



Dental Enrollment Kit

Harris County
UnitedHealthcare Dental PPO

March 2011



Key cost-savings and benefits:

No out-of-pocket costs for network services, as described†

Fees are not applied to the benefit period maximum

Fees are not applied to deductibles

Waiting Periods do not apply if services are required by a network dentist

No referral needed

Use this important benefit if:

Your obstetrician recommends that you visit a dentist for a check-up and cleaning

You're experiencing any symptoms of gum disease

Your dentist recommends additional cleanings throughout your pregnancy

Tips for maintaining good oral health during your pregnancy:

Make an appointment with your dentist within your first trimester for a checkup and cleaning

Schedule a follow-up appointment within your second trimester

Set a time twice each day to brush, and make sure to floss daily

See your dentist if your gums are becoming sensitive, or if you are experiencing any of the symptoms of gum disease††

If extensive dental work that includes medication or anesthesia is needed, you should have it done prior to the fourth month of your pregnancy to avoid any complications

Inform your dentist of any prescribed medications

Each time you visit your dentist, it's important you let them know how many weeks you are into your pregnancy.

† For indemnity plans or PPO plans with out-of-network options, fees are set to maximum allowable charges; the member may incur balance billing.

UnitedHealthcare Dental® plans are either underwritten or administered by: United HealthCare Insurance Company, Hartford, Connecticut (except NY) and United HealthCare Insurance Company of New York, Hauppauge, New York (NY only).

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Customer Care:

If you have questions about coverage, claims, locating a dentist in your area, or replacing a lost ID card, please visit myuhcdental.com. You also may contact UnitedHealthcare Dental Customer Care at the toll-free phone number listed on your dental ID card, Monday through Friday, 8 a.m. to 11 p.m., Eastern Time. Using the same toll-free telephone number, you can access our automated voice system 24 hours a day, seven days a week.

Symptoms of Gum Disease

Pregnancy periodontal disease is an inflammation of the gums and surrounding tissues. If you're experiencing any of the following symptoms, contact your dentist immediately.

Red, tender or swollen gums

Gums that bleed when you brush

Dark red or receding gums

Bad breath or a bad taste in your mouth

Preventing Gum Disease

Brush your teeth twice daily with a soft-bristle brush

Floss daily

Choose a healthy diet

See your dentist regularly

UnitedHealthcare Dental Prenatal Dental Care Program

Prenatal Dental Care Program

Keep this information with you so you know how to take advantage of your prenatal benefit.

1. Visit any dentist: Inform the dentist that you're pregnant and provide your stage of pregnancy
2. Make sure the dentist waives the eligible fees
3. Most Important: Remind the dentist to include the following on the claim form:

Your due date

Your attending physician's or obstetrician's name

Taking care of your teeth and gums during your pregnancy is an important part of your and your unborn child's overall good health and well-being. Experts say that disease related to the gums and tooth-support structures (periodontal disease) during pregnancy could lead to an increased risk of pre-term and very pre-term delivery.

If you don't get treatment for tooth-related disease while you are pregnant, you could place your unborn child at higher risk for neonatal problems and even life-long disabilities related to pre-term deliveries.*

That's why we've created a UnitedHealthcare Dental program, which provides additional network preventive dental care coverage for expectant mothers. If you are in your second or third trimester of pregnancy, you are eligible for this program's benefits as part of your benefit plan.

On your next visit, tell your dentist that you are pregnant. Provide the stage of your pregnancy and due date, and also make sure the dentist notes your attending physician's or obstetrician's name (this must be included on the claim form). All fees and expenses for cleanings, deep scaling (cleaning the teeth deeper down the tooth), debridement (removing dead or infected tissue) and periodontal maintenance will be waived, if your dentist requires these services.

*Baby Steps to a Healthy Pregnancy and On-time Delivery, American Academy of Periodontology, 2005. While periodontal disease may be a contributing factor to pre-term, low-weight babies, there are a number of other associated risk factors, such as: infection (especially genitor-urinary), diabetes mellitus, hypertension, late or no prenatal care, smoking, alcohol and illicit drug use. Visit www.marchofdimes.com for more information about pre-term risk factors.



You may choose to receive treatment from any dentist but by selecting a UnitedHealthcare Dental network dentist, you lower your out-of-pocket cost. Network dentists reduce standard fees for UnitedHealthcare Dental members - you save money, and you are not balanced billed.

About this plan ...

- Network dentists accept negotiated fees as payment in full.
- There is a "calendar year maximum" (the amount UnitedHealthcare Dental pays in claims for you and each enrolled dependent).
- Treatment procedures are categorized into service groups and your plan pays a specific percentage of the costs for each category.

You may find the names and locations of dentists in your local area by using the Directory of Participating Network Dentist Directory or, for the most current information, you may log on at www.yourdentalplan.com/harriscounty to use our online directory. There is no need to "pre-select" a dentist from the Directory at enrollment.

You will be able to search by city, county, zip code, or by a particular dentist's name or office location.

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UnitedHealthcare Dental
Options PPO/covered dental services

Harris County

dental plan
Custom (P8096)

NON-ORTHODONTICS			
	NETWORK	NON-NETWORK	
Individual Annual Calendar Year Deductible	\$50	\$50	
Family Annual Calendar Year Deductible	\$150	\$150	
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	\$1750 per person per Calendar Year	\$1750 per person per Calendar Year	
New enrollee's waiting period:	Network or Non-Network: 6 months Major and Endodontic Procedures		
Annual deductible applies to preventive and diagnostic services	Network or Non-Network: Preventive and diagnostic services do not apply to the annual deductible		
COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 per calendar year.
Radiographs	100%	100%	Bite-wing: Limited to 2 series of films per Calendar Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per calendar year.
Fluoride Treatment (Preventive)	100%	100%	Limited to one per calendar year.
Sealants	100%	100%	Limited to covered persons under the age of 18 years and once per first or second permanent molars every consecutive 36 months.
Space Maintainers	100%	100%	
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	80%	
Emergency Treatment / General Services	80%	80%	Limited to the relief of acute pain, bleeding or infection.
Simple Extractions	80%	80%	
Oral Surgery (includes surgical extractions)	80%	80%	
Periodontics	80%	80%	Periodontal Maintenance unless following active periodontal therapy
Endodontics	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	Replacement of crowns, gold restorative or cast posts - once every five years (if the tooth can be restored with less expensive materials, the benefit will be based on those materials).
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to once every five years.
Fixed Partial Dentures (Bridges)	50%	50%	Limited to once every five years, If more than one type of service can be used to treat a dental condition, the benefit payment will be based on the least expensive service, which is within the range of professionally accepted standards of dental practice.
Implant Services	50%	50%	Limited to once every five years.

* 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 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 fees negotiated with the provider.

***The benefit percentage applies to the schedule of maximum allowable amount. Maximum allowable amount is limitation on billed charges.

The Prenatal Dental Care 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 table 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 of 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: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

CDT-9 Code	Procedure Description	Maximum Allowable Amount
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	\$1314.00
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	\$479.00
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	\$752.00
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	\$479.00
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	\$771.00
D7465	Destruction of lesion(s) by physical or chemical method, by report	\$273.00
D7471	Removal of lateral exostosis (maxilla or mandible)	\$512.00
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	\$144.00
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple facial spaces)	\$247.00
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	\$684.00
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple facial spaces)	\$856.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	\$246.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	\$273.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$170.00
D7910	Suture of Recent Small Wounds up to 5cm	\$226.00
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	\$316.00
D7963	Frenuloplasty	\$365.00
D7970	Excision of Hyperplastic Tissue - Per Arch	\$326.00
D7971	Excision of Pericoronary Gingiva	\$103.00
D7983	Closure of salivary fistula	\$1192.00
(D9110-D9999): Adjunctive General Services		
D9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	\$47.00
D9210	Local Anesthesia not in conjunction with operative or surgical procedures	\$15.00
D9211	Local Block Anesthesia	\$22.00
D9212	Trigeminal Division Block Anesthesia	\$43.00
D9215	Local Anesthesia	\$15.00
D9220	Deep Sedation/General Anesthesia – First 30 minutes	\$188.00
D9221	Deep Sedation/General Anesthesia – each additional 15 minutes	\$79.00
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	\$26.00
D9241	Intravenous Conscious Sedation / Analgesia - First 30 Minutes	\$151.00
D9242	Intravenous Conscious Sedation / Analgesia – each additional 15 minutes	\$68.00
D9248	Non-intravenous conscious sedation	\$34.00
D9310	Consultation -Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician	\$99.00
D9410	House/Extended care facility call	\$130.00
D9420	Hospital call	\$179.00
D9430	Office Visit-Observation (During regulary scheduled hours) – no other services performed	\$34.00
D9440	Office Visit After Regularly Scheduled Hours	\$60.00
D9910	Application of Desensitizing Medicament	\$22.00
D9911	Application of Desensitizing Resin for cervical and/or root surface, per tooth	\$33.00

CDT-9 Code	Procedure Description	Maximum Allowable Amount
D6783	Crown- 3/4 Porcelain/Ceramic	\$558.00
D6790	Crown - Full Cast High Noble Metal	\$545.00
D6791	Crown - Full Cast Predominantly Base Metal	\$517.00
D6792	Crown - Full Cast Noble Metal	\$535.00
D6794	Crown - Titanium	\$671.00
D6920	Connector Bar	\$95.00
D6930	Recement Fixed Partial Denture	\$66.00
D6940	Stress Breaker	\$150.00
D6950	Precision Attachment	\$293.00
D6970	Post and Core in Addition to Fixed Partial Denture Retainer -Indirectly Fabricated	\$183.00
D6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	\$149.00
D6973	Core Build-Up for Retainer, Including any Pins	\$120.00
D6975	Coping – Metal	\$328.00
D6976	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$79.00
D6977	Each additional prefabricated post – same tooth	\$76.00
Oral Surgery (D7000-D7999): Nonsurgical and surgical extractions and related procedures; Includes pre-op and post-op evaluations and treatment under local anesthetic.		
D7111	Extraction, Coronal Remnants - Deciduous Tooth	\$69.00
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	\$72.00
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	\$129.00
D7220	Removal of Impacted Tooth - Soft Tissue	\$161.00
D7230	Removal of Impacted Tooth - Partially Bony	\$215.00
D7240	Removal of Impacted Tooth - Completely Bony	\$253.00
D7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	\$427.00
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	\$136.00
D7260	Oroantral Fistula Closure	\$1337.00
D7270	Tooth Reimplantation and/or Stabilization Of Accidentally Evulsed or Displaced Tooth	\$277.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	\$394.00
D7280	Surgical Access of an Unerupted Tooth	\$381.00
D7283	Placement of device to facilitate eruption of impacted tooth	\$76.00
D7285	Biopsy of Oral Tissue, hard (bone, tooth)	\$537.00
D7286	Biopsy of Oral Tissue, soft	\$221.00
D7287	Exfoliative Cytological sample collection	\$76.00
D7288	Brush Biopsy – transepithelial sample collection	\$57.00
D7290	Surgical repositioning of teeth	\$250.00
D7310	Alveoloplasty in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	\$150.00
D7311	Alveoloplasty in Conjunction with Extractions -One to Three Teeth or Tooth Spaces, Per Quadrant	\$133.00
D7320	Alveoloplasty Not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	\$671.00
D7321	Alveoloplasty Not in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	\$209.00
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	\$1202.00
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$3756.00
D7410	Excision of benign lesion up to 1.25 cm	\$834.00
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	\$845.00

Exclusions

The Policy will only pay for Necessary Services received by you or your Dependents if those are listed as Covered Expenses in the Summary of Benefits. No benefits are payable under this Policy for any expenses incurred for:

1. Any procedure started before the effective date or after the termination date of the Covered Person's insurance.
2. Any appliance delivered or placed more than ninety days after termination of the Covered Person's insurance.
3. Treatment by anyone other than a Dentist or Physician, except where performed by a duly qualified hygienist under the direction of a Dentist or Physician.
4. Treatment which does not meet accepted standards of dental practice, is experimental or cosmetic in nature or is not considered medically necessary. Personalization or characterization of dentures and facings on crowns and pontics behind the second bicuspid are always considered cosmetic.
5. Services and supplies related to the change of vertical dimension, restoration or maintenance of occlusion, splinting teeth, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for myofascial pain disorders (MPD) or temporomandibular joint dysfunction (TMJ).
6. Replacement of lost or stolen appliances or replacement of any appliance, prosthesis, crown, or bridge placed less than five (5) years before (temporary prosthetics are considered permanent and subject to this exclusion if not replaced by the permanent prosthetic within six (6) months).
7. Periodontal maintenance, unless following active periodontal therapy.
8. Prescribed drugs and medications or training in or supplies used for dietary counseling, oral hygiene or plaque control; sterilization charges; pulp caps or medicaments.
9. Care rendered within any facility of, or provided by: (1) the United States Government or any agency thereof; (2) any hospital or institution that does not require the Covered Person to pay for such services in the absence of insurance.
10. Any expenses paid by any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law or agency, except for Medicare or Medicaid.
11. Treatment of congenital malfunctions or malformations.
12. Treatment of service not recommended by a dentist.
13. Expenses resulting from injuries sustained or sickness contracted as a result of any war or act of war or participation in a riot or civil disturbance or while committing or attempting to commit a felony.
14. Charges for professional services rendered by any individual who is related to the Covered Person by blood, marriage or adoption.
15. Hospitalization for any procedure.
16. Orthodontic services unless orthodontics is a covered benefit under this Policy or any applicable rider.

Limitations - Benefits under this Policy are limited as follows:

1. Panoramic or full mouth x-ray series - once every 36 months.
2. Porcelain, porcelain with metal, or full gold crowns are covered only for individuals 14 years or older and on permanent teeth.
3. Replacement of crowns, gold restorative or cast posts - once every five years (if the tooth can be restored with less expensive materials, the benefit will be based on those materials).
4. If more than one type of service can be used to treat a dental condition, the benefit payment will be based on the least expensive service, which is within the range of professionally accepted standards of dental practice.
5. Replacement of dentures - once every five years and only if the original is unserviceable. When a permanent denture replaces a temporary one, charges for both are limited to the charge for the permanent one.

**Harris County
Custom Plan -Dental PPO**

CDT-9 Code	Procedure Description	Maximum Allowable Amount
Diagnostic (D0100-D0999): Exams; x-rays; and related tests.		
D0120	Periodic Oral Evaluation -Established Patient	\$22.00
D0140	Limited Oral Evaluation - Problem Focused (Emergency)	\$37.00
D0145	Oral Evaluation for a Patient Under three Years of Age and Counseling with Primary Caregiver	\$38.00
D0150	Comprehensive Oral Evaluation - New or Established Patient	\$39.00
D0160	Detailed and extensive oral evaluation – problem focused, by report	\$107.00
D0170	Re-Evaluation - Limited, Problem Focused (Established Patient; not Post-Operative Visit)	\$28.00
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	\$22.00
D0210	Intraoral - Complete Series (Including Bitewings) (x-ray)	\$59.00
D0220	Intraoral - Periapical First Film (x-ray)	\$13.00
D0230	Intraoral - Periapical Each Additional Film (x-ray)	\$10.00
D0240	Intraoral - Occlusal Film (x-ray)	\$17.00
D0250	Extraoral - First Film (x-ray)	\$23.00
D0260	Extraoral - Each Additional Film (x-ray)	\$22.00
D0270	Bitewings - Single Film (x-ray)	\$12.00
D0272	Bitewings - Two Films (x-ray)	\$19.00
D0273	Bitewings - Three Films (x-ray)	\$22.00
D0274	Bitewings - Four Films (x-ray)	\$26.00
D0277	Vertical Bitewings - Seven to Eight Films (x-ray)	\$41.00
D0290	Posterior-anterior or lateral skull and facial bone survey film	\$78.00
D0310	Sialography	\$201.00
D0330	Panoramic Film (x-ray)	\$48.00
D0340	Cephalometric film	\$59.00
D0350	Oral/Facial photographic images	\$26.00
D0415	Collection of Microorganisms for Culture and Sensitivity	\$21.00
D0416	Viral culture	\$26.00
D0421	Genetic test for susceptibility to oral diseases	\$16.00
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	\$26.00
D0460	Pulp Vitality Tests	\$24.00
D0470	Diagnostic Casts	\$50.00
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$31.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$60.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	\$72.00
D0475	Decalcification procedure	\$55.00
D0476	Special stains for microorganisms	\$55.00
D0477	Special stains, not for microorganisms	\$55.00
D0478	Immunohistochemical stains	\$55.00
D0479	Tissue in-site hybridization, including interpretation	\$91.00
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	\$55.00
D0481	Electron microscopy – diagnostic	\$423.00

CDT-9 Code	Procedure Description	Maximum Allowable Amount
D5750	Reline Complete Maxillary Denture (Laboratory)	\$216.00
D5751	Reline Complete Mandibular Denture (Laboratory)	\$216.00
D5760	Reline Maxillary Partial Denture (Laboratory)	\$213.00
D5761	Reline Mandibular Partial Denture (Laboratory)	\$213.00
D5810	Interim Partial denture (Maxillary)	\$341.00
D5811	Interim Partial denture (Mandibular)	\$367.00
D5820	Interim Partial Denture (Maxillary)	\$264.00
D5821	Interim Partial Denture (Mandibular)	\$280.00
D5850	Tissue Conditioning, (Maxillary)	\$65.00
D5851	Tissue Conditioning, (Mandibular)	\$68.00
Prosthetic, Fixed (D6000-D6999): Abutments, pontics and related procedures; Including diagnosis/models, preparation, temporization, fabrication and cementation of final restoration.		
D6010	Surgical Placement of Implant Body; endosteal implant	\$1195.00
D6040	Surgical Placement, eosteal implant	\$5200.00
D6050	Surgical Placement; transosteal implant	\$3400.00
D6055	Dental implant supported connecting bar	\$310.00
D6058	Abutment supported porcelain/ceramic crown	\$700.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	\$700.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base)	\$650.00
D6061	Abutment supported cast metal crown (noble metal)	\$660.00
D6062	Abutment supported cast metal crown (high noble metal)	\$658.00
D6190	Radiographic/surgical implant index, by report	\$140.00
D6194	Abutment supported retainer crown for FPD – (titanium)	\$679.00
D6205	Pontic – indirect resin based composite	\$411.00
D6210	Pontic - Cast High Noble Metal	\$501.00
D6211	Pontic - Cast Predominantly Base Metal	\$469.00
D6212	Pontic - Cast Noble Metal	\$488.00
D6214	Pontic - Titanium	\$632.00
D6240	Pontic - Porcelain Fused to High Noble Metal	\$494.00
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	\$457.00
D6242	Pontic - Porcelain Fused to Noble Metal	\$482.00
D6245	Pontic – Porcelain/Ceramic	\$520.00
D6250	Pontic - Resin with High Noble Metal	\$488.00
D6251	Pontic - Resin with Predominantly Base Metal	\$450.00
D6252	Pontic - Resin with to Noble Metal	\$465.00
D6545	Retainer – cast metal for resin bonded fixed prosthesis	\$208.00
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	\$233.00
D6624	Inlay – titanium	\$553.00
D6634	Onlay – titanium	\$581.00
D6710	Crown – indirect resin based composite	\$592.00
D6720	Crown - Resin with High Noble Metal	\$551.00
D6721	Crown - Resin with Predominantly Base Metal	\$523.00
D6722	Crown - Resin with Noble Metal	\$532.00
D6740	Crown – porcelain/ceramic	\$591.00
D6750	Crown - Porcelain Fused to High Noble Metal	\$564.00
D6751	Crown - Porcelain Fused to Predominantly Base Metal	\$527.00
D6752	Crown - Porcelain Fused to Noble Metal	\$539.00
D6780	Crown - 3/4 Cast High Noble Metal	\$532.00
D6781	Crown - 3/4 Cast Predominantly Base Metal	\$542.00
D6782	Crown - 3/4 Cast Noble Metal	\$504.00

CDT-9 Code	Procedure Description	Maximum Allowable Amount
D4266	Guided tissue regeneration – resorbable barrier, per site	\$554.00
D4267	Guided tissue regeneration – nonresorbable barrier, per site (included membrane removal)	\$328.00
D4270	Pedicle soft tissue graft	\$508.00
D4271	Free soft tissue graft, including donor	\$522.00
D4273	Subepithelial connective tissue graft procedures, per tooth	\$341.00
D4274	Distal or proximal wedge procedure	\$157.00
D4276	Combined connective tissue and double pedicle graft	\$421.00
D4341	Periodontal Scaling and Root Planing - Four or More Teeth, Per Quadrant	\$122.00
D4342	Periodontal Scaling and Root Planing, One to Three Teeth, Per Quadrant	\$67.00
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	\$81.00
D4910	Periodontal Maintenance	\$73.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	\$62.00
Prosthetic, Removable (D5000-D5899): Full and partial dentures; Includes fabrication and/or repair of prosthesis and routine post-delivery care.		
D5110	Complete Denture - Maxillary	\$705.00
D5120	Complete Denture - Mandibular	\$705.00
D5130	Immediate Denture - Maxillary	\$769.00
D5140	Immediate Denture - Mandibular	\$769.00
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	\$595.00
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	\$691.00
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	\$779.00
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	\$779.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	\$739.00
D5226	Mandibular partial denture – flexible base (including any clasps, rests or teeth)	\$858.00
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	\$454.00
D5410	Adjust Complete Denture - Maxillary	\$39.00
D5411	Adjust Complete Denture - Mandibular	\$39.00
D5421	Adjust Partial Denture - Maxillary	\$39.00
D5422	Adjust Partial Denture - Mandibular	\$39.00
D5510	Repair Broken Complete Denture Base	\$78.00
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	\$65.00
D5610	Repair Resin (Partial) Denture Base	\$84.00
D5620	Repair Cast (Partial Denture) Framework	\$90.00
D5630	Repair or Replace Broken Clasp (Partial Denture)	\$110.00
D5640	Replace Broken Teeth (Partial Denture) - Per Tooth	\$71.00
D5650	Add Tooth to Existing Partial Denture	\$97.00
D5660	Add Clasp to Existing Partial Denture	\$116.00
D5710	Rebase Complete Maxillary Denture	\$286.00
D5711	Rebase Complete Mandibular Denture	\$274.00
D5720	Rebase Maxillary Partial Denture	\$270.00
D5721	Rebase Mandibular Partial Denture	\$270.00
D5730	Reline Complete Maxillary Denture (Chairside)	\$162.00
D5731	Reline Complete Mandibular Denture (Chairside)	\$162.00
D5740	Reline Maxillary Partial Denture (Chairside)	\$148.00
D5741	Reline Mandibular Partial Denture (Chairside)	\$148.00

CDT-9 Code	Procedure Description	Maximum Allowable Amount
D0482	Direct immunofluorescence	\$65.00
D0483	Indirect immunofluorescence	\$65.00
D0484	Consultation on slides prepared elsewhere	\$124.00
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	\$150.00
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	\$51.00
Preventive (D1000-1999): Prohylaxis (cleanings), fluoride and related maintenance procedures.		
D1110	Prophylaxis - Adult	\$47.00
D1120	Prophylaxis -Child	\$30.00
D1203	Topical Application of Fluoride (Prophylaxis Not Included) - Child	\$16.00
D1204	Topical Application of Fluoride (Prophylaxis Not Included) - Adult	\$19.00
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients	\$52.00
D1351	Sealant - Per Tooth	\$27.00
D1510	Space Maintainer - Fixed - Unilateral	\$170.00
D1515	Space Maintainer - Fixed - Bilateral	\$225.00
D1520	Space Maintainer - Removable - Unilateral	\$211.00
D1525	Space Maintainer - Removable - Bilateral	\$289.00
D1550	Recementation of Space Maintainer	\$37.00
D1555	Removal of Fixed Space Maintainer	\$250.00
Restorative (D2000-2999): Amalgams, resins, pins and single crowns: Includes bases, pulp caps, liners and preparations, temporization and cementation of cast restorations and cast crowns.		
D2140	Amalgam - One Surface, Primary or Permanent	\$65.00
D2150	Amalgam - Two Surfaces, Primary or Permanent	\$83.00
D2160	Amalgam - Three Surfaces, Primary or Permanent	\$102.00
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	\$124.00
D2330	Resin-Based Composite - One Surface, Anterior	\$74.00
D2331	Resin-Based Composite - Two Surfaces, Anterior	\$94.00
D2332	Resin-Based Composite - Three Surfaces, Anterior	\$115.00
D2335	Resin-Based Composite -Four or More Surfaces, or Involving Incisal Angle (Anterior)	\$136.00
D2390	Resin-Based Composite Crown, Anterior	\$147.00
D2391	Resin-Based Composite - One Surface, Posterior	\$83.00
D2392	Resin-Based Composite - Two Surfaces, Posterior	\$113.00
D2393	Resin-Based Composite - Three Surfaces, Posterior	\$139.00
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	\$170.00
D2410	Gold foil – one surface	\$138.00
D2420	Gold foil – two surfaces	\$230.00
D2430	Gold foil – three surfaces	\$399.00
D2510	Inlay, Metallic, One Surface	\$365.00
D2520	Inlay, Metallic, Two Surfaces	\$414.00
D2530	Inlay, Metallic, Three or more surfaces	\$477.00
D2542	Onlay, Metallic, Two surfaces	\$476.00
D2543	Only, Metallic, Three surfaces or more	\$490.00
D2544	Only, Metallic, Four or more surfaces	\$509.00
D2610	Inlay, Porcelain/Ceramic, One surface	\$430.00
D2620	Inlay, Porcelain/Ceramic, Two surfaces	\$453.00
D2630	Inlay, Porcelain/Ceramic, Three or more surfaces	\$483.00
D2642	Onlay, Porcelain/Ceramic, Two surfaces	\$469.00

CDT-9 Code	Procedure Description	Maximum Allowable Amount
D2643	Onlay, Porcelain/Ceramic, Three surfaces	\$506.00
D2644	Onlay, Porcelain/Ceramic, Four or more surfaces	\$537.00
D2650	Inlay - Resin-Based Composite - One Surface	\$282.00
D2651	Inlay - Resin-Based Composite - Two Surfaces	\$336.00
D2652	Inlay - Resin-Based Composite - Three Surfaces	\$354.00
D2662	Onlay, Resin-Based Composite, Two surfaces	\$307.00
D2663	Onlay, Resin-Based Composite, Three surfaces	\$361.00
D2664	Onlay, Resin-Based Composite, Four or more surfaces	\$387.00
D2710	Crown, Resin-Based Composite (indirect)	\$218.00
D2720	Crown, Resin with High Noble metal	\$537.00
D2721	Crown, Resin with Predominantly Base metal	\$503.00
D2722	Crown, Resin with noble metal	\$514.00
D2740	Crown, Porcelain/Ceramic Substrate	\$551.00
D2750	Crown - Porcelain Fused to High Noble Metal	\$575.00
D2751	Crown - Porcelain Fused to Predominantly Base Metal	\$530.00
D2752	Crown - Porcelain Fused to Noble Metal	\$540.00
D2780	Crown - 3/4 Cast High Noble Metal	\$535.00
D2781	Crown - 3/4 Cast Predominantly Base Metal	\$500.00
D2782	Crown - 3/4 Cast Noble Metal	\$516.00
D2783	Crown - 3/4 Porcelain//Ceramic	\$506.00
D2790	Crown - Full Cast High Noble Metal	\$555.00
D2791	Crown - Full Cast Predominantly Base Metal	\$515.00
D2792	Crown - Full Cast Noble Metal	\$525.00
D2794	Crown - Titanium	\$575.00
D2799	Provisional Crown	\$210.00
D2910	Re-Cement Inlay, Onlay, or Partial Coverage Restoration	\$44.00
D2915	Re-Cement Cast or Prefabricated Post and Core	\$55.00
D2920	Re-Cement Crown	\$46.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	\$124.00
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	\$140.00
D2932	Prefabricated Resin Crown	\$153.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	\$171.00
D2940	Sedative Filling	\$48.00
D2950	Core Build-Up, Including Any Pins	\$119.00
D2951	Pin Retention - Per Tooth, in Addition to Restoration	\$25.00
D2952	Cast Post and Core In Addition to Crown -Indirectly Fabricated	\$181.00
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	\$92.00
D2954	Prefabricated Post and Core in Addition to Crown	\$150.00
D2955	Post Removal (Not in Conjunction with Endodontic Therapy)	\$114.00
D2957	Each Additional Prefabricated Post - Same Tooth	\$76.00
D2960	Labial Veneer (Resin Laminate) – Chairside	\$366.00
D2961	Labial Veneer (Resin Laminate) - Laboratory	\$410.00
D2962	Labial Veneer (Cosmetic) - Laboratory	\$445.00
D2971	Additional procedures to construct new crown under existing partial denture frame	\$79.00
D2975	Coping	\$276.00

CDT-9 Code	Procedure Description	Maximum Allowable Amount
Endodontics (D3000-D3999): Pulp caps; root canals; apical surgery; retrogrades; hemisections and related procedures.		
D3110	Pulp Cap - Direct (Excluding Final Restoration)	\$36.00
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	\$29.00
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) -Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	\$85.00
D3221	Pulpal Debridement, primary and permanent tooth	\$97.00
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	\$90.00
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	\$97.00
D3310	Endodontic Therapy - Anterior Tooth (Excluding Final Restoration)	\$359.00
D3320	Endodontic Therapy – Bicuspid Tooth (Excluding Final Restoration)	\$437.00
D3330	Endodontic Therapy - Molar (Excluding Final Restoration)	\$674.00
D3331	Treatment of Root Canal Obstruction; non-surgical access	\$124.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$321.00
D3346	Retreatment of Previous Root Canal Therapy - Anterior	\$481.00
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	\$568.00
D3348	Retreatment of Previous Root Canal Therapy - Molar	\$683.00
D3351	Apexification / Recalcification - Initial Visit (Apical Closure/Calcific Repair of Perforations, Root Resorption, Etc.)	\$203.00
D3352	Apexification / Recalcification - Interim Visit (Apical Closure/Calcific Repair of Perforations, Root Resorption, Etc.)	\$89.00
D3353	Apexification / Recalcification - Final Visit (Includes Completed Root Canal Therapy- Apical Closure/Calcific Repair of Perforations, Root Resorption, Etc.)	\$300.00
D3410	Apicoectomy/Periradicular Surgery - Anterior	\$410.00
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$447.00
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	\$506.00
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$169.00
D3430	Retrograde Filling - Per Root	\$124.00
D3450	Root Amputation per Root	\$251.00
D3460	Endodontic Endosseous Implant	\$1205.00
D3470	Intentional Reimplantation (including necessary splinting)	\$475.00
D3920	Hemisection – including root removal (excluding root canal therapy)	\$196.00
Periodontics (D4000-D4999): Includes root planning/curettage, gingival and osseous surgery and related procedures; Includes pre-op and post-op evaluations and local anesthetic; charting must be performed in conjunction with these procedures.		
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$361.00
D4211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$155.00
D4240	Gingival Flap Procedure, Including Root Planing - Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$425.00
D4241	Gingival Flap Procedure, Including Root Planing - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$221.00
D4245	Apically positioned flap	\$312.00
D4249	Clinical Crown Lengthening - Hard Tissue	\$486.00
D4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Tooth Bounded Spaces, Per Quadrant	\$687.00
D4261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	\$357.00
D4263	Bone replacement graft – first site in quadrant	\$519.00
D4264	Bone replacement graft – each additional site in quadrant	\$393.00