2020 Dental Fee Schedule
SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to Schedules B, C, D and E for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Program and is not to be interpreted as Current Dental Terminology (“CDT”), CDT-2019 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association (“ADA”). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>ENROLLEE PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0100-D0999</td>
<td>I. DIAGNOSTIC</td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>means General Practitioner.</td>
<td></td>
</tr>
<tr>
<td>SP</td>
<td>means Specialty Care Practitioner.</td>
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</tr>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient ....................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused (GP) ...................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused (SP) ...................................</td>
<td>$20.00</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
<td>No Cost</td>
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<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient (GP) .............</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient (SP) .............</td>
<td>$20.00</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem focused, by report (GP) .............................................................................................................</td>
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</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem focused, by report (SP) .............................................................................................................</td>
<td>$20.00</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation - limited, problem focused (established patient; not post-operative visit)</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0171</td>
<td>Re-evaluation - post-operative office visit .........................................</td>
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<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient (GP) .............................................................................................................</td>
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</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient (SP) .............................................................................................................</td>
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</tr>
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<td>D0190</td>
<td>Screening of a patient .............................................................................</td>
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<tr>
<td>D0191</td>
<td>Assessment of a patient ...........................................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral - complete series of radiographic images ..................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first radiographic image .....................................</td>
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</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional radiographic image ......................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal radiographic image ...............................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing - single radiographic image ....................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two radiographic images ....................................................</td>
<td>No Cost</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings - three radiographic images ..................................................</td>
<td>No Cost</td>
</tr>
</tbody>
</table>
D2000-D2999  III. RESTORATIVE

- Includes indirect pulp capping, bases, liners and acid etch procedures.

D2140  Amalgam - one surface, primary or permanent ................................. $20.00
D2150  Amalgam - two surfaces, primary or permanent ................................ $22.00
D2160  Amalgam - three surfaces, primary or permanent ............................ $24.00
D2161  Amalgam - four or more surfaces, primary or permanent ....................... $26.00
D2330  Resin-based composite - one surface, anterior .................................. $21.00
D2331  Resin-based composite - two surfaces, anterior ................................ $26.00
D2332  Resin-based composite - three surfaces, anterior ............................. $30.00
D2335  Resin-based composite - four or more surfaces or involving incisal angle (anterior) ................................................................. $35.00
D2390  Resin-based composite crown, anterior ................................................ $50.00
D2391  Resin-based composite - one surface, posterior ................................. Optional
D2392  Resin-based composite - two surfaces, posterior ............................... Optional
D2393  Resin-based composite - three surfaces, posterior ............................. Optional
D2394  Resin-based composite - four or more surfaces, posterior .................. Optional
D2410  Gold foil - one surface ........................................................................ Optional
D2420  Gold foil - two surfaces ....................................................................... Optional
D2430  Gold foil - three surfaces .................................................................... Optional
D2510  Inlay - metallic - one surface  ............................................................... $180.00
D2520  Inlay - metallic - two surfaces .............................................................. $190.00
D2530  Inlay - metallic - three or more surfaces ........................................... $200.00
D2540  Onlay - metallic - two surfaces ............................................................ $196.00
D2543  Onlay - metallic - three surfaces ........................................................... $206.00
D2544  Onlay - metallic - four or more surfaces ............................................. $212.00
D2610  Inlay - porcelain/ceramic - one surface ............................................... Optional
D2620  Inlay - porcelain/ceramic - two surfaces ............................................. Optional
D2630  Inlay - porcelain/ceramic - three or more surfaces ............................. Optional
D2640  Onlay - porcelain/ceramic - two surfaces ........................................... Optional
D2643  Onlay - porcelain/ceramic - three surfaces ......................................... Optional
D2644  Onlay - porcelain/ceramic - four or more surfaces ............................. Optional
D2650  Inlay - resin-based composite - one surface ......................................... Optional
D2651  Inlay - resin-based composite - two surfaces ....................................... Optional
D2652  Inlay - resin-based composite - three or more surfaces ........................ Optional
D2662  Onlay - resin-based composite - two surfaces ..................................... Optional
D2663  Onlay - resin-based composite - three surfaces .................................. Optional
D2664  Onlay - resin-based composite - four or more surfaces ....................... Optional
D2710  Crown - resin-based composite (indirect) ............................................ $120.00
D2720  Crown - resin with high noble metal .................................................... $225.00
D2721  Crown - resin with predominantly base metal .................................... $225.00
D2722  Crown - resin with noble metal ........................................................... $225.00
D2740  Crown - porcelain/ceramic ................................................................. $225.00
D2750  Crown - porcelain fused to high noble metal ....................................... $225.00
D2751  Crown - porcelain fused to predominantly base metal ........................ $225.00
D2752  Crown - porcelain fused to noble metal ............................................. $225.00
D2780  Crown - 3/4 cast high noble metal ....................................................... $225.00
D2781  Crown - 3/4 cast predominantly base metal .......................................... $225.00
D2782  Crown - 3/4 cast noble metal .............................................................. $225.00
D2783  Crown - 3/4 porcelain/ceramic ............................................................. $225.00
D2790  Crown - full cast high noble metal ...................................................... $225.00
D2791  Crown - full cast predominantly base metal ......................................... $225.00
D2792  Crown - full cast noble metal .............................................................. $225.00
D2794  Crown - titanium ................................................................................. $225.00
D2910  Re-cement or re-bond inlay, onlay, veneer or partial coverage ...... $10.00
D2915  Re-cement or re-bond indirectly fabricated or prefabricated post and core .................................................. $10.00
D2920  Re-cement or re-bond crown ............................................................... $10.00
D2921  Reattachment of tooth fragment, incisal edge or cusp (anterior) .... $35.00
D2929  Prefabricated porcelain/ceramic crown - primary tooth - anterior ..... Optional
D2930  Prefabricated stainless steel crown - primary tooth ............................ $55.00
D2931  Prefabricated stainless steel crown - permanent tooth ....................... $55.00
D2932 Prefabricated resin crown - anterior primary tooth .................. $55.00
D2933 Prefabricated stainless steel crown with resin window - anterior primary tooth .......................... Optional
D2940 Protective restoration ................................................................. $16.00
D2941 Interim therapeutic restoration - primary dentition ................ $16.00
D2949 Restorative foundation for an indirect restoration ................. $20.00
D2950 Core buildup, including any pins when required .................... $20.00
D2951 Pin retention - per tooth, in addition to restoration ................ $20.00
D2952 Post and core in addition to crown, indirectly fabricated ........ $20.00
D2953 Each additional indirectly fabricated post - same tooth ........ $20.00
D2954 Prefabricated post and core in addition to crown ..................... $20.00
D2957 Each additional prefabricated post - same tooth ..................... $20.00
D2971 Additional procedures to construct new crown under existing partial denture framework ........... $45.00
D2980 Crown repair necessitated by restorative material failure .... $25+lab
D2981 Inlay repair necessitated by restorative material failure .......... $25+lab
D2982 Onlay repair necessitated by restorative material failure ....... $25+lab
D2983 Veneer repair necessitated by restorative material failure .... $25+lab
D2990 Resin infiltration of incipient smooth surface lesions - limited to permanent molars through age 15 ........................................... $10.00

D3000-D3999 IV. ENDODONTICS
D3110 Pulp cap - direct (excluding final restoration) ....................... No Cost
D3120 Pulp cap - indirect (excluding final restoration) ...................... No Cost
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament ................................................................. $16.00
D3221 Pulpal debridement, primary and permanent teeth .................. $15.00
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development ................................................................. $16.00
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) .................. $16.00
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) .................. $16.00
D3310 Root canal - endodontic therapy, anterior tooth (excluding final restorations) .................................................. $60.00
D3320 Root canal - endodontic therapy, premolar tooth (excluding final restorations) .................................................. $120.00
D3330 Root canal - endodontic therapy, molar tooth (excluding final restorations) .................................................. $180.00
D3331 Treatment of root canal obstruction; non-surgical access .......... $60.00
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth ................................................................. $60.00
D3346 Retreatment of previous root canal therapy - anterior ............. $72.00
D3347 Retreatment of previous root canal therapy - premolar .......... $144.00
D3348 Retreatment of previous root canal therapy - molar ............... $215.00
D3410 Apicoectomy - anterior ............................................................... $100.00
D3421 Apicoectomy - premolar (first root) ........................................ $100.00
D3425 Apicoectomy - molar (first root) ............................................. $100.00
D3426 Apicoectomy (each additional root) ......................................... $50.00
D3427 Periradicular surgery without apicoectomy ......................... $100.00
D3430 Retrograde filling - per root ......................................................... $50.00
**V. PERIODONTICS**

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>$175.00</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>$175.00</td>
</tr>
<tr>
<td>D4212</td>
<td>Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth</td>
<td>$175.00</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>$150.00</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>$150.00</td>
</tr>
<tr>
<td>D4245</td>
<td>Apically positioned flap</td>
<td>$150.00</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical crown lengthening - hard tissue</td>
<td>$175.00</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>$300.00</td>
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<tr>
<td>D4261</td>
<td>Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>$300.00</td>
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<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing - four or more teeth per quadrant</td>
<td>$45.00</td>
</tr>
<tr>
<td>D4342</td>
<td>Periodontal scaling and root planing - one to three teeth per quadrant</td>
<td>$45.00</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - 1 D1110, D1120 or D4346 per 6 month period</td>
<td>No Cost</td>
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<tr>
<td>D4355</td>
<td>Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit</td>
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<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
<td>$36.00</td>
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<tr>
<td>D4921</td>
<td>Gingival irrigation - per quadrant</td>
<td>No Cost</td>
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**VI. PROSTHODONTICS (removable)**

<table>
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<th>Code</th>
<th>Description</th>
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<tr>
<td>D5110</td>
<td>Complete denture - maxillary</td>
<td>$250.00</td>
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<tr>
<td>D5120</td>
<td>Complete denture - mandibular</td>
<td>$250.00</td>
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<tr>
<td>D5130</td>
<td>Immediate denture - maxillary</td>
<td>$325.00</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate denture - mandibular</td>
<td>$325.00</td>
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<tr>
<td>D5211</td>
<td>Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)</td>
<td>$270.00</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)</td>
<td>$270.00</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$270.00</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$295.00</td>
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<tr>
<td>D5221</td>
<td>Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
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<tr>
<td>D5222</td>
<td>Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>$270.00</td>
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<tr>
<td>D5223</td>
<td>Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$295.00</td>
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</table>
D5224  Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ................................................................. $295.00

D5225  Maxillary partial denture - flexible base (including any clasps, rests and teeth) 5 ..................................................................................................................... Optional

D5226  Mandibular partial denture - flexible base (including any clasps, rests and teeth) 5 ..................................................................................................................... Optional

D5282  Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary ................................................................. $270.00

D5283  Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular ....................................................... $270.00

D5410  Adjust complete denture - maxillary ......................................................... $10.00

D5411  Adjust complete denture - mandibular ........................................................ $10.00

D5421  Adjust partial denture - maxillary ............................................................... $10.00

D5422  Adjust partial denture - mandibular ............................................................... $10.00

D5510  Repair broken complete denture base, maxillary ...................................... $25.00

D5512  Repair broken complete denture base, maxillary ...................................... $25.00

D5520  Replace missing or broken teeth - complete denture (each tooth) ....... $10.00

D5610  Repair resin partial denture base, mandibular ........................................... $25.00

D5620  Repair cast partial framework, mandibular ................................................. $25.00

D5622  Repair cast partial framework, maxillary ................................................... $25.00

D5630  Repair or replace broken retentive/clasping materials - per tooth ......... $25.00

D5640  Replace broken teeth - per tooth ................................................................. $10.00

D5650  Add tooth to existing partial denture ........................................................... $10.00

D5660  Add clasp to existing partial denture - per tooth ....................................... $10.00

D5670  Replace all teeth and acrylic on cast metal framework (maxillary) ......... $165.00

D5671  Replace all teeth and acrylic on cast metal framework (mandibular) $165.00

D5710  Rebase complete maxillary denture ............................................................ $50.00

D5711  Rebase complete mandibular denture ........................................................ $50.00

D5720  Rebase maxillary partial denture ............................................................... $50.00

D5721  Rebase mandibular partial denture ............................................................. $50.00

D5730  Reline complete maxillary denture (chairside) ........................................ $30.00

D5731  Reline complete mandibular denture (chairside) ...................................... $30.00

D5740  Reline maxillary partial denture (chairside) .............................................. $30.00

D5741  Reline mandibular partial denture (chairside) ......................................... $30.00

D5750  Reline complete maxillary denture (laboratory) ...................................... $50.00

D5751  Reline complete mandibular denture (laboratory) ................................... $50.00

D5760  Reline maxillary partial denture (laboratory) ........................................... $50.00

D5761  Reline mandibular partial denture (laboratory) ....................................... $50.00

D5820  Interim partial denture (maxillary) ............................................................. No Cost

D5821  Interim partial denture (mandibular) .......................................................... No Cost

D5850  Tissue conditioning, maxillary .................................................................... $25.00

D5851  Tissue conditioning, mandibular .................................................................. $25.00

D5863  Overdenture - complete maxillary ............................................................ Optional

D5864  Overdenture - partial maxillary ................................................................. Optional

D5865  Overdenture - complete mandibular .......................................................... Optional

D5866  Overdenture - partial mandibular ............................................................. Optional
<table>
<thead>
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<th>Code</th>
<th>Description</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6210</td>
<td>Pontic - cast high noble metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6211</td>
<td>Pontic - cast predominantly base metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6212</td>
<td>Pontic - cast noble metal</td>
<td>$225.00</td>
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<tr>
<td>D6240</td>
<td>Pontic - porcelain fused to high noble metal</td>
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<td>D6241</td>
<td>Pontic - porcelain fused to predominantly base metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6250</td>
<td>Pontic - resin with high noble metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6251</td>
<td>Pontic - resin with predominantly base metal</td>
<td>$225.00</td>
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<tr>
<td>D6252</td>
<td>Pontic - resin with noble metal</td>
<td>$225.00</td>
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<tr>
<td>D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis</td>
<td>Optional</td>
</tr>
<tr>
<td>D6548</td>
<td>Retainer - porcelain/ceramic for resin bonded fixed prosthesis</td>
<td>Optional</td>
</tr>
<tr>
<td>D6549</td>
<td>Retainer - for resin bonded fixed prosthesis</td>
<td>Optional</td>
</tr>
<tr>
<td>D6600</td>
<td>Retainer inlay - porcelain/ceramic, two surfaces</td>
<td>Optional</td>
</tr>
<tr>
<td>D6601</td>
<td>Retainer inlay - porcelain/ceramic, three or more surfaces</td>
<td>Optional</td>
</tr>
<tr>
<td>D6602</td>
<td>Retainer inlay - cast high noble metal, two surfaces</td>
<td>$200.00</td>
</tr>
<tr>
<td>D6603</td>
<td>Retainer inlay - cast high noble metal, three or more surfaces</td>
<td>$200.00</td>
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<tr>
<td>D6604</td>
<td>Retainer inlay - cast predominantly base metal, two surfaces</td>
<td>$180.00</td>
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<td>D6605</td>
<td>Retainer inlay - cast predominantly base metal, three or more surfaces</td>
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<tr>
<td>D6606</td>
<td>Retainer inlay - cast noble metal, two surfaces</td>
<td>$190.00</td>
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<tr>
<td>D6607</td>
<td>Retainer inlay - cast noble metal, three or more surfaces</td>
<td>$200.00</td>
</tr>
<tr>
<td>D6608</td>
<td>Retainer onlay - porcelain/ceramic, two surfaces</td>
<td>Optional</td>
</tr>
<tr>
<td>D6609</td>
<td>Retainer onlay - porcelain/ceramic, three or more surfaces</td>
<td>Optional</td>
</tr>
<tr>
<td>D6610</td>
<td>Retainer onlay - cast high noble metal, two surfaces</td>
<td>$206.00</td>
</tr>
<tr>
<td>D6611</td>
<td>Retainer onlay - cast high noble metal, three or more surfaces</td>
<td>$212.00</td>
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<tr>
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<td>Retainer onlay - cast predominantly base metal, two surfaces</td>
<td>$196.00</td>
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<tr>
<td>D6613</td>
<td>Retainer onlay - cast predominantly base metal, three or more surfaces</td>
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<td>Retainer onlay - cast noble metal, two surfaces</td>
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<td>D6615</td>
<td>Retainer onlay - cast noble metal, three or more surfaces</td>
<td>$212.00</td>
</tr>
<tr>
<td>D6720</td>
<td>Retainer crown - resin with high noble metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6721</td>
<td>Retainer crown - resin with predominantly base metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6722</td>
<td>Retainer crown - resin with noble metal</td>
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<tr>
<td>D6750</td>
<td>Retainer crown - porcelain fused to high noble metal</td>
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<tr>
<td>D6751</td>
<td>Retainer crown - porcelain fused to predominantly base metal</td>
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</tr>
<tr>
<td>D6752</td>
<td>Retainer crown - porcelain fused to noble metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6780</td>
<td>Retainer crown - 3/4 cast high noble metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6781</td>
<td>Retainer crown - 3/4 cast predominantly base metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6782</td>
<td>Retainer crown - 3/4 cast noble metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6790</td>
<td>Retainer crown - full cast high noble metal</td>
<td>$225.00</td>
</tr>
<tr>
<td>D6791</td>
<td>Retainer crown - full cast predominantly base metal</td>
<td>$225.00</td>
</tr>
</tbody>
</table>
D6792 Retainer crown - full cast noble metal ........................................... $225.00
D6930 Re-cement or re-bond fixed partial denture ........................................... $15.00
D6940 Stress breaker ............................................................................................. $35.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111 Extraction, coronal remnants - primary tooth ........................................... $18.00
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) ................................................................................................. $18.00
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated .............................................................................................. $30.00
D7220 Removal of impacted tooth - soft tissue ........................................... $50.00
D7230 Removal of impacted tooth - partially bony ........................................... $75.00
D7240 Removal of impacted tooth - completely bony ........................................... $100.00
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications ................................................................................................. $100.00
D7250 Removal of residual tooth roots (cutting procedure) ................................ No Cost
D7251 Coronectomy - intentional partial tooth removal ........................................... $100.00
D7286 Incisional biopsy of oral tissue-soft ......................................................... $25.00
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ................................................................. $65.00
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ................................................................. $65.00
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ................................................................. $85.00
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ................................................................. $85.00
D7471 Removal of lateral exostosis (maxilla or mandible) ........................................... $65.00
D7472 Removal of torus palatinus ................................................................. $65.00
D7473 Removal of torus mandibularis ................................................................. $65.00
D7510 Incision and drainage of abscess - intraoral soft tissue ................................ No Cost
D7960 Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure ........................................... $50.00

D8000-D8999 XI. ORTHODONTICS

Pre and post orthodontic records include:
The benefit for pre-treatment records and diagnostic services includes: ................................................................. $200.00

D0210 Intraoral - complete series of radiographic images
D0322 Tomographic survey
D0330 Panoramic radiographic image
D0340 2D cephalometric radiographic image - acquisition, measurement and analysis
D0350 2D oral/facial photographic images obtained intraorally or extraorally
D0351 3D photographic image
D0470 Diagnostic casts

The benefit for post-treatment records includes: ................................................................. $70.00

D0210 Intraoral - complete series of radiographic images
D0470 Diagnostic casts
D8020 Limited orthodontic treatment of the transitional dentition $1,950.00
D8030 Limited orthodontic treatment of the adolescent dentition $1,950.00
D8040 Limited orthodontic treatment of the adult dentition $2,150.00
D8070 Comprehensive orthodontic treatment of the transitional dentition $1,950.00
D8080 Comprehensive orthodontic treatment of the adolescent dentition $1,950.00
D8090 Comprehensive orthodontic treatment of the adult dentition $2,150.00
D8660 Pre-orthodontic treatment examination to monitor growth and development (applied to treatment fee if patient proceeds with treatment) $25.00
D8670 Periodic orthodontic treatment visit - Inclusive of treatment fee No Cost
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)) No Cost
D8681 Removable orthodontic retainer adjustment No Cost

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES
D9110 Palliative (emergency) treatment of dental pain - minor procedure $15.00
D9211 Regional block anesthesia No Cost
D9212 Trigeminal division block anesthesia No Cost
D9215 Local anesthesia in conjunction with operative or surgical procedures No Cost
D9219 Evaluation for moderate sedation, deep sedation or general anesthesia No Cost
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician $25.00
D9311 Consultation with medical health care professional No Cost
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed $5.00
D9440 Office visit - after regularly scheduled hours $20.00
D9450 Case presentation, detailed and extensive treatment planning No Cost
D9932 Cleaning and inspection of removable complete denture, maxillary No Cost
D9933 Cleaning and inspection of removable complete denture, mandibular No Cost
D9934 Cleaning and inspection of removable partial denture, maxillary No Cost
D9935 Cleaning and inspection of removable partial denture, mandibular No Cost
D9986 Missed appointment - without 24 hour notice - per 15 minutes of appointment time $10.00
D9987 Canceled appointment - without 24 hour notice - per 15 minutes of appointment time $10.00
D9990 Certified translation or sign-language services - per visit No Cost
D9991 Dental case management - addressing appointment compliance barriers No Cost
D9992 Dental case management - care coordination No Cost
D9995 Teledentistry - synchronous; real-time encounter No Cost
D9996 Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review No Cost

Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Program. The applicable charge to the Enrollee is the difference between the Contract Dentist’s “filed fee” for the Optional procedure and the “filed fee” for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when
alternative choices are Benefits. "Filed fees" mean the Contract Dentist's fees on file with Alpha. Questions regarding this Program should be directed to the Customer Service department at 800-422-4234.

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialized Services, and are referred by the assigned Contract Dentist, must be authorized by Alpha. The Enrollee pays the Copayment specified for such services.

The Contract Dentist will provide Emergency Dental Services for covered procedures whenever possible. If an Enrollee requires Emergency Dental Services and is unable to access care from the Contract Dentist, then Alpha shall reimburse the Enrollee for the cost of such Emergency Dental Services which exceeds the Copayment. Emergency Dental Services shall be limited to listed procedures, and as described in code D9110 above: (Palliative (emergency) treatment of dental pain). Any further treatment of the cause of such Emergency Dental Services must be obtained from the Contract Dentist. All services are subject to the limitations and exclusions of the Program. Non-network Dentists will be paid at the usual and customary or an agreed upon rate.

FOOTNOTES

1 Services include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee, not to exceed $75.00 per month.

2 Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.

3 Porcelain on molars is considered optional treatment.

4 Base or noble metal is the Benefit if the Contract Dentist determines that it will restore the form and function of the tooth. High noble metal (precious), if elected by the Enrollee for a crown, bridge, indirectly fabricated post and core, inlay or onlay, will be charged to the Enrollee at the additional laboratory cost of the high noble metal. An additional laboratory charge also applies to a titanium crown.

5 Includes any adjustments for six months.
SCHEDULE B

Limitations of Benefits

* Frequency limitations do not apply when services are needed more frequently due to medical necessity as determined by the Contract Dentist.

1. Prophylaxis is limited to one treatment each six month* period (includes periodontal maintenance).

2. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five-year period from initial placement.

3. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

4. Crowns and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement.

5. Denture relines are limited to one per denture during any 12 consecutive months.

6. Periodontal treatments (scaling and root planing) are limited to four quadrants during any 12 consecutive months.

7. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period.

8. Bitewing x-rays are limited to not more than one series of four films in any six month* period.

9. A full mouth x-ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months*.

10. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.

11. Coverage is limited to the Benefit customarily provided. Enrollee must pay the difference in cost between the Contract Dentist's usual fees for the covered Benefit and the Optional or more expensive treatment plus any applicable Copayment.
12. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial denture to restore a missing tooth, are considered Optional treatment.

13. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspids.

14. A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, non-functional bridge and it meets the five year limitation for replacement.

15. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth.

16. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Alpha, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

17. Porcelain crowns and porcelain fused to metal crowns on all molars is considered Optional treatment.

18. Fixed bridges used to replace missing posterior teeth are considered Optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered Optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered procedure and Optional treatment, plus any Copayment for the covered procedure.

19. Benefits for dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with this Program are limited as follows:

Upon request of a newly covered Enrollee, Alpha will provide Benefits for the completion of covered services begun prior to the time his or her coverage became effective. Alpha will not provide coverage for incomplete services that are not otherwise Benefits under the terms and conditions of the Contract. Enrollees may request completion of treatment in progress by calling the Customer Service department at 800 422-4234 during normal business hours, or by sending a written request to Alpha.

Whenever possible, an Enrollee should complete treatment in progress with the Dentist who initiated the service. If such Dentist is an out-of-network Dentist, that Dentist must agree to the same terms and conditions that apply to an in-
network Dentist in order for Alpha to provide Benefits. Copayments and other cost sharing components will apply. Benefits may be adjusted so that the total paid by the Enrollee and/or coverage provided by all plans is not more than 100% of total Allowable Expenses (as defined in the Coordination of Benefits section of the Contract).

Should the Enrollee be unable to complete treatment with the Dentist who initiated the service, Alpha will make reasonable and appropriate arrangements for completion of such treatment by a Contract Dentist.
SCHEDULE C

Exclusions of Benefits

1. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist.

2. Dental procedures performed for purely cosmetic purposes.

3. Dental conditions arising out of and due to Enrollee’s employment for which Workers’ Compensation is payable. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision.

4. Treatment required by reason of war, declared or undeclared.

5. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

6. Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments of TMJ abnormalities.

7. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).

8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

9. Any service that is not specifically listed in Schedule A, Description of Benefits and Copayments.

10. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function (unless mandated by state law).

11. Cysts and malignancies.

12. Prescription drugs.

13. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.

14. Dental services received from any dental facility other than the assigned dental facility, unless expressly authorized by Alpha or as cited under Emergency Dental Services. To obtain Authorization, the Enrollee should call the Customer Service department at 800-422-4234.

15. Prophylactic removal of impactions (asymptomatic, nonpathological).
17. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
18. Placement of a crown where there is sufficient tooth structure to retain a standard filling.
19. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
20. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).
21. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction).
22. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization.
23. Any part of a preventive or soft tissue management program, which is not a listed covered service on Schedule A, Description of Benefits and Copayments.
24. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;
25. Cosmetic care as a result of orthodontic treatment.
27. Charges by the Contract Dentist for broken or missed appointments not reported within 24 hours.
SCHEDULE D

Orthodontic Limitations

The Program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The cost to the Enrollee for the treatment plan is listed in Schedule A, Description of Benefits and Copayments subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.

2. Benefits cover 24 months of active orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months.

3. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office visit fee not to exceed $75.00 per month.

4. Should an Enrollee’s coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination. In this event the Enrollee’s obligation shall be based on the Contract Orthodontist’s usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of $25.00 in addition to diagnostic record fees.

6. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the Contract Orthodontist’s usual fee.

7. The Copayment is payable to the Contract Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, (i) the Enrollee will not be entitled to a refund of any amounts previously paid, and (ii) the Enrollee will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
SCHEDULE E

Orthodontic Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.

2. Retreatment of orthodontic cases.

3. Changes in treatment necessitated by accident of any kind, and/or lack of Enrollee cooperation.


5. Myofunctional therapy.

6. Surgical procedures related to cleft palate, micrognathia or macrognathia.

7. Treatment related to temporomandibular joint disturbances.

8. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including, but not limited to: palatal expander, habit control appliance, pendulum, quad helix or herbst.

9. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75.00 per month.

10. Cosmetic care as a result of orthodontic treatment.

11. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

12. Extractions solely for the purpose of orthodontics.

13. Patient initiated transfer after bands have been placed.

14. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
Memorial Hermann Advantage HMO is provided by Memorial Hermann Health Plan, Inc., a Medicare Advantage organization with a Medicare contract. Enrollment in this plan depends on contract renewal.

Memorial Hermann Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.645.8448 (TTY 711).