California Family Dental HMO

This Schedule of Benefits lists the services available to you under your Access Dental Individual Plan, as well as the Copayments associated with each procedure. Please review the Benefits Description and Limitations & Exclusions Section below for a detailed description and additional information about how your Plan works.

The following Copayments apply when services are performed by your assigned Primary Care Dentist (PCD) or a Contracted Specialty Provider (with prior approval from Access Dental, also referred to as "the Plan"). If Specialty Services are recommended by your PCD, the treatment plan must be preauthorized in writing by the Plan prior to treatment in order for the services to be eligible for coverage.

The benefits shown below are performed as deemed appropriate by the assigned Primary Care Dentist subject to the limitations and exclusions of the program. You should discuss all treatment options with your PCD prior to services being rendered.

Specialty services require prior authorization from the Plan. A referral must be submitted to the Plan by your Primary Care Dentist for approval.

Procedure Category	Child-ONLY* Copay Range	Adult-Only** Copay Range
Diagnostic and Preventive Exams, Cleanings, Fluoride, Sealants, X-rays and Consultations	$0	$0
Basic Services Amalgam Fillings, Composite Fillings (Anterior Only) and Emergency Palliative	$0-$25	$0-$25
Major Services Crowns & Casts, Prosthodontics, Endodontics, Periodontics, and Oral Surgery	$0-$300	$0-$300
Orthodontia (Only for pre-authorized Medically Necessary Orthodontia)	$0-$350	N/A
Individual Deductible (Waived for Diagnostic and Preventive)	$0	N/A
Family Deductible (Waived for Diagnostic and Preventive)	$0	N/A
Out of Pocket Maximum (OOP) (per person)	$350	N/A
Out of Pocket Maximum (OOP) (2+ children)	$700	N/A
Annual Maximum	N/A	N/A
Ortho Lifetime Maximum	N/A	N/A
Office Visit (Per Visit)	$0	$0
Waiting Period	N/A	N/A

*This plan is available for individuals up to age 19

*This plan is available for individuals ages 19 and over.

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ADA Code	Code Description	EHB Copay	Adult Copay
Diagnostic (D0100-D999)			
Frequency limitations are calculated to the exact date.			
D0120	Periodic oral examination - established patient - *limited to two in a 12 month period*	$0	$0
D0140	Limited oral evaluation - problem focused	$0	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver - *limited to two in a 12 month period*	$0	Not Covered
D0150	Comprehensive oral evaluation - new or established patient - *limited to two in a 12 month period*	$0	$0
D0160	Detailed and extensive oral evaluation – problem focused, by report - *limited to two in a 12 month period*	$0	$0
D0170	Re-evaluation - limited, problem focused (established patient: not post-operative visit) - *limited to two in a 12 month period*	$0	$0
D0210	Intraoral - complete series (including bitewings)-*limited to once every 24 consecutive months*	$0	$0
D0220	Intraoral - periapical first film	$0	$0
D0230	Intraoral - periapical each additional film	$0	$0
D0240	Intraoral - occlusal film	$0	$0
D0250	Extraoral - first film	$0	$0
D0260	Extraoral - each addditional film	$0	$0
D0270	Bitewing - single film-*limited to 2 series every 12 months*	$0	$0
D0272	Bitewings - two films-*limited to 2 series every 12 months*	$0	$0
D0273	Bitewings - three films-*limited to 2 series every 12 months*	$0	$0
D0274	Bitewings - four films-*limited to 2 series every 12 months*	$0	$0
D0277	Vertical bitewings – 7 to 8 films	$0	$0
D0330	Panoramic film-*limited to once every 24 consecutive months*	$0	$0
D0415	Collection of microorganisms for culture and sensitivity	$0	$0
D0425	Caries susceptibility tests	$0	$0
D0460	Pulp vitality tests	$0	$0
D0470	Diagnostic casts	$0	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not Covered	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not Covered	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not Covered	$0
Preventive (D1000-D1999)	**Code Description**	**EHB Copay**	**Adult Copay**
Frequency limitations are calculated to the exact date.			
D1110	Prophylaxis – adult- *limited to 2 in a 12 month period*	$0	$0
D1120	Prophylaxis – child- *limited to 2 in a 12 month period*	$0	$0
D1203	Topical application of fluoride (prophylaxis not included) - child	$0	Not Covered
D1310	Nutritional counseling for control of dental disease	$0	$0
D1330	Oral hygiene instructions	$0	$0
D1351	Sealant - per tooth- *limited to permanent first and second molars only - limited to once in a 24 month period*	$0	Not Covered
D1510	Space maintainer - fixed – unilateral	$0	Not Covered
D1515	Space maintainer - fixed – bilateral	$0	Not Covered
D1520	Space maintainer - removable - unilateral	$0	$0

D1525	Space maintainer - removable - bilateral	$0	$0
D1550	Recementation of space maintainer	$0	Not Covered
Restorative (D2000-D2999)	**Code Description**	**EHB Copay**	**Adult Copay**
Frequency limitations are calculated to the exact date. **Fillings**: Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners, and acid etch procedures **Crowns**: There is additional co-payment of $125 per unit for treatment plans of 7 or more units. There is an additional co-payment of $75 per unit for porcelain on molars. Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals. The replacement of crowns requires the existing restoration to be 5+ years old.			
D2140	Amalgam - one surface, primary or permanent	$25	$0
D2150	Amalgam - two surfaces, primary or permanent	$40	$0
D2160	Amalgam - three surfaces, primary or permanent	$40	$0
D2161	Amalgam - four or more surfaces, primary or permanent	$40	$0
D2330	Resin-based composite - one surface, anterior	$40	$0
D2331	Resin-based composite - two surfaces, anterior	$40	$0
D2332	Resin-based composite - three surfaces, anterior	$40	$0
D2390	Resin-based composite crown, anterior	$40	$35
D2391	Resin-based composite – one surface, posterior	$40	$55
D2392	Resin-based composite – two surfaces, posterior	$40	$65
D2393	Resin-based composite – three surfaces, posterior	$40	$75
D2394	Resin-based composite – four or more surfaces, posterior	$40	$85
D2510	Inlay - metallic - one surface	Not Covered	$165
D2520	Inaly - metallic - two surfaces	Not Covered	$165
D2530	Inlay - metallic three or more surfaces	Not Covered	$165
D2542	Onlay - metallic - two surfaces	Not Covered	$165
D2543	Onlays - metallic - three surfaces	Not Covered	$165
D2544	Onlays - metallic - four or more surfaces	Not Covered	$165
D2610	Inlay - porcelian/ceramic - one surface	Not Covered	$165
D2620	Inlay - porcelian/ceramic - two surfaces	Not Covered	$165
D2630	Inlay - porcelain/ceramic - three or more surfaces	Not Covered	$165
D2642	Onlay - porcelain/ceramic - two surfaces	Not Covered	$165
D2643	Onlay - porcelain/ceramic - three surfaces	Not Covered	$165
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not Covered	$165
D2650	Inlay - resin-based composite - one surface	Not Covered	$165
D2651	Inlay - resin-based composite - two surfaces	Not Covered	$165
D2652	Inlay - resin-based composite - three or more surfaces	Not Covered	$165
D2662	Onlay - resin-based composite - two surfaces	Not Covered	$165
D2663	Onlay - resin-based composite - three surfaces	Not Covered	$165
D2664	Onlay - resin-based composite - four or more surfaces	Not Covered	$165
D2710	Crown - resin-based composite (indirect)	Not Covered	$50
D2712	Crown - 3/4 resin=based composite (indirect)	Not Covered	$50
D2720	Crown - resin with high noble metal	Not Covered	$165
D2721	Crown - resin with predominantly base metal	Not Covered	$95
D2722	Crown - resin with noble metal	Not Covered	$95
D2740	Crown - porcelain/ceramic substrate	Not Covered	$240
D2750	Crown - porcelain fused to high noble metal	$300	$300
D2751	Crown - porcelain fused to predominantly base metal	$300	$300
D2752	Crown - porcelain fused to noble metal	$300	$300
D2780	Crown - 3/4 cast high noble metal	$365	$165
D2781	Crown - 3/4 cast predominantly base metal	$365	$165
D2782	Crown - 3/4 cast noble metal	$365	$165
D2783	Crown – ¾ porcelain/ceramic	$365	$165
D2790	Crown - full cast high noble metal	$365	$165

D2791	Crown - full cast predominantly base metal	$365	$165
D2792	Crown - full cast noble metal	$365	$165
D2794	Crown - titanium	Not Covered	$165
D2799	Provisional crown	Not Covered	$0
D2910	Recement inlay, onlay, or partial coverage restoration	$0	$0
D2915	Recement cast or prefabricated post and core	$0	$0
D2920	Recement crown	$0	$0
D2930	Prefabricated stainless steel crown - primary tooth	$150	$15
D2931	Prefabricated stainless steel crown - permanent tooth	$150	$15
D2932	Prefabricated resin crown	Not Covered	$25
D2933	Prefabricated stainless steel crown with resin window	Not Covered	$20
D2940	Sedative filling	$50	$5
D2950	Core buildup, involving and including any pins	$100	$15
D2951	Pin retention - per tooth, in addition to restoration	$0	$10
D2952	Post and core in addition to crown, indirectly fabricated	$100	$35
D2953	Each additional indirectly fabricated post - same tooth	Not Covered	$25
D2954	Prefabricated post and core in addition to crown	$100	$20
D2955	Post removal (not in conjunction with endodontic therapy)	Not Covered	$10
D2957	Each additional prefabricated post - same tooth	Not Covered	$15
D2960	Labial veneer (resin laminate) - chairside	Not Covered	$250
D2970	Temporary crown (fractured tooth)	Not Covered	$5
D2971	Additional procedures to construct new crown under existing partial denture framework	Not Covered	$28
D2980	Crown repair, by report	Not Covered	$15
Endodontics (D3000-D3999)	**Code Description**	**EHB Copay**	**Adult Copay**
Including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia, all irrigants, obstruction of root canals and routine follow-up care. Retreatment of a root canal, within a 24 month period, is not payable to the same provider that did the original root canal.			
D3110	Pulp cap - direct (excluding final restoration)	$50	$0
D3120	Pulp cap – indirect (excluding final restoration)	$50	$0
D3220	Therapeutic pulpotomy (excluding final restoration)	$50	$0
D3221	Pulpal debridement, primary and permanent teeth	Not Covered	$10
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	Not Covered	$15
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final resotration)	Not Covered	$20
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final resotration)	Not Covered	$20
D3310	Anterior Root Canal Therapy(excluding final restoration)	$300	$55
D3320	Bicuspid Root Canal Therapy (excluding final restoration)	$365	$120
D3330	Molar (excluding final restoration)	$300	$250
D3331	Treatment of root canal obstruction; non-surgical access	Not Covered	$55
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not Covered	$55
D3333	Internal root repair of perforation defects	Not Covered	$55
D3346	Retreatment of previous root canal therapy – anterior	Not Covered	$85
D3347	Retreatment of previous root canal therapy – bicuspid	Not Covered	$150
D3348	Retreatment of previous root canal therapy – molar	Not Covered	$380
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Not Covered	$75
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	Not Covered	$50

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D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	Not Covered	$50
D3410	Apicoectomy/periradicular surgery – anterior	Not Covered	$60
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	Not Covered	$70
D3425	Apicoectomy/periradicular surgery – molar (first root)	Not Covered	$80
D3426	Apicoectomy/periradicular surgery (each additional root)	Not Covered	$50
D3430	Retrograde filling - per root	Not Covered	$60
D3450	Root amputation - including any root removal	Not Covered	$0
D3920	Hemisection (including any root removal), not includnig root canal therapy	Not Covered	$30
Periodontics (D4000-D4999) {TMI: Surgery 4000-4299}	**Code Description**	**EHB Copay**	**Adult Copay**
Including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia, all irrigants, obstruction of root canals and routine follow-up care. Includes pre-operative and post operative evaluations and treatment of natural teeth under a local anesthetic Root planing is limited to four quadrants during any 12 consecutive months			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$150	$150
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	Not Covered	$150
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	Not Covered	$130
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	Not Covered	$80
D4245	Apically positioned flap	Not Covered	$125
D4249	Clinical crown lengthening - hard tissue	Not Covered	$125
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	Not Covered	$285
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	Not Covered	$230
D4263	Bone replacement graft - first site in quadrant	Not Covered	$210
D4264	Bone replacement graft - each additional site in quadrant	Not Covered	$70
D4270	Pedicle soft tissue graft procedure	Not Covered	$205
D4271	Free soft tissue graft procedure (including donor site surgery)	Not Covered	$205
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	Not Covered	$45
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to five (5) quadrant treatments in any 12 consecutive months*	$75	$25
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to five (5) quadrant treatments in any 12 consecutive months*	$0	$20
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Not Covered	$25
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	Not Covered	$60
D4910	Periodontal maintenance	Not Covered	$15
D4910	Additional periodontal maintenance - additional per 12 month period - *limited to five (5) quadrant treatments in any 12 consecutive months*	Not Covered	$55
Removable Prosthodontics (D5000-D5899)	**Code Description**	**EHB Copay**	**Adult Copay**
Frequency limitations are calculated to the exact date. For all listed dentures and partial dentures, co-payment includes after delivery adjustments and tissue conditioning, if needed, for the first 6 months after insertion. The member must continue to be eligible, and the service must be provided at the PCD's facility where the denture was originally inserted. Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months. Replacement of a denture or a partial denture requires the existing denture to be 5+ years old, unless it is due to loss of a natural functioning tooth. Replacement			

will be a benefit, only if the existing denture is unsatisfactory and cannot be made serviceable.			
D5110	Complete denture – maxillary – *limited to once every 60 months*	$365	$140
D5120	Complete denture – mandibular – *limited to once every 60 months*	$365	$140
D5130	Immediate denture – maxillary – *limited to once every 60 months*	$365	$165
D5140	Immediate denture – mandibular – *limited to once every 60 months*	$365	$165
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – *limited to once every 60 months*	$365	$120
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – *limited to once every 60 months*	$365	$120
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including. any conventional clasps, rests and teeth) – *limited to once every 60 months*	$365	$160
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) – *limited to once every 60 months*	$365	$160
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth) – *limited to once every 60 months*	$365	$210
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth) – *limited to once every 60 months*	$365	$210
D5410	Adjust complete denture – maxillary – *limited to once every 60 months*	$50	$10
D5411	Adjust complete denture – mandibular – *limited to once every 60 months*	$50	$10
D5421	Adjust partial denture – maxillary – *limited to once every 60 months*	$50	$10
D5422	Adjust partial denture – mandibular – *limited to once every 60 months*	$50	$10
D5510	Repair broken complete denture base	$125	$20
D5520	Replace missing or broken teeth - complete denture (each tooth)	$125	$10
D5610	Repair resin denture base	$125	$20
D5620	Repair cast framework	$125	$20
D5630	Repair or replace broken clasp	$125	$20
D5640	Replace broken teeth - per tooth	$125	$10
D5650	Add tooth to existing partial denture	$125	$10
D5660	Add clasp to existing partial denture	$125	$10
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not Covered	$135
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not Covered	$115
D5710	Rebase complete maxillary denture	Not Covered	$55
D5711	Rebase complete mandibular denture	Not Covered	$55
D5720	Rebase maxillary partial denture	Not Covered	$55
D5721	Rebase mandibular partial denture	Not Covered	$55
D5730	Reline complete maxillary denture (chairside)	$125	$20
D5731	Reline complete mandibular denture (chairside)	$125	$20
D5740	Reline maxillary partial denture (chairside)	$125	$20
D5741	Reline mandibular partial denture (chairside)	$125	$20
D5750	Reline complete maxillary denture (laboratory)	$150	$60
D5751	Reline complete mandibular denture (laboratory)	$150	$60
D5760	Reline maxillary partial denture (laboratory)	$150	$60
D5761	Reline mandibular partial denture (laboratory)	$150	$60
D5820	Interim partial denture (maxillary)	$250	$75
D5821	Interim partial denture (mandibular)	$250	$75
D5850	Tissue conditioning, maxillary - *limited to two per denture*	$75	$0
D5851	Tissue conditioning, mandibular – *limited to two per denture*	$75	$0
Fixed Prosthodontics (D6200-D6999)	**Code Description**	**EHB Copay**	**Adult Copay**
Frequency limitations are calculated to the exact date. Prosthodontics fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge]).			

There is an additional co-payment of $125 per unit for treatment plans of 7 or more units. There is an additional co-payment of $75 per unit for porcelain on molars. Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals. The replacement of retainers and pontics requires the existing bridge to be 5+ years old.
Implants and implant-related procedures are not covered.

D6210	Pontic - cast high noble metal – *limited to once every 60 months*	$365	$165
D6211	Pontic - cast predominantly base metal – *limited to once every 60 months*	$365	$165
D6212	Pontic - cast noble metal – *limited to once every 60 months*	$365	$165
D6214	Pontic - titanium– *limited to once every 60 months*	Not Covered	$165
D6240	Pontic - porcelain fused to high noble metal – *limited to once every 60 months*	$365	$165
D6241	Pontic - porcelain fused to predominantly base metal – *limited to once every 60 months*	$365	$165
D6242	Pontic - porcelain fused to noble metal – *limited to once every 60 months*	$365	$165
D6245	Pontic - porclain/ceramic – *limited to once every 60 months*	Not Covered	$240
D6250	Pontic - resin with high noble metal – *limited to once every 60 months*	Not Covered	$165
D6251	Pontic - resin with predominantly base metal – *limited to once every 60 months*	Not Covered	$165
D6252	Pontic - resin with noble metal – *limited to once every 60 months*	Not Covered	$165
D6253	Provisional pontic – *limited to once every 60 months*	Not Covered	$0
D6600	Inlay - porcelain/ceramic - two surfaces – *limited to once every 60 months*	Not Covered	$165
D6601	Inlay - porcelain/ceramic - three or more surfaces – *limited to once every 60 months*	Not Covered	$165
D6602	Inlay - cast high noble metal, two surfaces– *limited to once every 60 months*	Not Covered	$165
D6603	Inlay - cast high noble metal, three or more surfaces – *limited to once every 60 months*	Not Covered	$165
D6604	Inlay - cast predominantly base metal, two surfaces – *limited to once every 60 months*	Not Covered	$40
D6605	Inlay - cast predominantly base metal, three or more surfaces – *limited to once every 60 months*	Not Covered	$40
D6606	Inlay - cast noble metal, two surfaces – *limited to once every 60 months*	Not Covered	$100
D6607	Inlay - cast noble metal, three or more surfaces – *limited to once every 60 months*	Not Covered	$100
D6608	Onlay - porcelain/ceramic, two surfaces – *limited to once every 60 months*	Not Covered	$165
D6609	Onlay - porcelain/ceramic, three or more surfaces – *limited to once every 60 months*	Not Covered	$165
D6610	Onlay - cast high noble metal, two surfaces – *limited to once every 60 months*	Not Covered	$165
D6611	Onlay - cast high noble metal, three or more surfaces – *limited to once every 60 months*	Not Covered	$165
D6612	Onlay - cast predominantly base metal, two surfaces – *limited to once every 60 months*	Not Covered	$40
D6613	Onlay - cast predominantly base metal, three or more surfaces – *limited to once every 60 months*	Not Covered	$40
D6614	Onlay - cast noble metal, two surfaces – *limited to once every 60 months*	Not Covered	$100
D6615	Onlay - cast noble metal, three or more surfaces – *limited to once every 60 months*	Not Covered	$100
D6710	Crown - indirect resin based composite – *limited to once every 60 months*	Not Covered	$165
D6720	Crown - resin with high noble metal – *limited to once every 60 months*	Not Covered	$165
D6721	Crown - resin with predominantly base metal – *limited to once every 60 months*	Not Covered	$165
D6722	Crown - resin with noble metal – *limited to once every 60 months*	Not Covered	$165
D6740	Crown - porcelain/ceramic – *limited to once every 60 months*	Not Covered	$240
D6750	Crown - porcelain fused to high noble metal – *limited to once every 60 months*	Not Covered	$165
D6751	Crown - porcelain fused to predominantly base metal – *limited to once every 60 months*	Not Covered	$165

D6752	Crown - porcelain fused to noble metal – *limited to once every 60 months*	Not Covered	$165
D6780	Crown - 3/4 cast high noble metal – *limited to once every 60 months*	Not Covered	$165
D6781	Crown - 3/4 cast predominantly base metal – *limited to once every 60 months*	Not Covered	$165
D6782	Crown - 3/4 cast noble metal – *limited to once every 60 months*	Not Covered	$165
D6783	Crown - 3/4 porcelain/ceramic – *limited to once every 60 months*	Not Covered	$165
D6790	Crown - full cast high noble metal – *limited to once every 60 months*	Not Covered	$165
D6791	Crown - full cast predominantly base metal – *limited to once every 60 months*	Not Covered	$165
D6792	Crown - full cast noble metal – *limited to once every 60 months*	Not Covered	$165
D6794	Crown – titanium – *limited to once every 60 months*	Not Covered	$165
D6930	Recement fixed partial denture – *limited to once every 60 months*	Not Covered	$0
D6940	Stress breaker	Not Covered	$0
Oral and Maxillofacial Surgery (D7000-D7999)	**Code Description**	**EHB Copay**	**Adult Copay**
Includes pre-operative and postoperative evaluations and treatment under a local anesthetic. Removal of pathology-free 3rd molars is not covered. Biopsy of oral tissue does not include pathology laboratory services.			
D7111	Extraction, coronal remnants – deciduous tooth	$45	$0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	$65
D7210	Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$135	$25
D7220	Removal of impacted tooth - soft tissue	$135	$50
D7230	Removal of impacted tooth - partially bony	$135	$70
D7240	Removal of impacted tooth - completely bony	$160	$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$135	$110
D7250	Surgical removal of residual tooth roots (cutting procedure)	$135	$0
D7270	Tooth reimplantation and/or stabilization of accidentally evlused or displaced tooth	Not Covered	$85
D7280	Surgical access of an unerupted tooth	Not Covered	$90
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not Covered	$90
D7283	Placement of device to facility eruption of impacted tooth	Not Covered	$0
D7286	Biopsy of oral tissue - soft (all others)	Not Covered	$0
D7287	Exfoliative cytological sample collection	Not Covered	$50
D7288	Brush biopsy - transepithelial sample collection	Not Covered	$50
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Not Covered	$50
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Not Covered	$50
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Not Covered	$70
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Not Covered	$70
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Not Covered	$0
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Not Covered	$0
D7471	Removal of lateral exostosis (maxilla or mandible)	Not Covered	$0
D7472	Removal of torus palatinus	Not Covered	$0
D7473	Removal of torus mandibularis	Not Covered	$0
D7510	Incision and drainage of abscess - intraoral soft tissue	Not Covered	$10
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated	Not Covered	$15

	(includes drainage of multiple fascial spaces)		
D7520	Incision and drainage of abscess - extraoral soft tissue	Not Covered	$10
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Not Covered	$15
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	Not Covered	$20
D7963	Frenuloplasty	Not Covered	$20
D7970	Excision of hyperplastic tissue - per arch	Not Covered	$55
Orthodontics (D8000-D8999)	**Code Description**	**EHB Copay**	**Adult Copay**
Orthodontic treatment includes medically-necessary orthodontia only.			
D8010	Limited orthodontic treatment of the primary dentition	$350	Not Covered
D8020	Limited orthodontic treatment of the transitional dentition	$350	Not Covered
D8030	Limited orthodontic treatment of the adolescent dentition	$350	Not Covered
D8040	Limited orthodontic treatment of the adult dentition	$350	Not Covered
D8050	Interceptive orthodontic treatment of the primary dentition	$350	Not Covered
D8060	Interceptive orthodontic treatment of the transitional dentition	$350	Not Covered
D8070	Comprehensive orthodontic treatment of the transitional dentition	$350	Not Covered
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	Not Covered
D8090	Comprehensive orthodontic treatment of the adult dentition	$350	Not Covered
D8210	Removable appliance therapy	$0	Not Covered
D8220	Fixed appliance therapy	$0	Not Covered
D8660	Pre-orthodontic treatment visit	$0	Not Covered
D8670	Periodic orthodontic treatment visit (as part of contract)	$0	Not Covered
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$0	Not Covered
D8690	Orthodontic treatment (alternative billing to a contract fee)	$100	Not Covered
D8691	Repair of orthodontic appliance	$0	Not Covered
D8999	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$0	Not Covered
Adjunctive General Services (D9000-D9999)	**Code Description**	**EHB Copay**	**Adult Copay**
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0	$5
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Not Covered	$0
D9211	Regional block anesthesia	$0	$0
D9212	Trigeminal division block anesthesia	$0	$0
D9215	Local anesthesia	$0	$0
D9220	Deep sedation/general anesthesia – first 30 minutes	Not Covered	$165
D9221	Deep sedation/general anesthesia – each additional 15 minutes	Not Covered	$80
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$0	$15
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	Not Covered	$165
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	Not Covered	$80
D9248	Non-intravenous conscious sedation	$0	$15
D9310	Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0	$5
D9440	Office visit - after regularly scheduled hours	$0	$25
D9450	Case presentation, detailed and extensive treatment planning	Not Covered	$0
D9910	Application of desensitizing medicament	Not Covered	$15
D9940	Occlusal guard, by report	Not Covered	$100

D9942	Repair and/or reline of occlusal guard	Not Covered	$50
D9951	Occlusal adjustment, limited	Not Covered	$35
D9952	Occlusal adjustment - complete	Not Covered	$55
D9972	External bleaching - per arch	Not Covered	$125

If services for a listed procedure are performed by the assigned PCD, the member pays the specified co-payment.

You may be charged for missed appointments if you do not give the dental office at least 24 hours notice of cancellation.

Listed procedures, which require a dentist to provide specialized services, and are referred by the assigned PCD, must be preauthorized in writing by the Plan. The member pays the co-payment specified for such services. Procedures not listed above are not covered, however may be available at the PCD's contracted fees. "Contracted fees" means the PCD's fees on file with the Plan.

Excluded Benefits

The following dental benefits are excluded under the plan:

1. Any service that is not specifically listed as a covered benefit.
2. Services, which in the opinion of the attending dentist are not necessary to the member's dental health.
3. Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficacy have not been determined for use in the treatment for which the item or service in question is recommended or prescribed.
4. Services, which were provided without cost to the member by State government or an agency thereof, or any municipality, county or other subdivisions.
5. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the member.
6. Dental Services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonably should have known that an emergency care situation did not exist.
7. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the member became eligible for such services.
8. Procedures, appliances, or restorations to correct congenital or developmental malformations, unless specifically listed in the Benefits section above.
9. Hospital charges of any kind.
10. General anesthesia or intravenous sedation.
11. Dispensing of drugs not normally supplied in a dental office
12. Major surgery for fractures and dislocations
13. Treatment of root canal obstruction
14. Loss or theft of dentures or bridgework without appropriate documentation (i.e. police report or natural disaster).
15. Malignancies.
16. The cost of precious metals used in any form of dental benefits.
17. Implants and implant-related services
18. Placement and replacement of Cantilever and Maryland/Resin-bonded bridges
19. Extraction of pathology-free teeth, including supernumerary teeth (unless for medically necessary orthodontics)
20. Cosmetic dental care
21. Services of a pedodontist/pediatric dentist, except when the member is unable to be treated by his or her PCD, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her PCD is a pedodontist/pediatric dentist.