D6094	Abutment Supported Crown - Titanium	$1,103	$1,103
D6095	Repair Implant Abutment, By Report	$215	$215
D6101	Debridement Of A Periimplant Defect	$285	$306
D6102	Debride/Osseous Contour Of Periimplant Defect	$539	$580
D6103	Bone Graft For Repair Of Periimplant Defect	$232	$249
D6104	Bone Graft At Time Of Implant Placement	$284	$305
D6110	Implant Supported Removable Full Denture-Max	$1,413	$1,413
D6111	Implant Supported Removable Full Denture-Mand	$1,413	$1,413
D6112	Implant Supported Removable Partial-Max	$1,550	$1,550
D6113	Implant Supported Removable Partial-Mand	$1,550	$1,550
D6190	Radiographic/Surgical Implant Index, By Report	$184	$195
D6194	Abutment Supported Retainer Crown - Titanium	$1,103	$1,103
D6205	Pontic - Indirect Resin-Based Composite	$269	$269
D6210	Pontic - Cast High Noble Metal	$735	$735
D6211	Pontic - Cast Base Metal	$623	$623
D6212	Pontic - Cast Noble Metal	$692	$692
D6214	Pontic - Titanium	$735	$735
D6240	Pontic - Pfm (High Noble)	$774	$774
D6241	Pontic - Pfm (Base Metal)	$683	$683
D6242	Pontic - Pfm (Noble Metal)	$728	$728
D6245	Pontic - Porcelain/Ceramic	$774	$774
D6250	Pontic - Resin With High Noble Metal	$774	$774

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D6251	Pontic - Resin With Base Metal	$683	$683
D6252	Pontic - Resin With Noble Metal	$728	$728
D6253	Provisional Pontic	$197	$197
D6545	Retainer - Cast Metal-Bonded Fixed Prosthesis	$286	$286
D6548	Retainer-Porcelain/Ceramic-Bonded Fixed Prosthesis	$286	$286
D6549	Resin Retainer-Resin Bonded Fixed Prosth	$143	$143
D6600	Retainer Inlay-Porcelain/Ceramic, 2 Surfaces	$572	$572
D6601	Retainer Inlay-Porcelain/Ceramic, 3+ Surfaces	$620	$620
D6602	Retainer Inlay-Cast High Noble, 2 Surfaces	$569	$569
D6603	Retainer Inlay-Cast High Noble, 3 Or More Surfaces	$612	$612
D6604	Retainer Inlay-Cast Base Metal, 2 Surfaces	$569	$569
D6605	Retainer Inlay-Cast Base Metal, 3 Or More Surfaces	$612	$612
D6606	Retainer Inlay-Cast Noble, 2 Surfaces	$569	$569
D6607	Retainer Inlay-Cast Noble, 3 Or More Surfaces	$612	$612
D6608	Retainer Onlay-Porcelain/Ceramic, 2 Surfaces	$599	$599
D6609	Retainer Onlay-Porcelain/Ceramic, 3 Or More Surfaces	$693	$693
D6610	Retainer Onlay-Cast High Noble, 2 Surfaces	$586	$586
D6611	Retainer Onlay-Cast High Noble, 3 Or More Surfaces	$689	$689
D6612	Retainer Onlay-Cast Base Metal, 2 Surfaces	$586	$586
D6613	Retainer Onlay-Cast Base Metal, 3 Or More Surfaces	$689	$689
D6614	Retainer Onlay-Cast Noble Metal, 2 Surfaces	$586	$586
D6615	Retainer Onlay-Cast Noble Metal, 3 Or More Surfaces	$689	$689
D6624	Retainer Inlay-Titanium	$569	$569
D6634	Retainer Onlay-Titanium	$586	$586
D6710	Retainer Crown-Indirect Resin-Based Cmpste	$269	$269
D6720	Retainer Crown-Resin With High Noble Metal	$404	$404
D6721	Retainer Crown-Resin W/Predominantly Base Metal	$404	$404
D6722	Retainer Crown-Resin With Noble Metal	$404	$404
D6740	Retainer Crown-Porcelain/Ceramic Substrate	$789	$789
D6750	Retainer Crown-Porcelain On High Noble Metal	$774	$774
D6751	Retainer Crown-Porcelain On Pred Base Metal	$683	$683
D6752	Retainer Crown-Porcelain On Noble Metal	$728	$728
D6780	Retainer Crown-3/4 Cast High Noble Metal	$688	$688
D6781	Retainer Crown-3/4 Cast Predominantly Base Metal	$623	$623
D6782	Retainer Crown-3/4 Cast Noble Metal	$692	$692
D6783	Retainer Crown-3/4 Porcelain/Ceramic	$789	$789
D6790	Retainer Crown-Full Cast High Noble Metal	$735	$735
D6791	Retainer Crown-Full Cast Predominantly Base Metal	$623	$623
D6792	Retainer Crown-Full Cast Noble Metal	$692	$692
D6793	Provisional Retainer Crown	$197	$197
D6794	Retainer Crown-Titanium	$735	$735
D6930	Recement, Rebond Fixed Partial Denture	$78	$78
D6940	Stress Breaker	$207	$207
D6980	Fixed Partial Denture Repair, By Repair	$143	$143
D6985	Pediatric Partial Denture, Fixed	$304	$304
D7111	Extraction, Coronal Remnants, Deciduous Tooth	$55	$58
D7140	Extraction, Erupted Tooth/Exposed Root	$79	$83
D7210	Surgical Removal W/Elevation/Sectioning	$151	$161
D7220	Removal Of Impacted Tooth - Soft Tissue	$195	$209

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D7230	Removal Of Impacted Tooth - Partial Bony	$259	$280
D7240	Removal Of Impacted Tooth - Full Bony	$317	$340
D7241	Removal Of Impacted Tooth - Full Bony W/Comp	$348	$374
D7250	Surgical Removal Of Residual Tooth Roots	$159	$166
D7251	Coronectomy-Intentional Partial Tooth Removal	$244	$262
D7260	Oroantral Fistula Closure	$351	$379
D7261	Primary Closure Of A Sinus Perforation	$351	$379
D7280	Surgical Access Of An Unerupted Tooth	$259	$280
D7282	Mobilization Of Erupted/Malpositioned Tooth	$362	$362
D7283	Device To Facilitate Eruption Of Imp Tooth	$103	$110
D7285	Biopsy Of Oral Tissue - Hard	$288	$308
D7286	Biopsy Of Oral Tissue - Soft	$160	$171
D7288	Brush Biopsy-Transepithelial Sample	$80	$80
D7291	Transseptal Fiberotomy, By Report	$70	$76
D7292	Surgical Place: Temporary Anchor Device, Screw Plate	$348	$374
D7293	Surgical Place: Temporary Anchor Device With Flap	$296	$318
D7294	Surgical Place: Temporary Anchor Device Without Flap	$226	$243
D7310	Alveoloplasty With Extraction, 4 Or More Teeth/Quad	$135	$145
D7311	Alveoloplasty With Ext, 1-3 Teeth/Quad	$68	$73
D7320	Alveoloplasty W/Out Extraction, 4 Or More Teeth/Quad	$176	$188
D7321	Alveoloplasty W/Out Ext, 1-3 Teeth/Quad	$123	$132
D7410	Excision Of Benign Lesion Up To 1.25cm	$196	$210
D7411	Excision Of Benign Lesion > 1.25cm	$284	$305
D7412	Excision Of Benign Lesion, Complicated	$314	$336
D7413	Excision Of Malignant Lesion Up To 1.25cm	$196	$210
D7414	Excision Of Malignant Lesion > 1.25cm	$284	$305
D7415	Excision Of Malignant Lesion, Complicated	$314	$336
D7440	Excision Of Malignant Tumor-Lesion To 1.25cm	$248	$265
D7441	Excision Of Malignant Tumor-Lesion > 1.25cm	$260	$280
D7450	Removal Of Benign Odontogenic Cyst/Tumor To 1.25cm	$241	$260
D7451	Removal Of Benign Odontogenic Cyst/Tumor > 1.25cm	$246	$263
D7460	Removal Of Benign Nonodontogenic Cyst/Tumor To 1.25	$207	$223
D7461	Removal Of Benign Nonodontogenic Cyst/Tumor > 1.25	$440	$473
D7465	Destruction Of Lesion By Physical/Chemical	$98	$98
D7471	Removal Of Lateral Exostosis-Maxilla Or Mandible	$311	$334
D7472	Removal Of Torus Palatinus	$311	$334
D7473	Removal Of Torus Mandibularis	$311	$334
D7485	Surgical Reduction Of Osseous Tuberosity	$311	$311
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	$102	$109
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complex	$112	$120
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	$122	$131
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complex	$135	$144
D7880	Occlusal Orthotic Device, By Report	$385	$385
D7881	Occlusal Orthotic Device Adjustment	$96	$96
D7953	Bone Replacement Graft Ridge Preservation-Per Site	$284	$305
D7960	Frenulectomy - Separate Procedure	$234	$252
D7963	Frenuloplasty	$374	$403
D7970	Excision Of Hyperplastic Tissue Per Arch	$196	$196
D7971	Excision Of Pericoronal Gingiva	$112	$112

CDT Code	Description	Fee Schedule Amount	
		General	Specialist
D7972	Surgical Reduction Of Fibrous Tuberosity	$156	$156
D8010, D8020, D8030, D8040	Limited Orthodontic Treatment	$859	$859
D8050, D8060	Interceptive Orthodontic Treatment	$1,216	$1,216
D8070, D8080, D8090	Comprehensive Orthodontic Treatment	$3,838	$3,838
D8210	Removable Appliance Therapy	$234	$234
D8220	Fixed Appliance Therapy	$234	$234
D8660	Pre-Orthodontic Treatment Examination	$47	$47
D8670	Periodic Orthodontic Treatment Visit (As Part Of Contract)	$136	$136
D8680	Orthodontic Retention	$446	$446
D8681	Removable Orthodontic Retainer Adjustment	$31	$31
D8693	Re-Cement Or Rebond Fixed Retainers	$62	$62
D8694	Repair Or Fixed Retainers, Includes Reattachment	$62	$62
D8999	Unspecified Orthodontic Procedure, By Report	$289	$289
D9110	Palliative Treatment Of Dental Pain-Minor Procedure	$59	$64
D9120	Fixed Partial Denture Sectioning	$117	$117
D9215	Local Anesthesia	$0	$0
D9219	Evaluation-Deep Sedation/General Anesthesia	$46	$46
D9223	Deep Sedation / General Anesth-15 Minutes	$115	$124
D9230	Administration Of Nitrous Oxide/Anxiolysis/Analgesia	$32	$35
D9243	Intravenous Mod Sedation / Analgesia-15 Minutes	$115	$124
D9248	Non-Intravenous Conscious Sedation	$218	$235
D9310	Consultation (Other Than Requesting Doctor)	$71	$76
D9430	Office Visit For Observation-No Other Service	$34	$36
D9440	Office Visit - After Regular Hours	$69	$69
D9610	Therapeutic Parenteral Drug, Single	$31	$33
D9612	Therapeutic Parenteral Drugs, Two Or More, Diff Medications	$47	$50
D9940	Occlusal Guard, By Report	$385	$385
D9942	Repair And/Or Reline Of Occlusal Guard	$58	$58
D9943	Occlusal Guard Adjustment	$96	$96
D9951	Occlusal Adjustment - Limited	$67	$72
D9952	Occlusal Adjustment - Complete	$179	$191
D9971	Odontoplasty 1-2 Teeth	$67	$67
D9972	External Bleaching - Per Arch	$254	$254
D9973	External Bleaching - Per Tooth	$38	$38
D9974	Internal Bleaching - Per Tooth	$153	$153
D9975	External Bleaching For Home Application, Per Arch	$153	$153