



Schedule of Benefits and Subscriber Copayments

ADA CODE	PROCEDURE	PATIENT PAYS	ADA CODE	PROCEDURE	PATIENT PAYS
DIAGNOSTIC					
D0120	PERIODIC ORAL EVALUATION (limit two every 12 months)	\$0	D2722	CROWN-RESIN WITH NOBLE METAL	\$328
D0140	LIMITED ORAL EVALUATION	\$0	D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	\$352
D0150	COMPREHENSIVE ORAL EVALUATION	\$0	D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	\$347
D0160	DETAIL AND EXTENSIVE ORAL EVALUATION	\$0	D2751	CROWN-PORCELAIN FUSED TO PREDOM BASE METAL	\$323
D0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT)	\$0	D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$331
D0180	COMPREHENSIVE PERIODONTAL EVALUATION	\$0	D2790	CROWN-FULL CAST HIGH NOBLE METAL	\$335
			D2791	CROWN-FULL CAST PREDOM BASE METAL	\$317
			D2792	CROWN-FULL CAST NOBLE METAL	\$323
X-RAYS AND TESTS					
D0210	INTRAORAL-COMPLETE SERIES INCL BITEWINGS (limit one every 3 years)	\$0	OTHER RESTORATIVE SERVICES		
D0220	INTRAORAL-PERAPICAL-FIRST FILM	\$0	D2910	RECEMENT INLAY	\$29
D0230	INTRAORAL-PERAPICAL-EACH ADD FILM	\$0	D2920	RECEMENT CROWN	\$30
D0240	INTRAORAL-OCCLUSAL FILM	\$0	D2930	PREFAB STAINL STEEL CROWN-PRIM TOOTH	\$82
D0250	EXTRAORAL-FIRST FILM	\$0	D2931	PREFAB STAINL STEEL CROWN-PERM TOOTH	\$93
D0260	EXTRAORAL-EACH ADDITIONAL FILM	\$0	D2932	PREFABRICATED RESIN CROWN	\$101
D0270	BITEWING-SINGLE FILM (limit two every 12 months)	\$0	D2940	SEDATIVE FILLING	\$12
D0272	BITEWINGS - TWO FILMS (limit two every 12 months)	\$0	D2950	BUILDUP INCLUDING ANY PINS	\$78
D0274	BITEWINGS - FOUR FILMS (limit two every 12 months)	\$0	D2951	PIN RETENTION/PER TOOTH	\$17
D0277	VERTICAL BITEWINGS (limit two every 12 months)	\$0	D2952	CAST POST & CORE IN ADD TO CROWN	\$119
D0330	PANORAMIC FILM (limit one every 3 years)	\$0	D2954	PREFAB POST & CORE IN ADD TO CROWN	\$99
D0470	DIAGNOSTIC CASTS	\$33	ENDODONTIC SERVICES		
PREVENTIVE SERVICES					
D1110	PROPHYLAXIS ADULTS (limit 1 every 6 months)	\$0	D3220	THERAPEUTIC PULPOTOMY EXCLUDING FINAL RESTORATION	\$20
D1120	PROPHYLAXIS-CHILD (limit 1 every 6 months)	\$0	D3310	ROOT CANAL THERAPY-ANT EXC FINAL RESTORATION	\$214
D1201	TOP APPL FLUORIDE INCL PROPHY-CHILD (limit 2 every 12 months for child < 16)	\$0	D3320	ROOT CANAL THERAPY-BICUSPID EXC FINAL RESTORATION	\$262
D1203	TOP APPL FLUORIDE EXCL PROPHY-CHILD (limit 2 every 12 months for child < 16)	\$0	D3330	ROOT CANAL THERAPY-MOLAR EXC FINAL RESTORATION	\$338
D1351	SEALANT - PER TOOTH (limit 1 per tooth every 12 months for child < 13)	\$7	D3346	RETREAT PREVIOUS ROOT CANAL-ANTERIOR	\$288
D1510	SPACE MAINTAINER-FIXED UNILATERAL	\$44	D3347	RETREAT PREVIOUS ROOT CANAL-BICUSPID	\$340
D1515	SPACE MAINTAINER-FIXED BILATERAL	\$58	D3348	RETREAT PREVIOUS ROOT CANAL-MOLAR	\$408
D1520	SPACE MAINTAINER-REMOVBLE UNILATERAL	\$55	D3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	\$245
D1525	SPACE MAINTAINER-REMOVABLE BILATERAL	\$75	D3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID FIRST ROOT	\$268
D1550	RECEMENTATION OF SPACE MAINTAINER	\$10	D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR FIRST ROOT	\$303
MINOR RESTORATIVE SERVICES					
D2140	AMALGAM-ONE SURFACE PRIMARY OR PERMANENT	\$14	D3426	APICOECTOMY/PERIRADICULAR SURGERY-EA ADD ROOT	\$101
D2150	AMALGAM-TWO SURFACES PRIMARY OR PERMANENT	\$18	D3430	RETROGRADE FILLING-PER ROOT	\$74
D2160	AMALGAM-THREE SURFACES PRIMARY OR PERMANENT	\$22	PERIODONTAL SERVICES		
D2161	AMALGAM-FOUR OR MORE SURFACES PRIMARY OR PERMANENT	\$27	D4210	GINGIVECTOMY/GINGIVOPLASTY-FOUR OR MORE TEETH, PER QUAD (limit 1 every 12 months)	\$202
D2330	RESIN-ONE SURFACE ANTERIOR	\$17	D4211	GINGIVECTOMY/GINGIVOPLASTY-ONE TO THREE TEETH, PER QUAD (limit 1 every 12 months)	\$54
D2331	RESIN-TWO SURFACES ANTERIOR	\$22	D4240	GINGIVAL FLAP INCL RT PLANING, FOUR OR MORE TEETH, PER QUAD (limit 1 every 12 months)	\$238
D2332	RESIN-THREE SURFACES ANTERIOR	\$26	D4241	GINGIVAL FLAP INCL RT PLANING, ONE TO THREE TEETH, PER QUAD (limit 1 every 12 months)	\$203
D2335	RESIN-FOUR OR MORE SURFACES OR INCISAL ANGLE	\$31	D4249	CROWN LENGTHENING-HARD TISSUE	\$272
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	\$37	D4260	OSSEOUS SURGERY, FOUR OR MORE CONTIGUOUS TEETH, PER QUAD	\$385
D2391	RESIN - ONE SURFACE, POSTERIOR	\$18	D4261	OSSEOUS SURGERY, ONE TO THREE TEETH, PER QUAD	\$345
D2392	RESIN - TWO SURFACES, POSTERIOR	\$23	D4341	PERIODONTAL ROOT PLANING, FOUR OR MORE CONTIGUOUS TEETH, PER QUAD (limit 2 per quad every 12 months)	\$29
D2393	RESIN - THREE SURFACES, POSTERIOR	\$29	D4342	PERIODONTAL ROOT PLANING, ONE TO THREE TEETH, PER QUAD (limit 2 per quad every 12 months)	\$60
D2394	RESIN - FOUR OR MORE SURFACES, POSTERIOR	\$39	D4355	FULL MOUTH DEBRIDEMENT COMPREHENSIVE PERIDONT E&D	\$19
MAJOR RESTORATIVE SERVICES					
Inlay and Onlay Restorations (Limited to one per tooth every 5 years)					
D2510	INLAY-METALLIC-ONE SURFACE	\$233	D4910	PERIODONTAL MAINTENANCE (limit 2 every 12 months)	\$17
D2520	INLAY-METALLIC-TWO SURFACES	\$265	REMOVABLE PARTIAL AND COMPLETE DENTURES (Limit replacement to every 5 years)		
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	\$305	D5110	COMPLETE DENTURE - UPPER	\$409
D2542	ONLAY-METALLIC-TWO SURFACES	\$300	D5120	COMPLETE DENTURE - LOWER	\$409
D2543	ONLAY-METALLIC-THREE SURFACES	\$313	D5130	IMMEDIATE DENTURE - UPPER	\$446
D2544	ONLAY-METALLIC-FOUR+ SURFACES	\$325	D5140	IMMEDIATE DENTURE - LOWER	\$446
D2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	\$274	D5211	UPPER PARTIAL-RESIN BASE W/CONV CLSPS-RSTS&TH	\$345
D2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES	\$290	D5212	LOWER PARTIAL-RESIN BASE W/CONV CLSPS-RSTS&TH	\$401
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	\$308	D5213	UPPER PARTIAL-CAST METAL RESIN BASE W/CONV CLSPS	\$452
D2642	ONLAY-PORCELAIN/CERAMIC-TWO SURFACES	\$300	D5214	LOWER PARTIAL-CAST METAL RESIN BASE W/CONV CLSPS	\$452
D2643	ONLAY-PORCELAIN/CERAMIC-THREE SURFACES	\$323	D5410	ADJUST COMPLETE DENTURE - UPPER	\$23
D2644	ONLAY-PORCELAIN/CERAMIC-FOUR+ SURFACES	\$343	D5411	ADJUST COMPLETE DENTURE - LOWER	\$23
D2650	INLAY-COMPOSITE/RESIN-ONE SURFACE LAB PROCESS	\$180	D5421	ADJUST PARTIAL DENTURE - UPPER	\$23
D2651	INLAY-COMPOSITE/RESIN-TWO SURFACE LAB PROCESS	\$215	D5422	ADJUST PARTIAL DENTURE - LOWER	\$23
D2652	INLAY-COMPOSITE/RESIN-THREE OR MORE SURFACE LAB	\$226	PROSTHETIC REPAIRS		
D2662	ONLAY-COMPOSITE/RESIN-TWO SURFACES	\$196	D5510	REPAIR BROKEN COMPLETE DENTURE BASE	\$45
D2663	ONLAY-COMPOSITE/RESIN-THREE SURFACES	\$231	D5520	REPLACE MISSING/BROKEN TEETH-COMPL DENT-EA TOOTH	\$38
D2664	ONLAY-COMPOSITE/RESIN-FOUR+ SURFACES	\$247	D5610	REPAIR RESIN DENTURE BASE	\$49
CROWNS (Limited to one crown per tooth every 5 years)					
D2710	CROWN-RESIN-LABORATORY	\$139	D5620	REPAIR CAST FRAMEWORK	\$52
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	\$343	D5630	REPAIR OR REPLACE BROKEN CLASP	\$64
D2721	CROWN-RESIN WITH PREDOM BASE METAL	\$321			

ORTHODONTIC	
D8070/	Comprehensive Orthodontic Treatment of the transitional/adolescent dentition
D8080	Children up to 19 years of age
	Up to 24 months of routine orthodontic treatment for Class I and Class II cases
	Consultation
	Evaluation.....
	Records/Treatment Planning
	Orthodontic Treatment.....
D8090	Comprehensive Orthodontic Treatment of the adult dentition
	Adults 19 years of age and over
	Up to 24 months of routine orthodontic treatment for Class I and Class II cases
	Consultation.....
	Evaluation.....
	Records/Treatment Planning
	Orthodontic Treatment.....
D8680	Retention.....

All procedures listed might not be performed by the Participating General Dentist you select. The co-payments shown apply to those Participating General Dentists who do perform those services. Therefore, you are encouraged to discuss the availability of the scheduled services with your Participating General Dentist. Procedures not listed on this schedule of benefits, that are performed by the Participating General Dentist, will be charged at that Participating General Dentist's usual and customary fee less 20%.

Should you need a specialist (i.e. Endodontist, Oral Surgeon, Orthodontist, Periodontist, Prosthodontist, Pediatric Dentist), you may be referred by your Participating General Dentist. Co-payment amounts are applicable when treatment is performed by a Participating Specialist. Procedures not listed on this schedule of benefits, that are performed by a Participating Specialist, will be charged at that Participating Specialist's usual and customary fee less 20%.

1. No service of any dentist other than a Participating General Dentist or Participating Specialist will be covered by Company, except out-of-area emergency care as provided in Section VIII, Paragraph B of the Certificate of Benefits.
2. Whenever any Contributions or Copayments are delinquent, Member will not be entitled to receive Benefits, transfer Dental Facilities, or enjoy any of the other privileges of a Member in good standing.
3. Company does not provide coverage for the following services:
 - a) Cost of hospitalization and pharmaceuticals, drugs or medications.
 - b) Services which in the opinion of the Participating General Dentist or Participating Specialist are not Necessary Treatment to establish and/or maintain the Member's oral health.
 - c) Any service that is not consistent with the normal and/or usual services provided by the Participating General Dentist or Participating Specialist or which in the opinion of the Participating General Dentist or Participating Specialist would endanger the health of the Member.
 - d) Any service or procedure which the Participating General Dentist or Participating Specialist is unable to perform because of the general health or physical limitations of the Member.
 - e) Any dental treatment started prior to the Member's effective date for eligibility of benefits.
 - f) Services for injuries and conditions which are paid or payable under Workers' Compensation or Employers' Liability laws.
 - g) Treatment for cysts, neoplasms and malignancies.
 - h) General anesthesia.