UnitedHealthcare®
National Options PPO 20 Network/covered dental services

dental plan
1P951 /FS02

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Annual Maximum Benefit *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1500 per person per Calendar Year	$1500 per person per Calendar Year	$1500 per person per Lifetime	$1500 per person per Lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Child Only Up to Age 19			

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	$25.00	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	$11.00	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	$75.00	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	$72.00	
Dental Prophylaxis (Cleanings)	100%	$52.00	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	$31.00	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	$27.00	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	$212.00	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations (Amalgam or Anterior Composite)*	80%	$47.20	Multiple restorations on one surface will be treated as a single filling.
General Services - Emergency Treatment	80%	$37.60	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Services - Occlusal Guards	80%	$231.20	Limited to 1 guard every consecutive 36 months.
General Services - Anesthesia	80%	$43.20	When clinically necessary.
Simple Extractions	80%	$29.60	Limited to 1 time per tooth per lifetime.
Oral Surgery - Brush Biopsy	80%	$56.80	
Oral Surgery - Surgical Extractions	80%	$105.60	
Oral Surgery - Partial/Bony	80%	$137.40	
Oral Surgery - Other	80%	$375.20	
Endodontics - Pulpotomy	80%	$68.00	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Endodontics - Other	80%	$28.80	
Periodontal Maintenance	80%	$56.00	Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Periodontics - Non Surgical	80%	$93.60	Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
Periodontics - Surgical	80%	$225.60	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Periodontics - Osseous Surgery	80%	$518.40	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
MAJOR DENTAL SERVICES			
Inlays/Onlays/Crowns*	50%	$55.00	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	$416.00	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	50%	$103.50	Limited to 1 time per tooth per consecutive 60 months.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	$1,862.00	

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

** The network percentage of benefits is based on the discounted fee negotiated with the provider.

****The non-network Plan Pays is based on the allowable amount applicable for the same service that would have been rendered by a network provider. For a complete list of amounts, please refer to your Certificate of Coverage.

.Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage.

Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental® Options PPO Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United HealthCare Services, Inc.

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;
B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
C. The least costly, clinically accepted treatment; and
D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

1. PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.
2. COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.
3. BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.
4. EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.
5. DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.
6. FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
7. SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
9. RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.
10. PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.
11. INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. POST AND CORES Covered only for teeth that have had root canal therapy.
14. SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
15. SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.
16. ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
17. PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
18. FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
20. RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
21. REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
22. PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
24. FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
25. GENERAL ANESTHESIA Covered only when clinically necessary.
26. OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
27. PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
28. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
29. CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

GENERAL EXCLUSIONS

21. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situsedin the state of Arizona, in order to comply with state regulations.
22. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
25. Foreign Services are not Covered unless required as an Emergency.
26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
27. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

ADA Code and Description	Plan Pays
D0120 PERIODIC ORAL EVALUATION EST PT	$25.00
D0140 LTD ORAL EVALUATION - PROBLEM FOCUS	$40.00
D0145 ORAL EVAL PT<3 AND COUNSEL	$31.00
D0150 COMP ORAL EVALUATION - NEW/EST PT	$36.00
D0160 DTL&EXT ORAL EVAL - PROB FOCUS RPT	$71.00
D0170 RE-EVALUATION - LTD PROBLEM FOCUSED	$32.00
D0180 COMP PERIODONTAL EVAL - NEW/EST PT	$33.00
D0210 INTRAORAL-COMPLETE SERIES RADIOGRAPHIC IMAGES	$75.00
D0220 INTRAORAL PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$13.00
D0230 INTRAORL PERIAPICAL EA ADD RADIOGRAPHIC IMAGE	$10.00
D0240 INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	$19.00
D0250 EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	$30.00
D0251 EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	$30.00
D0270 BITEWING - SINGLE RADIOGRAPHIC IMAGE	$11.00
D0272 BITEWINGS - TWO RADIOGRAPHIC IMAGE	$21.00
D0273 BITEWINGS - THREE RADIOGRAPHIC IMAGE	$27.00
D0274 BITEWINGS - FOUR RADIOGRAPHIC IMAGE	$32.00
D0277 VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGE	$46.00
D0330 PANORAMIC RADIOGRAPHIC IMAGE	$59.00
D0340 2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS	$35.50
D0350 2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY	$35.00
D0351 3D PHOTOGRAPHIC IMAGE	$35.00
D0364 CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW-LESS THAN ONE WHOLE JAW	$107.00
D0365 CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MANDIBLE	$107.00
D0366 CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW OF ONE FULL DENTAL ARCH-MAXILLA	$107.00
D0367 CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS	$107.00
D0368 CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	$107.00
D0414 LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	$72.00
D0415 COLLECT MICROORAGNISMS CULT & SENS	$72.00
D0416 VIRAL CULTURE	$72.00
D0431 ADJUNCT PREDX TST NO CYTOL/BX PROC	$46.00
D0460 PULP VITALITY TESTS	$25.00
D0470 DIAGNOSTIC CASTS	$55.00
D0601 CARIES RISK ASSESSMENT AND DOCUMENTATION, LOW	$31.00
D0602 CARIES RISK ASSESSMENT AND DOCUMENTATION, MODERATE	$31.00
D0603 CARIES RISK ASSESSMENT AND DOCUMENTATION, HIGH	$31.00
D1110 PROPHYLAXIS - ADULT 1	$52.00
D1120 PROPHYLAXIS - CHILD 1	$39.00
D1206 TOP FLUORIDE VARNISH	$31.00
D1208 TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$25.00
D1351 SEALANT - PER TOOTH	$27.00
D1352 PREV RESIN RESTORATION IN MOD HIGH CARIES RISK PATIENT- PERM TOOTH	$27.00
D1353 SEALANT REPAIR – PER TOOTH	$13.50
D1510 SPACE MAINTAINER - FIXED-UNILATERAL	$212.00
D1515 SPACE MAINTAINER - FIXED-BILATERAL	$322.00
D1520 SPACE MAINTAINER - REMOVABLE-UNI	$264.00
D1525 SPACE MAINTAINER - REMOVABLE-BIL	$348.00
D1550 RECEMENT OR RE-BOND SPACE MAINTAINER	$33.00
D1555 REMOVAL OF FIXED SPACE MAINTAINER	$33.00
D1575 DISTAL SHOE SPACE MAINTAINER – FIXED – UNILATERAL	$212.00
D2140 AMALGAM-ONE SURFACE PRIMARY/PERM	$47.20
D2150 AMALGAM-TWO SURFACES PRIMARY/PERM	$61.60
D2160 AMALGAM-3 SURFACES PRIMARY/PERM	$76.80

ADA Code and Description	Plan Pays
D2161 AMALGAM-FOUR/MORE SURF PRIM/PERM	$92.00
D2330 RESIN COMPOS - ONE SURFACE ANTERIOR	$60.80
D2331 RESIN COMPOS - 2 SURFACES ANTERIOR	$76.00
D2332 RESIN COMPOS - 3 SURFACES ANTERIOR	$96.00
D2335 RSN COMPOS-4/> SURF/W/INCISAL ANG	$105.60
D2390 RESIN COMPOS CROWN ANTERIOR	$55.00
D2391 RESIN COMPOS - 1 SURFACE POSTERIOR	$47.20
D2392 RESIN COMPOS - 2 SURFACES POSTERIOR	$61.60
D2393 RESIN COMPOS - 3 SURFACES POSTERIOR	$76.80
D2394 RESIN COMPOS - 4/MORE SURFACES POST	$92.00
D2410 GOLD FOIL - ONE SURFACE	$47.20
D2420 GOLD FOIL - TWO SURFACES	$61.60
D2430 GOLD FOIL - THREE SURFACES	$76.80
D2510 INLAY - METALLIC - ONE SURFACE	$47.20
D2520 INLAY - METALLIC - TWO SURFACES	$61.60
D2530 INLAY - METALLIC - 3/MORE SURFACES	$76.80
D2542 ONLAY - METALLIC - TWO SURFACES	$271.50
D2543 ONLAY METALLIC THREE SURFACES	$284.50
D2544 ONLAY METALLIC FOUR OR MORE SURF	$307.00
D2610 INLAY - PORCELN/CERAMIC - 1 SURFACE	$47.20
D2620 INLAY - PORCELN/CERAMIC - 2 SURF	$61.60
D2630 INLAY - PORCELN/CERAM - 3/MORE SURF	$76.80
D2642 ONLAY - PORCELN/CERAMIC - 2 SURF	$271.50
D2643 ONLAY - PORCELN/CERAMIC - 3 SURF	$284.50
D2644 ONLAY - PORCELN/CERAM - 4/MORE SURF	$307.00
D2650 INLAY-RSN COMPOS COMPOS/RSN-1 SURF	$47.20
D2651 INLAY-RSN COMPOS COMPOS/RSN-2 SURF	$61.60
D2652 INLAY-RSN COMPOS COMPOS/RSN-3/>SURF	$76.80
D2662 ONLAY-RSN COMPOS COMPOS/RSN-2 SURF	$213.50
D2663 ONLAY-RSN COMPOS COMPOS/RSN-3 SURF	$242.50
D2664 ONLAY-RSN COMPOS COMPOS/RSN-4/>	$273.00
D2710 CROWN RESINBASED COMPOSITE INDIRECT	$90.00
D2712 CROWN 3/4 RESNBASED COMPOS INDIRECT	$103.50
D2720 CROWN - RESIN WITH HIGH NOBLE METAL*	$288.00
D2721 CROWN - RESIN W/PREDOM BASE METAL	$271.50
D2722 CROWN - RESIN WITH NOBLE METAL*	$288.00
D2740 CROWN - PORCELAIN/CERAMIC	$311.50
D2750 CROWN - PORCELN FUSED HI NOBLE METL*	$311.50
D2751 CROWN-PORCELN FUSD PREDOM BASE METL	$298.50
D2752 CROWN - PORCELAIN FUSED NOBLE METAL*	$311.50
D2780 CROWN - 3/4 CAST HIGH NOBLE METAL*	$295.50
D2781 CROWN - 3/4 CAST PREDOM BASE METL	$289.00
D2782 CROWN - 3/4 CAST NOBLE METAL*	$295.50
D2783 CROWN - 3/4 PORCELAIN/CERAMIC	$295.50
D2790 CROWN - FULL CAST HIGH NOBLE METAL*	$301.00
D2791 CROWN - FULL CAST PREDOM BASE METL	$293.50
D2792 CROWN - FULL CAST NOBLE METAL*	$301.00
D2794 CROWN TITANIUM*	$301.00
D2799 PROVISIONAL CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$90.00
D2910 RECEMENT OR RE-BOND INLAY ONLAY VENEER OR PART COV REST	$24.50
D2915 RECEMENT OR RE-BOND INDIRECTLY FABRICATED PREFAB POST & CORE	$24.50
D2920 RECEMENT OR RE-BOND CROWN	$24.50
D2921 REATTACHMENT OF TOOTH FRAGMENT	$38.00
D2930 PRFABR STAINLESS STEEL CROWN-PRIM	$65.50
D2931 PRFABR STAINLESS STEEL CROWN-PERM	$66.00

ADA Code and Description	Plan Pays
D2932 PREFABRICATED RESIN CROWN	$70.50
D2933 PRFABR STNLSS STEEL CROWN RSN WNDOW	$100.50
D2934 PREFAB ESTHTC COATED STNLESS STEEL CROWN - PRIMARY	$65.50
D2940 SEDATIVE FILLING	$23.50
D2921 INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION	$23.50
D2950 CORE BUILDUP INCLUDING ANY PINS	$61.50
D2951 PIN RETN - PER TOOTH ADDITION REST	$14.00
D2952 POST & CORE ADD CROWN INDIRECT FAB	$83.50
D2953 EA ADD INDIRECT FAB POST SAME TOOTH	$31.50
D2954 PREFABR POST&CORE ADDITION CROWN	$83.50
D2957 EA ADD PREFABR POST - SAME TOOTH	$31.50
D2960 LABIAL VENEER (LAMINATE) - CHAIRSIDE	$138.50
D2961 LABIAL VENEER (RESIN LAMINATE) - LABORATORY	$186.00
D2962 LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY	$239.50
D2975 COPING	$198.00
D2980 CROWN REPAIR	$50.50
D2981 INLAY REPAIR	$50.50
D2982 ONLAY REPAIR	$50.50
D3110 PULP CAP - DIRECT	$28.80
D3120 PULP CAP - INDIRECT	$24.80
D3220 TX PULPOT-CORONL DENTNOCEMENTL JUNC	$68.00
D3221 PULPAL DEBRID PRIMARY&PERM TEETH	$84.00
D3222 PARTIAL PULPOTOMY	$68.00
D3230 PULPAL THERAPY - ANT PRIMARY TOOTH	$111.20
D3240 PULPAL THERAPY - POST PRIMARY TOOTH	$129.60
D3310 ANTERIOR	$306.40
D3330 ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATIONS)	$364.80
D3330 MOLAR	$518.40
D3331 TX RC OBSTRUCTION; NON-SURG ACCESS	$140.00
D3332 INCMPL ENDO TX;INOP UNRSTR/FX TOOTH	$160.80
D3333 INTRL ROOT REPAIR PERFORATION DEFEC	$93.60
D3346 RETX PREVIOUS RC THERAPY - ANTERIOR	$368.00
D3347 RETX PREVIOUS RC THERAPY - BICUSPID	$431.20
D3348 RETX PREVIOUS RC THERAPY - MOLAR	$548.80
D3351 APEXIFICAT/RECALCIFICAT - INIT VST	$152.00
D3352 APEXIFICAT/RECALCIFICAT-INTERIM	$107.20
D3353 APEXIFICAT/RECALCIFICAT-FINAL VISIT	$198.40
D3355 PULPAL REGENERATION - INITIAL VISIT	$152.00
D3356 PULPAL REGENERATION -INTERIM MEDICAMENT REPLACEMENT	$107.20
D3357 PULPAL REGENERATION - COMPLETION OF TREATMENT	$198.40
D3410 APICOECTOMY - ANTERIOR	$317.60
D3421 APICOECTOMY - PREMOLAR (FIRST ROOT)	$360.00
D3425 APICOECTOMY - MOLAR (FIRST ROOT)	$385.60
D3426 APICOECTOMY - (EACH ADDITIONAL ROOT)	$142.40
D3427 PERIRADICULAR SURGERY WITHOUT APICOECTOMY	$142.40
D3430 RETROGRADE FILLING - PER ROOT	$87.20
D3450 ROOT AMPUTATION - PER ROOT	$209.60
D3470 INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING)	$361.60
D3920 HEMISECTION NOT INCL RC THERAPY	$174.40
D4210 GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	$225.60
D4211 GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	$63.20
D4230 ANOTOMICAL CROWN EXPOSURE - 4 OR MORE CONTIG TEETH OR BONDED TOOTH SPACES	$423.20
D4231 ANOTOMICAL CROWN EXPOSURE - 1 TO 3 TEETH OR BONDED TOOTH SPACES PER QUAD	$112.80
D4240 GINGL FLP 4/>CNTIG/BOUND TEETH QUAD	$237.60
D4241 GINGL FLP 1-3 CNTIG/BND TEETH QUAD	$119.20

ADA Code and Description	Plan Pays
D4245 APICALLY POSITIONED FLAP	$370.40
D4249 CLIN CROWN LEN - HARD TISSUE	$325.60
D4260 OSSEOUS SURG 4/> CNTIG TEETH QUAD	$518.40
D4261 OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$259.20
D4263 BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT	$288.80
D4264 BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – EACH ADDITIONAL SITE IN QUADRANT	$216.80
D4265 BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$144.80
D4266 GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE	$401.60
D4267 GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)	$468.00
D4268 SURGICAL REVISION PROCEDURE, PER TOOTH	$252.80
D4270 PEDICLE SOFT TISSUE GRAFT PROCEDURE	$320.00
D4273 AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$254.40
D4274 MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	$295.20
D4275 NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE, 1ST TOOTH	$347.20
D4276 COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH	$254.40
D4277 FREE SOFT TISSUE GRAFT PROCEDURE -1ST TOOTH	$347.20
D4283 AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$127.20
D4285 NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURIGCAL SITES – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	$173.60
D4320 PROVISIONAL SPLINTING - INTRACORONAL	$93.60
D4321 PROVISIONAL SPLINTING - EXTRACORONAL	$84.00
D4341 PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$90.40
D4342 PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$45.60
D4346 SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	$44.80
D4355 FULL MOUTH DEBRID COMP ORAL EVAL&DX ON A SUBSEQUENT VISIT	$53.60
D4381 LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$72.80
D4910 PERIODONTAL MAINTENANCE	$56.00
D4920 UNSCHEDULED DRESSING CHANGE	$46.40
D5110 COMPLETE DENTURE - MAXILLARY	$416.00
D5120 COMPLETE DENTURE - MANDIBULAR	$416.00
D5130 IMMEDIATE DENTURE - MAXILLARY	$448.00
D5140 IMMEDIATE DENTURE - MANDIBULAR	$448.00
D5211 MAX PARTIAL DENTURE - RESIN BASE	$292.50
D5212 MAND PARTIAL DENTUR - RESIN BASE	$292.50
D5213 MAX PART DENTUR-CAST METL W/RSN	$484.50
D5214 MAND PART DENTUR- CAST METL W/RSN	$484.50
D5221 IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$143.50
D5222 IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$143.50
D5223 IMMEDIATE MAXILLARY PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$179.38
D5224 IMMEDIATE MANDIBULAR PARTIAL DENTURE – CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	$179.38
D5225 MAXILLARY PARTIAL DENTURE FLEX BASE	$484.50
D5226 MANDIBULAR PART DENTURE FLEX BASE	$484.50
D5281 REMV UNI PART DENTUR-1 PC CAST METL	$233.00
D5410 ADJUST COMPLETE DENTURE - MAXILLARY	$21.00
D5411 ADJUST COMPLETE DENTUR - MANDIBULAR	$21.00
D5421 ADJUST PARTIAL DENTURE - MAXILLARY	$21.00
D5422 ADJUST PARTIAL DENTURE – MANDIBULAR	$21.00
D5511 REPAIR BROKEN COMPLETE DENTURE BASE - MANDIBULAR	$40.50
D5512 REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	$40.50
D5520 REPL MISS/BROKEN TEETH-CMPL DENTUR	$34.00
D5611 REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	$40.50
D5612 REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	$40.50
D5621 REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	$46.00

ADA Code and Description	Plan Pays
D5622 REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	$46.00
D5630 REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	$49.50
D5640 REPLACE BROKEN TEETH - PER TOOTH	$35.50
D5650 ADD TOOTH EXISTING PARTIAL DENTURE	$46.00
D5660 ADD CLASP EXISTING PARTIAL DENTURE - PER TOOTH	$56.00
D5670 REPL ALL TEETH&ACRYLC FRMEWRK MAX	$175.50
D5671 REPL ALL TEETH&ACRYLC FRMEWRK MAND	$175.50
D5710 REBASE COMPLETE MAXILLARY DENTURE	$134.50
D5711 REBASE COMPLETE MANDIBULAR DENTURE	$134.50
D5720 REBASE MAXILLARY PARTIAL DENTURE	$134.50
D5721 REBASE MANDIBULAR PARTIAL DENTURE	$82.50
D5730 RELINE CMPL MAXIL DENTURE CHAIRSIDE	$82.50
D5731 RELINE CMPL MAND DENTURE CHAIRSIDE	$82.50
D5740 RELINE MAXIL PART DENTURE CHAIRSIDE	$82.50
D5741 RELINE MAND PART DENTURE CHAIRSIDE	$82.50
D5750 RELINE CMPL MAXIL DENTURE LAB	$117.00
D5751 RELINE CMPL MAND DENTRUE LABORATORY	$117.00
D5760 RELINE MAXIL PART DENTURE LAB	$117.00
D5761 RELINE MAND PART DENTURE LABORATORY	$117.00
D5810 INTERIM COMPLETE DENTURE (MAXILLARY)	$179.50
D5811 INTERIM COMPLETE DENTURE (MANDIBULAR)	$179.50
D5820 INTERIM PARTIAL DENTURE MAXILLARY	$143.50
D5821 INTERIM PARTIAL DENTURE MANDIBULAR	$143.50
D5850 TISSUE CONDITIONING MAXILLARY	$39.00
D5851 TISSUE CONDITIONING MANDIBULAR	$39.00
D5863 OVERDENTURE - COMPLETE MAXILLARY	$416.00
D5864 OVERDENTURE - COMPLETE MANDIBULAR	$416.00
D5865 OVERDENTURE - PARTIAL MAXILLARY	$484.50
D5866 OVERDENTURE - PARTIAL MANDIBULAR	$484.50
D6205 PONTIC- INDIRECT RESIN BASED COMPOSITE	$103.50
D6210 PONTIC - CAST HIGH NOBLE METAL*	$301.00
D6211 PONTIC - CAST PREDOM BASE METAL	$293.50
D6212 PONTIC - CAST NOBLE METAL *	$301.00
D6214 PONTIC TITANIUM *	$301.00
D6240 PONTIC-PORCELN FUSED HI NOBLE METL *	$311.50
D6241 PONTIC-PORCLN FUSD PREDOM BASE METL	$298.50
D6242 PONTIC - PORCELN FUSED NOBLE METAL *	$311.50
D6245 PONTIC - PORCELAIN/CERAMIC	$311.50
D6250 PONTIC - RESIN W/HIGH NOBLE METAL *	$292.50
D6251 PONTIC RESIN W/PREDOM BASE METAL	$282.00
D6252 PONTIC RESIN W/NOBLE METAL *	$292.50
D6253 PROVISIONAL PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$119.00
D6545 RETAINER- CASE MTL FOR RESIN FXD PROS	$129.50
D6548 RET-PORC/CER FOR RESIN BONDED FIXED PROS	$129.50
D6549 RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	$129.50
D6600 RETAINER INLAY-PORCELAIN/CERAMIC 2 SURFACES	$220.50
D6601 RETAINER INLAY - PORCELN/CERAMIC 3/MORE SURF	$253.50
D6602 RETAINER INLAY - CAST HI NOBLE METAL 2 SURF	$220.50
D6603 RETAINER INLAY-CAST HI NOBLE METL 3/> SURF	$266.50
D6604 RETAINER INLAY-CAST PREDOM BASE METL 2 SURF	$242.50
D6605 RETAINER INLAY-CAST PREDOM BASE METL 3/>SURF	$253.00
D6606 RETAINER INLAY - CAST NOBLE METAL 2 SURFACES	$220.50
D6607 RETAINER INLAY - CAST NOBLE METL 3/MORE SURF	$266.50
D6608 RETAINER ONLAY - PORCELN/CERAMIC 2 SURFACES	$230.00
D6609 RETAINER ONLAY - PORCELN/CERAMIC 3/MORE SURF	$253.50

ADA Code and Description	Plan Pays
D6610 RETAINER ONLAY - CAST HI NOBLE METAL 2 SURF	$276.50
D6611 RETAINER ONLAY-CAST HI NOBLE METL 3/> SURF	$305.00
D6612 RETAINER ONLAY-CAST PREDOM BASE METL 2 SURF	$262.00
D6613 RETAINER ONLAY-CAST PREDOM BASE METL 3/>SURF	$290.50
D6614 RETAINER ONLAY - CAST NOBLE METAL 2 SURFACES	$276.50
D6615 RETAINER ONLAY - CAST NOBLE METL 3/MORE SURF	$305.00
D6624 RETAINER INLAY - TITANIUM	$266.50
D6634 RETAINER ONLAY - TITANIUM	$333.50
D6710 RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE	$103.50
D6720 RETAINER CROWN - RESIN WITH HIGH NOBLE METAL *	$299.50
D6721 RETAINER CROWN - RESIN PREDOMINANTLY BASE METAL	$284.00
D6722 RETAINER CROWN - RESIN WITH NOBLE METAL *	$299.50
D6740 RETAINER CROWN - PORCELAIN/CERAMIC	$311.50
D6750 RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL *	$311.50
D6751 RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$298.50
D6752 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL *	$311.50
D6780 RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL *	$279.50
D6781 RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	$300.00
D6782 RETAINER CROWN - 3/4 CAST NOBLE METAL *	$307.00
D6783 RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	$307.00
D6790 RETAINER CROWN - FULL CAST HIGH NOBLE METAL *	$301.00
D6791 RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	$293.50
D6792 RETAINER CROWN - FULL CAST NOBLE METAL *	$301.00
D6793 PROVISIONAL RETAINER CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$89.50
D6794 RETAINER CROWN - TITANIUM *	$301.00
D6930 RECEMENT OR RE-BOND FIXED PARTIAL DENTURE	$34.00
D6980 FIXED PARTIAL DENTURE REPAIR	$104.50
D7111 XTRCT CORONL RMNNTS PRIMARY TOOTH	$29.60
D7140 EXTRAC ERUPTED TOOTH/EXPOSED ROOT	$58.40
D7210 EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$105.60
D7220 REMOVAL IMPACT TOOTH - SOFT TISSUE	$146.40
D7230 REMOVAL IMPACT TOOTH - PARTLY BONY	$183.20
D7240 REMOVAL IMPACTED TOOTH - CMPL BONY	$233.60
D7241 REMV IMP TOOTH-CMPL BNY W/SURG COMP	$258.40
D7250 REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$108.00
D7260 OROANTRAL FISTULA CLOSURE	$375.20
D7261 PRIMARY CLOSURE OF A SINUS PERFORATION	$375.20
D7270 TOOTH REIMPL&/STBL ACC DISPLCD	$174.40
D7272 TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)	$295.20
D7280 EXPOSURE OF AN UNERUPTED TOOTH	$232.80
D7282 MOBILZ ERUPT/MALPSTN TOOTH AID ERUP	$164.80
D7283 PLACEMENT DEVICE FACILITATE ERUPT IMPACTED TOOTH	$116.80
D7285 INCISIONAL BIOPSY OF ORAL TISSUE HARD	$125.60
D7286 INCISIONAL BIOPSY OF ORAL TISSUE SOFT	$114.40
D7287 EXTOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	$56.80
D7288 BRUSH BIOPSY	$56.80
D7291 TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	$34.40
D7310 ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$102.40
D7311 ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$51.20
D7320 ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$139.20
D7321 ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$69.60
D7340 VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	$336.00
D7350 VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	$717.60
D7410 EXCISION OF BENIGN LESION UP TO 1.25 CM	$136.00

ADA Code and Description	Plan Pays
D7450 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$148.80
D7451 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$438.40
D7460 REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM	$171.20
D7461 REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	$297.60
D7472 REMOVAL OF TORUS PALATINUS	$136.80
D7473 REMOVAL OF TORUS MANDIBULARIS	$136.80
D7510 I&D ABSCESS-INTRAORAL SOFT TISS	$66.40
D7511 I & D ABSC INTRAORAL SOFT TISS COMP	$83.20
D7520 I & D OF ABSCESS EXTRAORAL SOFT TISSUE	$133.60
D7521 I & D OF ABSCESS EXTRAORAL COMPLICATED	$166.40
D7530 REMO OF FORREIGN BODY - SKIN SUBCUTANEOUS	$71.20
D7540 REMOVAL OF REACTION-PRODUCING FOREIGN BODIES - MUSCULOSKELETAL SYSTEM	$218.40
D7550 PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE	$232.80
D7560 MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOT FRAGMENT OR FOREIGN BODY	$434.40
D7960 FRENULECTOMY SEPARATE PROCEDURE	$164.00
D7963 FRENULOPLASTY	$164.00
D7970 EXC HYPERPLASTIC TISSUE-PER ARCH	$148.80
D7971 EXCISION OF PERICORONAL GINGIVA	$75.20
D7972 SURGICAL RDUC FIBROUS TUBEROSITY	$148.80
D7997 APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCHBAR	$76.80
D8010 LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	Up to Plan Maximum
D8020 LIMITED ORTHODONTIC TREATMENT OF THE TRASITIONAL DENTITION	Up to Plan Maximum
D8030 LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	Up to Plan Maximum
D8040 LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION	Up to Plan Maximum
D8050 INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	Up to Plan Maximum
D8060 INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	Up to Plan Maximum
D8070 COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION)	$1,862.00
D8080 COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	Up to Plan Maximum
D8090 COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$1,953.00
D8210 REMOVABLE APPLIANCE THERAPY	Up to Plan Maximum
D8220 FIXED APPLIANCE THERAPY	Up to Plan Maximum
D8660 PRE-ORTHODONTIC TREATMENT EXAM TO MONITOR GROWTH AND DEVELOPMENT	Up to Plan Maximum
D8670 PERIODIC ORTHODONTIC TREATMENT VISIT	Up to Plan Maximum
D8680 ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINERS)	Up to Plan Maximum
D8690 ORTHODONTIC TREATMENT, (ALTERNATIVE BILLING TO A CONTRACT FEE)	Up to Plan Maximum
D8691 REPAIR OF ORTHODONTIC APPLIANCE	Up to Plan Maximum
D8693 RECEMENT OR RE-BOND FIXED RETAINERS	$16.50
D8694 REPAIR OF FIXED RETAINERS, INCLUDES REATTACHMENT	Up to Plan Maximum
D9110 PALLIATVE TX DENTAL PAIN-MINOR PROC	$37.60
D9120 FIXED PARTIAL DENTURE SECTIONING	$68.50
D9210 LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	$18.50
D9219 EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	$43.20
D9222 DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	$70.00
D9223 DEEP SEDATION/GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	$70.00
D9230 ANALGESIA ANXIOLYSIS, INHALATION OF NITROUS OXIDE	$20.00
D9239 INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANESTHESIA - FIRST 15 MINUTES	$164.00
D9243 INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	$79.00
D9248 NON-INTRAVENOUS (CONSCIOUS) SEDATION, THIS INCLUDES NON-IV MINIMAL AND MODERATE SEDATION	$107.20
D9310 CNSLT DX DENT/PHY NOT REQ DENT/PHY	$43.20
D9610 THERAPEUTIC PARENTERAL DRUG SINGLE ADMINISTRATION	$40.00
D9630 DRUGS OR MEDICAMENTS DISPENSED IN THE OFFICE FOR HOME USE	$20.00
D9910 APPLICATION OF DESENSITIZING MEDICAMENT	$20.00
D9911 APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH	$30.40
D9940 OCCLUSAL GUARD BY REPORT	$231.20
D9942 REPAIR AND/OR RELINE OCCCLUSAL GUARDS	$69.60

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D9943 OCCLUSAL GUARD ADJUSTMENT	$21.00
D9951 OCCLUSAL ADJUSTMENT - LIMITED	$44.00
D9952 OCCLUSAL ADJUSTMENT - COMPLETE	$201.60