BlueCross BlueShield of Texas

BlueCare Dental[SM] 2A

Blue Cross and Blue Shield of Texas *(herein called "BCBSTX, We, Us, Our")*

REQUIRED OUTLINE OF COVERAGE

I. **Read Your Policy Carefully.** This Outline of Coverage provides a very brief description of some important features of Your Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of You, Your Physician or Professional Other Provider and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

II. The Policy is designed to provide You with coverage for diagnostic and preventive dental care, as well as almost every form of specialty dental treatment.

Coverage is provided for the benefits outlined in Paragraph III. The benefits described in Paragraph III may be limited by Paragraph IV.

III. **Benefits**. Your dental care benefits are highlighted below.

A. **Benefit Period –** Your Benefit Period is a Calendar Year (begins January 1 and ends December 31).

B. **Deductible –** The Calendar Year Deductible will be subtracted once during each Calendar Year from each Participant's total Eligible Expenses.

Benefits	Deductible Amount
Calendar Year Deductibles • Individual • Maximum Annual Deductible per Family	 $75 $225

C. **Covered Services**

All benefits are based upon the Allowable Amount, which is the amount determined by BCBSTX as the maximum amount eligible for payment of benefits. A Contracting Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for services provided by a Non-Contracting Dentist will be based upon the same Allowable Amount, and it is likely that the Non-Contracting Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses. A 12 month waiting period may apply to some services. (The waiting period is waived for services obtained from a Contracting Dentist for Dependent children under age 19.)

The Deductibles, Coinsurance Amount, Annual Maximum and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

Covered Services	Benefit Payable Adult Services (Age 19 and Over)	Benefit Payable Pediatric Services (Applies Dependent Children under the age of 19.)
Diagnostic Evaluations Deductible waived	See attached Schedule of Benefits Amount	80%
Preventive Services Deductible waived	See attached Schedule of Benefits Amount	80%
Diagnostic Radiographs Deductible waived	See attached Schedule of Benefits Amount	80%
Miscellaneous Preventive Services	See attached Schedule of Benefits Amount	80%
Basic Restorative Services	See attached Schedule of Benefits Amount	50%
Non-Surgical Extractions	See attached Schedule of Benefits Amount	50%
Non-surgical Periodontal Services	See attached Schedule of Benefits Amount	50%
Adjunctive Services	See attached Schedule of Benefits Amount	50%
Endodontic Services	See attached Schedule of Benefits Amount	50%
Oral Surgery Services	See attached Schedule of Benefits Amount	50%
Surgical Periodontal Services*	See attached Schedule of Benefits Amount	50%
Major Restorative Services*	See attached Schedule of Benefits Amount	50%
Prosthodontic Services*	See attached Schedule of Benefits Amount	50%
Miscellaneous Restorative and Prosthodontic Services*	See attached Schedule of Benefits Amount	50%
Implants	Not covered	50%
Orthodontia (Deductible waived)		
Pediatric Orthodontia	Not Covered	50%
Optional Orthodontia	Not covered	Not covered
Annual Maximum	$1,000	Unlimited
Out-of-Pocket Maximum	None	
1 Child:		$350
2+ Children:		$700

*12 Month Benefit Waiting Period may apply. (The waiting period is waived for services for Dependent children under age 19.)

All benefits are based upon the Allowable Amount, which is the amount determined by BCBSTX as the maximum amount eligible for payment of benefits. A Contracting Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for services provided by a Non-Contracting Dentist will be based upon the same Allowable Amount, and it is likely that the Non-Contracting Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses.

IV. Limitations and Exclusions

These general Limitations and Exclusions apply to all services described in the dental Policy. Dental coverage is limited to services provided by a Dentist or a dental auxiliary licensed to perform services covered under this dental Policy.

Important Information About Your Dental Benefits

- **Dental Procedures Which Are Not Dentally Necessary**

  Please note that in order to provide You with dental care benefits at a reasonable cost, this Policy provides benefits only for those covered services for eligible dental treatment that are determined by BCBSTX to be Dentally Necessary.

  No Benefits will be provided for procedures which are not Dentally Necessary. Dentally Necessary generally means that a specific procedure provided to You is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to You, as determined by BCBSTX.

  The fact that Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Dentally Necessary.

- **Care By More Than One Dentist**

  If You change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if You had stayed with the same Dentist until Your treatment was completed. There will be no duplication of benefits.

- **Alternate Benefits**

  In all cases in which there is more than one service or Course of Treatment to treat your dental condition, the benefit will be based on the least costly covered service or Course of Treatment, as determined by BCBSTX. The alternate benefit Copayment or Coinsurance, if any, will be based on the less costly Covered Service plus you will be responsible to pay the difference between the less costly service and more costly elected service.

  When two or more services are submitted and the services are considered part of the same service, We will pay the most comprehensive service as determined by BCBSTX.

  When two or more services are submitted on the same day and the services are considered mutually exclusive (one service contradicts the need for the other service), We will pay for the service that represents the final treatment as determined by BCBSTX.

  If You and Your Dentist decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the least costly course of treatment or procedures for dental services, as determined by Us.

- **Non-Compliance with Prescribed Care**

  Any additional treatment and resulting liability which is caused by the lack of a Participant's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Participant.

Exclusions — What Is Not Covered
No benefits will be provided under this Policy for:

- Services or supplies not specifically listed as a covered service, or when they are related to a non-covered service.
- Amounts which are in excess of the Allowable Amount, as determined by BCBSTX.
- Dental services treatment of congenital or developmental malformation or services performed for cosmetic purposes including but not limited to bleaching teeth, lack of tooth enamel and grafts to improve aesthetics, except as included in the Medically Necessary Orthodontic Benefit subsection of the Covered Dental Services section in the Policy.

- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Policy or if resulting from Accidental Injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Policy.
- Dental services which are performed due to an Accidental Injury. For Participants age 19 and over injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.
- Services and supplies for any illness or injury suffered after the Participant's Effective Date as a result of war or any act of war, declared or undeclared, or while on active or reserve duty in the armed forces of any country or international authority.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental/Investigational and/or Unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants for Participants age 19 and over.
- Services or supplies for which You are not required to make payment or would have no legal obligation to pay if You did not have this or similar coverage.
- Services or supplies for which "discounts" or waiver of Deductible or coinsurance amounts are offered.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Claims for a service which is for the same service performed on the same date for the same member.
- Services or supplies received for behavior management or consultation purposes.
- Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- Any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Charges for nutritional, tobacco or oral hygiene counseling.
- Charges for local, state or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state or federal mandates.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, or preparations or medicament carriers.
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to Your Effective Date under this Policy; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after Your Effective Date.
- Any services, treatments or supplies included as covered services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planning when billed for separately.
- Charges for occlusion analysis, diagnostic casts or occlusal adjustments.
- Gold foil restorations.
- Cone beam imaging and cone beam MRI procedures.
- Sealants for teeth other than permanent molars.
- Orthodontic care for dependent children age 19 and over.
- Localized delivery of antimicrobial agents or chemotherapeutic agents.

- Benefits for bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
- Anatomical crown exposures.
- The replacement of a lost, missing or stolen appliances and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension, to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
- Restoration occlusion on incisal edges due to bruxism or harmful habits.
- Treatment to replace teeth which were missing prior to the Effective Date.
- Congenitally missing teeth.
- Replacement or repair of an orthodontic appliance.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
- Comprehensive periodontal evaluations or problem-focused evaluations if covered services are rendered on the same date as any other oral evaluation and by the same Dentist.
- Tests and oral pathology procedures, or for re-evaluations.
- Any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.
- Local anesthesia, nitrous oxide analgesia, or other drugs or medicaments and/or their application.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal.
- Endodontic therapy if you discontinue endodontic treatment.
- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.
- Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

BCBSTX may, without waiving these exclusions, elect to provide benefits for care and services while awaiting the decision of whether or not the care and services fall within the exclusions listed above. If it is later determined that the care and services are excluded from the Participant's coverage, We will be entitled to recover the amount we have allowed for benefits under this Policy. The Participant must provide BCBSTX with all documents We need to enforce its rights under this provision.

V. Renewability

This Policy is renewable at the option of the Subscriber unless terminated as discussed below.

If Your coverage this Dental Policy is terminated for any reason BCBSTX will provide You with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage. If You purchased this Policy through the Exchange, BCBSTX will also notify the Exchange, of the termination effective date and the reason for termination.

Termination in a Dental Plan purchased through the Exchange

For Plans purchased through the Exchange, Your and Your Dependents' coverage will be terminated due to the following events and will end on the dates specified below:

a. When You terminate Your coverage in this Dental Policy including as a result of Your obtaining other Minimum Essential Coverage, with reasonable, appropriate notice to the Exchange, if applicable, and BCBSTX. For the purposes of this section, reasonable notice is defined as 14 days from the requested effective date of termination; or

   The last day of coverage will be:

   - The termination date specified by You, if You provide reasonable written notice; or
   - 14 days after the termination is requested by You, if You do not provide reasonable notice; or
   - On a date determined by BCBSTX, if BCBSTX is able to effectuate termination in fewer than 14 days and You request an earlier termination effective date; or

b. In the event your coverage is purchased through the Exchange, when You are no longer eligible for Exchange-Certified Dental Plan coverage through the Exchange. The last day of coverage is the last day of the month following the month in which the notice is sent by the Exchange unless You request and earlier termination effective date;or

c. This Dental Plan terminates or is decertified; or

d. You change from one Dental Plan to another during an annual open enrollment period or special enrollment period. The last day of coverage in Your prior Dental Plan is the day before the effective date of coverage in Your Dental Plan.

Termination by Blue Cross and Blue Shield of Texas

The coverage of the Subscriber and all covered Dependents under this Policy will terminate on the earliest of the following dates:

a. On the last day of the last period for which the premium for this Policy has been paid, subject to the grace period provided in the section entitled **Premiums** of this Policy; or

b. On the last day of any Policy Month upon written request for termination of this Policy made by You and received prior thereto; or

c. On the date Your coverage for dental insurance cancels or terminates; or

d. On the Policy Effective Date for fraudulent or intentional misrepresentation of a material fact; or

e. On Your date of death; or

f. On the date following 90 days advance notice by Us to the Subscriber, but only if We are terminating all other this particular type of individual coverage for all Subscribers provided that We act uniformly without regard to any health-status related factor of covered individuals;

If You purchased coverage through the Exchange and there is a conflict between **Termination in a Dental Plan purchased through the Exchange** and **Termination by BCBSTX**, the provision that is most favorable to the Subscriber will apply.

VI. Premiums

A. The initial premium rate for Your Plan selection under this Policy is $_____.

Enclose the premium with your application.

Premiums are payable monthly or quarterly and are due on the first day of each Policy Month.

The initial premium is required to place the insurance in force. There is no insurance unless the first month's premium is paid.

[When You renew BCBSTX coverage or reenroll by selecting a new product, You will need to be current on Your premium payments. Any past due premium payments for coverage We provided will be due at the beginning of the new plan year in addition to current premium charges. New coverage will not be effective until all such payments are made.]

[When Blue Cross and Blue Shield of Texas receives a premium payment, Blue Cross and Blue Shield of Texas may apportion the premium payments to this Policy and other policies issued to you by Blue Cross and Blue Shield of Texas, on a pro rata basis, based on the amount due under the respective policies.]

B. **Grace Period**

Except as provided below, a Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the Policy shall continue in force shall continue in force, subject to its termination in accordance with the provisions hereof.

In the event you are receiving an Advance Premium Tax Credit under the Affordable Care Act, You have a three-month Grace Period for paying premiums. If full premium is not paid within one month of the premium due date, claim payments for Eligible Expenses received during the second and third months of the Grace Period under this Policy will be pended until full premium payment is made. If full payment of the premium is not made within the three months Grace Period, then coverage under this Policy will automatically terminate on the last day of the first month of the three-month grace period. BCBSTX will not process any claims for services after the date of termination, except as otherwise required by applicable state or federal law.

ADA	Description	Scheduled Benefit
		Region I
D0120	Periodic Oral Evaluation - Established Patient	$28
D0140	Limited Oral Evaluation - Problem Focused	$43
D0145	Oral Evaluation For A Patient Under Three Years Of Age And Counseling With Primary Caregiver	$43
D0150	Comprehensive Oral Evaluation - New Or Established Patient	$43
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	$43
D0180	Comprehensive Periodontal Evaluation - New Or Established Patient	$43
D0210	Intraoral - Complete Series Of Radiographic Images	$82
D0220	Intraoral - Periapical First Radiographic Image	$16
D0230	Intraoral - Periapical Each Additional Radiographic Image	$12
D0240	Intraoral - Occlusal Radiographic Image	$23
D0250	Extraoral - First Radiographic Image	$31
D0260	Extraoral - Each Additional Radiographic Image	$29
D0270	Bitewing - Single Radiographic Image	$17
D0272	Bitewings - Two Radiographic Images	$26
D0273	Bitewings - Three Radiographic Images	$32
D0274	Bitewings - Four Radiographic Images	$38
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	$50
D0330	Panoramic Radiographic Image	$72
D0363	Cone Beam – Three-Dimensional Image Reconstruction Using Existing Data, Includes Multiple Images	$408
D0364	Cone Beam CT Capture And Interpretation With Limited Field Of View – Less Than One Whole Jaw	$658
D0365	Cone Beam CT Capture And Interpretation With Field Of View Of One Full Dental Arch – Mandible	$658
D0366	Cone Beam CT Capture And Interpretation With Field Of View Of One Full Dental Arch – Maxilla	$658
D0367	Cone Beam CT Capture And Interpretation With Field Of View Of Both Jaws, With Or Without Cranium	$658
D0368	Cone Beam CT Capture And Interpretation For TMJ Series Including Two Or More Exposures	$964
D0369	Maxillofacial MRI Capture And Interpretation	$1,724
D0370	Maxillofacial Ultrasound Capture And Interpretation	$580
D0380	Cone Beam CT Image Capture With Limited Field Of View – Less Than One Whole Jaw	$525
D0381	Cone Beam CT Image Capture With Field Of View Of One Full Dental Arch – Mandible	$525
D0382	Cone Beam CT Image Capture With Field Of View Of One Full Dental Arch–Maxilla, With/Without Cranium	$525
D0383	Cone Beam CT Image Capture With Field Of View Of Both Jaws, With Or Without Cranium	$525
D0384	Cone Beam CT Image Capture For TMJ Series Including Two Or More Exposures	$768
D0385	Maxillofacial MRI Image Capture	$1,254
D0386	Maxillofacial Ultrasound Image Capture	$314
D1110	Prophylaxis - Adult	$58
D1120	Prophylaxis - Child	$41
D1206	Topical Application Of Fluoride Varnish	$33
D1208	Topical Application Of Fluoride	$22
D1351	Sealant - Per Tooth	$32
D1352	Preventive Resin Restoration In A Moderate To High Caries Risk Patient – Permanent Tooth	$41
D1510	Space Maintainer - Fixed - Unilateral	$102
D1515	Space Maintainer - Fixed - Bilateral	$134

ADA	Description	Scheduled Benefit
		Region I
D1520	Space Maintainer - Removable - Unilateral	$126
D1525	Space Maintainer - Removable - Bilateral	$172
D1550	Re-Cementation Of Space Maintainer	$22
D1555	Removal Of Fixed Space Maintainer	$22
D2140	Amalgam - One Surface, Primary Or Permanent	$61
D2150	Amalgam - Two Surfaces, Primary Or Permanent	$74
D2160	Amalgam - Three Surfaces, Primary Or Permanent	$90
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	$111
D2330	Resin-Based Composite - One Surface, Anterior	$70
D2331	Resin-Based Composite - Two Surfaces, Anterior	$88
D2332	Resin-Based Composite - Three Surfaces, Anterior	$106
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	$126
D2390	Resin-Based Composite Crown, Anterior	$150
D2391	Resin-Based Composite - One Surface, Posterior	$78
D2392	Resin-Based Composite - Two Surfaces, Posterior	$106
D2393	Resin-Based Composite - Three Surfaces, Posterior	$132
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	$158
D2410	Gold Foil - One Surface	$184
D2420	Gold Foil - Two Surfaces	$306
D2430	Gold Foil - Three Surfaces	$531
D2510	Inlay - Metallic - One Surface	$241
D2520	Inlay - Metallic - Two Surfaces	$273
D2530	Inlay - Metallic - Three Or More Surfaces	$315
D2542	Onlay - Metallic-Two Surfaces	$309
D2543	Onlay - Metallic-Three Surfaces	$323
D2544	Onlay - Metallic-Four Or More Surfaces	$336
D2610	Inlay - Porcelain/Ceramic - One Surface	$284
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	$299
D2630	Inlay - Porcelain/Ceramic - Three Or More Surfaces	$319
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	$310
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	$334
D2644	Onlay - Porcelain/Ceramic - Four Or More Surfaces	$354
D2650	Inlay - Resin-Based Composite - One Surface	$186
D2651	Inlay - Resin-Based Composite - Two Surfaces	$222
D2652	Inlay - Resin-Based Composite - Three Or More Surfaces	$233
D2662	Onlay - Resin-Based Composite - Two Surfaces	$203
D2663	Onlay - Resin-Based Composite - Three Surfaces	$238
D2664	Onlay - Resin-Based Composite - Four Or More Surfaces	$255
D2710	Crown - Resin-Based Composite (Indirect)	$144
D2712	Crown - ¾ Resin-Based Composite (Indirect)	$144
D2720	Crown - Resin With High Noble Metal	$354
D2721	Crown - Resin With Predominantly Base Metal	$332
D2722	Crown - Resin With Noble Metal	$339

ADA	Description	Scheduled Benefit
		Region I
D2740	Crown - Porcelain/Ceramic Substrate	$364
D2750	Crown - Porcelain Fused To High Noble Metal	$354
D2751	Crown - Porcelain Fused To Predominantly Base Metal	$334
D2752	Crown - Porcelain Fused To Noble Metal	$342
D2780	Crown - 3/4 Cast High Noble Metal	$344
D2781	Crown - 3/4 Cast Predominantly Base Metal	$324
D2782	Crown - 3/4 Cast Noble Metal	$335
D2783	Crown - 3/4 Porcelain/Ceramic	$354
D2790	Crown - Full Cast High Noble Metal	$346
D2791	Crown - Full Cast Predominantly Base Metal	$328
D2792	Crown - Full Cast Noble Metal	$334
D2794	Crown - Titanium	$346
D2910	Recement Inlay, Onlay, Or Partial Coverage Restoration	$46
D2915	Recement Cast Or Prefabricated Post And Core	$46
D2920	Recement Crown	$48
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	$113
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$82
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	$93
D2932	Prefabricated Resin Crown	$101
D2933	Prefabricated Stainless Steel Crown With Resin Window	$113
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	$113
D2940	Protective Restoration	$50
D2950	Core Buildup, Including Any Pins	$125
D2951	Pin Retention - Per Tooth, In Addition To Restoration	$17
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	$120
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	$60
D2954	Prefabricated Post And Core In Addition To Crown	$99
D2957	Each Additional Prefabricated Post - Same Tooth	$50
D2960	Labial Veneer (Resin Laminate) - Chairside	$474
D2961	Labial Veneer (Resin Laminate) - Laboratory	$538
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	$584
D2980	Crown Repair Necessitated By Restorative Material Failure	$73
D2981	Inlay Repair Necessitated By Restorative Material Failure	$73
D2982	Onlay Repair Necessitated By Restorative Material Failure	$73
D2983	Veneer Repair Necessitated By Restorative Material Failure	$73
D3110	Pulp Cap - Direct (Excluding Final Restoration)	$35
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	$28
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	$83
D3221	Pulpal Debridement, Primary And Permanent Teeth	$91
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth With Incomplete Root Development	$102
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	$88
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	$94
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	$351

ADA	Description	Scheduled Benefit
		Region I
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	$429
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	$554
D3331	Treatment Of Root Canal Obstruction; Non-Surgical Access	$163
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	$310
D3333	Internal Root Repair Of Perforation Defects	$143
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	$351
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	$429
D3348	Retreatment Of Previous Root Canal Therapy - Molar	$554
D3351	Apexification/Recalcification/Pulpal Regeneration – Initial Visit	$199
D3352	Apexification/Recalcification/Pulpal Regeneration - Interim Medication Replacement	$87
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root Canal Therapy)	$294
D3410	Apicoectomy/Periradicular Surgery - Anterior	$402
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$439
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	$497
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	$166
D3430	Retrograde Filling - Per Root	$122
D3450	Root Amputation - Per Root	$246
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	$193
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	$312
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	$83
D4230	Anatomical Crown Exposure - Four Or More Contiguous Teeth Per Quadrant	$453
D4231	Anatomical Crown Exposure - One To Three Teeth Per Quadrant	$190
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth - Per Quad	$367
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth - Per Quad	$184
D4245	Apically Positioned Flap	$343
D4249	Clinical Crown Lengthening - Hard Tissue	$419
D4260	Osseous Surgery (Including Flap Entry And Closure) - Four Or More Contiguous Teeth - Per Quad	$593
D4261	Osseous Surgery (Including Flap Entry And Closure) - One To Three Contiguous Teeth - Per Quad	$297
D4263	Bone Replacement Graft - First Site In Quadrant	$179
D4264	Bone Replacement Graft - Each Additional Site In Quadrant	$90
D4270	Pedicle Soft Tissue Graft Procedure	$438
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth	$481
D4274	Distal Or Proximal Wedge Procedure (When Not In Conjunction With Surgical Procedures In Area)	$136
D4275	Soft Tissue Allograft	$272
D4276	Combined Connective Tissue And Double Pedicle Graft, Per Tooth	$481
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery), First Tooth Or Edentulous Tooth	$451
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery), Each Additional Contiguous Tooth	$451
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	$121
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	$61
D4355	Full Mouth Debridement To Enable Comprehensive Evaluation And Diagnosis	$80
D4910	Periodontal Maintenance	$72
D5110	Complete Denture - Maxillary	$412

ADA	Description	Scheduled Benefit
		Region I
D5120	Complete Denture - Mandibular	$412
D5130	Immediate Denture - Maxillary	$449
D5140	Immediate Denture - Mandibular	$449
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	$348
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	$404
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Incl Clasps, Rests, eeth)	$455
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Dent Bases (Incl Clasps, Rests, Teeth)	$455
D5225	Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	$348
D5226	Mandibular Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	$404
D5281	Removable Unilateral Partial Denture - One Piece Cast Metal (Including Clasps And Teeth	$265
D5410	Adjust Complete Denture - Maxillary	$23
D5411	Adjust Complete Denture - Mandibular	$23
D5421	Adjust Partial Denture - Maxillary	$23
D5422	Adjust Partial Denture - Mandibular	$23
D5510	Repair Broken Complete Denture Base	$45
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	$38
D5610	Repair Resin Denture Base	$49
D5620	Repair Cast Framework	$53
D5630	Repair Or Replace Broken Clasp	$64
D5640	Replace Broken Teeth - Per Tooth	$42
D5650	Add Tooth To Existing Partial Denture	$57
D5660	Add Clasp To Existing Partial Denture	$68
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	$158
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	$158
D5710	Rebase Complete Maxillary Denture	$167
D5711	Rebase Complete Mandibular Denture	$160
D5720	Rebase Maxillary Partial Denture	$158
D5721	Rebase Mandibular Partial Denture	$158
D5730	Reline Complete Maxillary Denture (Chairside)	$94
D5731	Reline Complete Mandibular Denture (Chairside)	$94
D5740	Reline Maxillary Partial Denture (Chairside)	$87
D5741	Reline Mandibular Partial Denture (Chairside)	$87
D5750	Reline Complete Maxillary Denture (Laboratory)	$126
D5751	Reline Complete Mandibular Denture (Laboratory)	$126
D5760	Reline Maxillary Partial Denture (Laboratory)	$124
D5761	Reline Mandibular Partial Denture (Laboratory)	$124
D5850	Tissue Conditioning, Maxillary	$86
D5851	Tissue Conditioning, Mandibular	$86
D5860	Overdenture - Complete, By Report	$412
D5861	Overdenture - Partial, By Report	$348
D6053	Implant/Abutment Supported Removable Denture For Completely Edentulous Arch	$1,117
D6054	Implant/Abutment Supported Removable Denture For Partially Edentulous Arch	$1,117
D6058	Abutment Supported Porcelain/Ceramic Crown	$861

ADA	Description	Scheduled Benefit
		Region I
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	$850
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	$803
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	$819
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$816
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$711
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$743
D6065	Implant Supported Porcelain/Ceramic Crown	$847
D6066	Implant Supported Porcelain Fused To Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$825
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$801
D6068	Abutment Supported Retainer For Porcelain/Ceramic Fpd	$854
D6069	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (High Noble Metal)	$850
D6070	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Predominantly Base Metal)	$803
D6071	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Noble Metal)	$819
D6072	Abutment Supported Retainer For Cast Metal Fpd (High Noble Metal)	$829
D6073	Abutment Supported Retainer For Cast Metal Fpd (Predominantly Base Metal)	$757
D6074	Abutment Supported Retainer For Cast Metal Fpd (Noble Metal)	$805
D6075	Implant Supported Retainer For Ceramic Fpd	$847
D6076	Implant Supported Retainer For Porcelain Fused To Metal Fpd (Titanium, Titanium Alloy Or High Noble)	$825
D6077	Implant Supported Retainer For Cast Metal Fpd (Titanium, Titanium Alloy, Or High Noble Metal)	$801
D6092	Recement Implant/Abutment Supported Crown	$66
D6093	Recement Implant/Abutment Supported Fixed Partial Denture	$104
D6094	Abutment Supported Crown - (Titanium)	$674
D6101	Debridement Of A Periimplant Defect And Surface Cleaning Of Exposed Implant Surfaces	$184
D6102	Debridement And Osseous Contouring Of A Periimplant Defect	$297
D6103	Bone Graft For Repair Of Periimplant Defect – Not Including Flap Entry And Closure	$179
D6194	Abutment Supported Retainer Crown For Fpd - (Titanium)	$694
D6205	Pontic - Indirect Resin Based Composite	$130
D6210	Pontic - Cast High Noble Metal	$325
D6211	Pontic - Cast Predominantly Base Metal	$304
D6212	Pontic - Cast Noble Metal	$316
D6214	Pontic - Titanium	$325
D6240	Pontic - Porcelain Fused To High Noble Metal	$321
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	$296
D6242	Pontic - Porcelain Fused To Noble Metal	$312
D6245	Pontic - Porcelain/Ceramic	$331
D6250	Pontic - Resin With High Noble Metal	$316
D6251	Pontic - Resin With Predominantly Base Metal	$292
D6252	Pontic - Resin With Noble Metal	$301
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	$135
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	$148
D6600	Inlay - Porcelain/Ceramic, Two Surfaces	$300
D6601	Inlay - Porcelain/Ceramic, Three Or More Surfaces	$300

ADA	Description	Scheduled Benefit
		Region I
D6602	Inlay - Cast High Noble Metal, Two Surfaces	$280
D6603	Inlay - Cast High Noble Metal, Three Or More Surfaces	$321
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	$280
D6605	Inlay - Cast Predominantly Base Metal, Three Or More Surfaces	$321
D6606	Inlay - Cast Noble Metal, Two Surfaces	$280
D6607	Inlay - Cast Noble Metal, Three Or More Surfaces	$321
D6608	Onlay -Porcelain/Ceramic, Two Surfaces	$300
D6609	Onlay - Porcelain/Ceramic, Three Or More Surfaces	$300
D6610	Onlay - Cast High Noble Metal, Two Surfaces	$329
D6611	Onlay - Cast High Noble Metal, Three Or More Surfaces	$343
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	$329
D6613	Onlay - Cast Predominantly Base Metal, Three Or More Surfaces	$343
D6614	Onlay - Cast Noble Metal, Two Surfaces	$329
D6615	Onlay - Cast Noble Metal, Three Or More Surfaces	$343
D6624	Inlay - Titanium	$321
D6634	Onlay - Titanium	$343
D6710	Crown - Indirect Resin Based Composite	$144
D6720	Crown - Resin With High Noble Metal	$357
D6721	Crown - Resin With Predominantly Base Metal	$339
D6722	Crown - Resin With Noble Metal	$345
D6740	Crown - Porcelain/Ceramic	$376
D6750	Crown - Porcelain Fused To High Noble Metal	$366
D6751	Crown - Porcelain Fused To Predominantly Base Metal	$341
D6752	Crown - Porcelain Fused To Noble Metal	$350
D6780	Crown - 3/4 Cast High Noble Metal	$345
D6781	Crown - 3/4 Cast Predominantly Base Metal	$345
D6782	Crown - 3/4 Cast Noble Metal	$321
D6783	Crown - 3/4 Porcelain/Ceramic	$355
D6790	Crown - Full Cast High Noble Metal	$353
D6791	Crown - Full Cast Predominantly Base Metal	$335
D6792	Crown - Full Cast Noble Metal	$347
D6794	Crown - Titanium	$353
D6930	Recement Fixed Partial Denture	$43
D6980	Fixed Partial Denture Repair Necessitated By Restorative Material Failure	$73
D6985	Pediatric Partial Denture, Fixed	$348
D7111	Extraction, Coronal Remnants - Deciduous Tooth	$70
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	$70
D7210	Surgical Removal Of Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth	$124
D7220	Removal Of Impacted Tooth - Soft Tissue	$156
D7230	Removal Of Impacted Tooth - Partially Bony	$207
D7240	Removal Of Impacted Tooth - Completely Bony	$243
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	$306
D7250	Surgical Removal Of Residual Tooth Roots (Cutting Procedure)	$131

ADA	Description	Scheduled Benefit
		Region I
D7251	Coronectomy – Intentional Partial Tooth Removal	$327
D7280	Surgical Access Of An Unerupted Tooth	$286
D7310	Alveoloplasty In Conjunction With Extractions – Four Or More Teeth Or Tooth Spaces, Per Quadrant	$145
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	$73
D7320	Alveoloplasty Not In Conjunction With Extractions –Four Or More Teeth Or Tooth Spaces, Per Quadrant	$647
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	$324
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	$1,123
D7350	Vestibuloplasty - Ridge Extension	$3,268
D7410	Excision Of Benign Lesion Up To 1.25 Cm	$490
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm	$776
D7412	Excision Of Benign Lesion, Complicated	$858
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	$462
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	$725
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	$607
D7472	Removal Of Torus Palatinus	$721
D7473	Removal Of Torus Mandibularis	$680
D7485	Surgical Reduction Of Osseous Tuberosity	$607
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	$138
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	$173
D7960	Frenulectomy – Also Known As Frenectomy Or Frenotomy – Separate Procedure Not Incidental To Another	$305
D7963	Frenuloplasty	$381
D7970	Excision Of Hyperplastic Tissue - Per Arch	$314
D7971	Excision Of Pericoronal Gingiva	$100
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	$43
D9220	Deep Sedation/General Anesthesia - First 30 Minutes	$174
D9221	Deep Sedation/General Anesthesia - Each Additional 15 Minutes	$73
D9241	Intravenous Conscious Sedation/Analgesia - First 30 Minutes	$137
D9242	Intravenous Conscious Sedation/Analgesia - Each Additional 15 Minutes	$58
D9248	Non-Intravenous Conscious Sedation	$29