Schedule of Dental Benefits
SoloCare Individual Plans with Dental Benefits
01/01/2022 – 12/31/2022

This document is called the Schedule of Dental Benefits and only applies to Alliant Health Plans' (Alliant) SoloCare medical plans with dental benefits. Please refer to this schedule whenever you require dental services. It describes how to access dental care, what dental services are covered by Alliant, what limits apply to covered services, and what portion of the dental care costs you are required to pay.

Sometimes, Alliant may send you documents that are amendments, endorsements, attachments, inserts, or riders. When you receive these documents, they become a part of your **SoloCare** Certificate of Coverage.

The Dental Benefits Within Your Plan Are Not Limited by Provider Network
Your Plan allows you the freedom to select the Dentist of your choice.

The Dental Benefits Herein Accumulate to Your Plan's Out-of-Pocket Maximum.
The dental benefits herein are subject to your medical plan's Deductible and Coinsurance. These dental benefits accumulate to the Out-Of-Pocket Maximum for your medical plan. Please check your Summary of Benefits and Coverage for specific Deductible, Coinsurance, Copayments, and Out-Of-Pocket Maximums for your Plan.

Thank you for choosing **SoloCare**.

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SCHEDULE OF DENTAL BENEFITS

The Schedule of Dental Benefits is a Schedule of the benefit maximums, Covered Services, and exclusions that apply when you receive care from a Dentist. Please refer to the Covered Services section of this Schedule of Dental Benefits for a more complete explanation of the specific services covered. All Covered Services are subject to the conditions, exclusions, limitations, terms, and provisions of your Plan, including any attachments or riders.

Coverage Year
One year, January 1 – December 31 (also called year or calendar year). Benefits reset each January 1.

Deductible
The Deductible is the amount you must pay before Alliant begins to pay for Covered Services. You must meet your Deductible every Coverage Year before Alliant will pay for Covered Services. Preventive care services are covered and reimbursable prior to meeting your Deductible. Deductible requirements are stated in your Summary of Benefits and Coverage.

Benefit Maximums
The following benefit maximums are the dollar amount Alliant will pay for Covered Services for each Member, subject to the coverage percentages identified in your Plan's Summary of Benefits and Coverage. If you do not reach your Annual Benefit Maximums, unused amounts will not carry over to the next coverage year. See Summary of Benefits and Coverage.

Service	Pediatric	Adult
All Services (Preventive Dental, Basic Dental, Major Dental, & Dentally Necessary Orthodontia)	Benefit Maximum Not Applicable	$1,000 Annual Benefit Maximum for all services; services not covered for cosmetic care

Coinsurance and Out-of-Pocket Maximums
The portion which you must pay (the Coinsurance) is stated in your Summary of Benefits and Coverage. Your dental benefits accumulate to your Plan's Out-of-Pocket Maximum. Alliant will pay up to the Annual Benefit Maximum for certain benefits. You are responsible for the remainder of your dental services.

DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Accidental Dental – is damage to the mouth, teeth, and supporting tissue due directly to an accident. It does not include damage to the teeth, appliances, or prosthetic devises that results from chewing or biting food or other substances.

Covered Services – are services or treatments as described in this Schedule of Dental Benefits which are performed, prescribed, directed or authorized by a Dentist. To be considered a Covered Service, the service must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under your Plan's Certificate of Coverage is in force;
- Not specifically excluded or limited by this Schedule of Dental Benefits; and
- Specifically included as a Covered benefit within this Schedule of Dental Benefits.

Cosmetic Care – are services that are primarily for the purpose of improving appearance including but not limited to:

- Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
- Characterizations and personalization of prosthetic devices.

Dentally Necessary Orthodontic Care – Only those services medically necessary as evidenced by a severe and handicapping malocclusion are covered and qualify for orthodontic care. Orthodontic procedures are a benefit only when it meets one or more of the qualifying conditions and claims are submitted with appropriate CDT and ICD-10 codes, listed below. All services must be provided by a licensed orthodontist. Qualifying Conditions:

- Cleft Palate
- Deep Impinging Overbite
- Anterior Impactions
- Severe Traumatic Deviations
- Overjet greater than 9mm
- Severe Maxillary Anterior Crowding, greater than 8mm

Dentist – is a person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Emergency Dental Services –Treatment of a potentially life-threatening dental emergency to stop ongoing tissue bleeding, alleviate severe pain or infection. Some examples of dental emergencies provided by ADA include:

- Uncontrolled bleeding;
- Cellulitis or soft tissue infection with swelling that potentially compromises a patient's airway;
- Trauma to facial bones that may obstruct an airway and make breathing difficult;
- Tooth or jaw pain.

Essential Health Benefits (EHB) –are, for the purposes of this coverage, pediatric dental services that Alliant is required to cover under the Patient Protection and Affordable Care Act and any other applicable regulations. EHB and its provisions apply to Members through age 18 only.

Provider – is any Physician, health care practitioner, pharmacy, supplier or facility, including, but not limited to, a Hospital, clinical laboratory, Ambulatory Surgery Center, Retail Health Clinic, Skilled Nursing

Facility, Long Term Acute Care facility, or Home Health Care Agency holding all licenses required by law to provide health care services.

Plan – refers to the Alliant Health Plans' SoloCare medical health insurance plan you have chosen for the 2022 Calendar year.

DENTAL PROVIDERS AND CLAIMS PAYMENT

You have the freedom to choose the Dentist you want for your dental care. However, your choice of Dentist can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your Dentist does not accept the reimbursement amount determined by Alliant.

Payments are made by Alliant only when the Covered Services have been completed. Your Plan may require additional information from you or your Provider before a claim can be considered complete and ready for processing. In order to properly process a claim, your Provider may be requested to submit a corrected claim. For example, if your Dentist submits a claim for an adult dental cleaning when the service performed was a pediatric dental cleaning, Alliant will deny the claim and request that the dentist submit a corrected claim. Duplicate claims previously processed will be denied.

This section describes how Alliant determines the amount of reimbursement for Covered Services. Reimbursement for dental services rendered by a Dentists is based on the Maximum Allowed Amount for the type of service performed.

The Maximum Allowed Amount is the maximum amount of reimbursement Alliant will pay for Covered Services, as defined in this Schedule, by a Dentist or Member.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Coinsurance. In addition, when you receive Covered Services from a Dentist, you may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges.

When you receive Covered Services from a Dentist, Alliant will apply processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect Alliant's determination of the Maximum Allowed Amount. Here are two examples of scenarios to illustrate when the Maximum Allowed Amount may change, according to claims processing rules.

Example 1: Your Dentist may have submitted a claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, the claim will be denied with a remark code to designate the reason for the denial.

Example 2: When multiple procedures are performed on the same day by the same dental Provider or other dental Providers, we may reduce the Maximum Allowed Amount for those additional procedures, because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent a duplicate payment for a dental procedure that may be considered incidental or inclusive.

Provider Network Status
Your Plan allows you the freedom to select the Dentist of your choice. There are no network limitations or requirements for referrals for advanced dental services.

Dentists
Alliant does not require Dentists to sign a written contractual agreement, but we request that the Dentist accept the Maximum Allowed Amount. For Covered Services you receive from a Dentists, the Maximum Allowed Amount will be the lesser of the Dentist's actual charges or the Maximum Allowed Cost (MAC) determined by Alliant as follows:

1. An amount based on our Out-of-Network Dentist fee schedule, referred to as the Maximum Allowed Cost (MAC), which we have established in our discretion, and which we reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar contracted Providers, and other industry cost, reimbursement and utilization data;
2. An amount based on information provided by a third-party vendor, which may reflect comparable Providers' fees and costs to deliver care;
3. An amount negotiated by us or a third-party vendor which has been agreed to by the Provider.

The Maximum Allowed Cost (MAC) for Emergency Dental Services is calculated as described in Title 33 of the Official Code of Georgia Annotated (OCGA) 33-20E-4; with respect to Emergency Dental Services, we will calculate the MAC as the greater of:

1. The verifiable contracted amount paid by all eligible insurers for the provision of the same or similar services as determined by the Georgia Department of Insurance.
2. The most recent verifiable amount agreed to by Alliant and the nonparticipating emergency Dentist for the provision of the same services during such time as such dentist was In-Network with Alliant.
3. Such higher amount as Alliant may deem appropriate given the complexity and circumstances of the services provided.

The amount paid does not include any amount of Coinsurance, Copayment, or Deductible you may owe. Dentists of emergency dental services may bill you for any Coinsurance, Copayment, or Deductible you may owe according to the terms of your policy. In the event you receive a surprise bill for nonemergency medical services from a Dentist, and you did NOT actively choose the Dentist prior to receiving services, we calculate the MAC as described above. Alliant reserves the right to request documentation from the Dentist to confirm whether you received services through no choice of your own.

Dentists may send you a bill and collect for the amount of the dentist's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Dentist charges. This amount may be significant.

Customer service is also available to assist you in determining the Maximum Allowed Amount for a particular service from a Dentist. In order for us to assist you, you will need to obtain the specific procedure code(s) from your dentist for the services the Dentist will render. You will also need to know the Dentist's charges to calculate your out-of-pocket responsibility. Although customer service can assist you with this pre-service information, the Maximum Allowed Amount for your claim will be based on the actual claim submitted.

Member Cost Share
For certain Covered Services and depending on your dental program, you may be required to pay a part of the Maximum Allowed Amount (for example, a Deductible and/or Coinsurance). Please see your plan's Summary of Benefits and Coverage for your cost share responsibilities and limitations or call Customer Service at (866) 403-2785.

Payment of Benefits
You authorize Alliant to make payments directly to Dentists for Covered Services. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an alternate recipient, or that person's custodial parent or designated representative. Any payments made by us will discharge our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law. Once a Provider gives a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Benefits payable under the contract may be paid directly to the Member unless you assign the payment directly to the Provider by indicating so on the claim form.

Explanation of Benefits
After you receive dental care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Alliant to help you understand the coverage you are receiving. The EOB shows:

- total amounts charged for services/supplies received
- the amount of the charges satisfied by your coverage
- the amount for which you are responsible (if any)
- general information about your appeals rights and for ERISA plans, information regarding the right to bring an action after the appeals process.

COVERED SERVICES

Only services listed in this section may be covered under your Plan. All Covered Services are subject to the terms, limitations, and exclusions of your Plan's certificate. See your Summary of Benefits and Coverage for your cost share amounts, such as any applicable Deductibles and/or any Coinsurance.

Your Dental Benefits
Alliant does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Schedule of Dental Benefits. We evaluate the procedures submitted to us on your claim to determine if they are a Covered Service under this Schedule of Dental Benefits.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was dentally necessary orthodontic care. Medical records may be requested and/or required for Alliant to determine if the service is Dentally Necessary. See the Orthodontic Care sections for more information.

Your Dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Schedule of Dental Benefits. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your Dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your Dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your Dentist. It provides you and the Dentist with an idea of what your out-of-pocket costs will be for the dental care treatment. This will allow the Dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, endodontic, oral surgery, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for Covered Services.

A pretreatment estimate does not authorize treatment or determine its medical necessity and does not guarantee benefits. The estimate will be based on your current eligibility and your Plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Alliant's final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to your Plan may affect our final payment.

You can ask your Dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your Dentist can give you the procedure codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

Pediatric Essential Health Benefits

The following services are available to pediatric Members through the end of the month in which they turn 19. Once you have met your Deductible, dental services will be covered at the listed Coinsurance amounts up to the Maximum Allowed Amount as determined by Alliant for each Covered Service. Preventive care services are covered and reimbursable prior to meeting your Deductible. Deductible requirements are stated in your Summary of Benefits and Coverage.

PREVENTIVE CARE

Oral Exams – Two oral exams are covered each calendar year. If you get two comprehensive exams by the same dentist, the second is covered as the periodic oral exam.

- Periodic and comprehensive oral evaluations.
- Limited, Problem focused oral evaluations

Periodontal Evaluations – Limit 2 per year. Service covered for Members who have symptoms of periodontal disease and for patients who have risk factors such as smoking, diabetes, or other issues. Not payable when prophylaxis or comprehensive oral evaluation is performed.

Radiographs – The following radiographs are covered:

- Bitewing X-Rays: Limit 2 per year
- Full Mouth X-Rays: Limit 1 series per 3 years
- Panoramic X-Rays: Limit 1 series per 5 years

Dental Cleaning (prophylaxis) – Limit 2 per year. Includes scaling and polishing procedures to remove plaque, tartar, and stain. Covered as child prophylaxis for Members 13 and younger and covered as adult prophylaxis for Members 14 and older.

Fluoride Treatment – Topical Fluoride limited to 2 per year.

Sealants or Preventive Resin Restorations – Limit 1 per tooth per 3 years. Service is for application of sealants to occlusal surface of permanent molars that are free of decay and restoration.

Installation of initial space maintainers for retaining space when a primary tooth is lost – Limit to 1 initial space maintainer. Does not include separate adjustment expenses.

Recementation of space maintainers – Limit to 1 recementation.
Removal of fixed space maintainers

BASIC AND RESTORATIVE SERVICES

Fillings (restorations) – Covered for primary or permanent teeth. Limit once per tooth surface per 2 years. Two types are covered:

- Composite restorations are covered for anterior teeth only. Molar or Bicuspid teeth restorations will be alternative services and paid up to the maximum allowed for an Amalgam filling. Any remaining expenses incurred are the Member's responsibility. One surface having multiple restorations is counted as one restoration.
- Amalgam restorations are a mixture of metals formed to fill cavities that resulted from tooth decay; also known as "silver fillings". One surface having multiple restorations is counted as one restoration.

Emergency Treatment – Service covered for infection or temporary pain relief only if no other services outside of the exam and x-rays were performed on the same date of service.
Radiographs – The following radiograph is covered:

- Other X-Rays (intra-oral periapical and occlusal and extra-oral x-rays): As needed to diagnose specific treatment.

MAJOR AND COMPLEX SERVICES

Pre-fabricated Stainless Steel Crowns – Covered on primary or permanent teeth that cannot be restored with Composite or Amalgam restorations. Limit 1 per tooth per 5 years.
Resin Based Composite Resin Crown, Anterior – Covered on primary or permanent teeth that cannot be restored with Composite or Amalgam restorations. Limit 1 per tooth per 5 years.
Initial placements for permanent teeth: Covered when tooth cannot be repaired with direct placement filling material as a result of decay or injury. Includes onlays, crowns, veneers, core build-ups and posts and implant supported crowns and abutments. Limit to 1 per tooth per 5 years.
Replacement of inlays, onlays, crowns or other restorations of permanent teeth – Treatment covered if:

- 5 years have passed since initial placement and is not/cannot be made serviceable.
- Accidental injury has caused damage beyond repair while restoration was in the oral cavity.
  Or
- Extraction of functioning teeth (with the exception of third molars or teeth not in full occlusion with an opposing tooth or prosthesis requires replacement).

Restorative cast post and core build-up – Includes 1 post per tooth and 1 pin per surface. Limit once per 5 years when it is necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.
Pin Retention – Limit 1 time per 5 years. Covered as an addition to a restoration that is not combined with core build-up.

Endodontic Therapy and Services – Covered on primary or permanent teeth. Limit all root canal treatment to once per tooth/root per lifetime.

- Root Canal therapy and retreatment: includes treatment and fillings. Tests, labs, x-rays, intraoperative, tests, or other follow-up care is considered fundamental to the therapy.
- Periradicular surgical procedures: refers to surgery to the external root surface and includes root amputation, tooth reimplementation, apicoectomy, and/or surgical isolation.
- Partial pulpotomy for apexogenesis

- Vital pulpotomy
- Pulp debridement, pulp therapy
- Apexification/recalcification

Periodontic Services

- Scaling and Root Planning: Limit 1 per quadrant per 2 years when tooth pocket is 4 millimeters or deeper.
- Maintenance: any combination of periodontal maintenance and prophylaxis is covered 4 times per year for Members who have completed a previous periodontal treatment (removal of bacteria from gum pockets, scaling/polishing teeth, periodontal evaluation, gum pocket measurements).
    - Periodontics Surgical - The most inclusive procedure will be considered if more than one surgical procedure is administered on the same day.
    - Separate pre/post-operative care and evaluation fees within 3 months are not considered a part of pediatric dental benefits.
    - One type of periodontal surgical procedure per area of mouth (quadrant) every three years
    - One bone surgery per single tooth (or multiple teeth within the same quadrant) per 3 years
    - One type of tissue graft per tooth (does not exceed two teeth) per year
- Covered Services
        - Osseous surgery
        - Bone replacement graft
        - Pedicle soft tissue graft
        - Free soft tissue graft
        - Subepithelial connective tissue graft
        - Soft tissue allograft
        - Combined connective tissue and double pedicle graft
        - Distal/proximal wedge – Covered on natural teeth only

Prosthodontic Services

- Initial placement of Bridges, Complete Dentures, and Partial Dentures: Limit 1 per 5 years.
    - Includes pontics, inlays, onlays, and crowns: Limit 1 per tooth per 5 years

Replacements/Repairs and Adjustments

- Denture adjustments covered once it has been 6 months since initial installation, or adjustment performed by dental Provider that is not the one who provided the denture.
- Replacement of bridges, complete dentures, and partial dentures**.** Treatment covered if:
    - 5 years have passed since initial placement and is not/cannot be made serviceable;
    - Accidental injury has caused damage beyond repair while restoration was in the oral cavity;

  or
    - Extraction of functioning teeth (with the exception of third molars or teeth not in full occlusion with an opposing tooth or prosthesis requires replacement).

Recementation of Bridge – Limit once per 5 years.

Tissue Conditioning – Covered once per 2 years.

Relines or Rebases – Covered after 6 months of installation of permanent appliance. Limit 1 time per 3 years.

ORAL SURGERY SERVICES

Simple Extraction – Covered Services include:

- Extraction of coronal remnants of a deciduous tooth

- Extraction of erupted tooth or exposed root for permanent and primary teeth

Surgical Extraction – Any combination of the following are covered once every 6 years. Covered Services include:

- Surgical Removal of Erupted tooth requiring removal of bone
- Removal of residual tooth roots
- Coronectomy
- Tooth reimplant
- Tooth Transplantation
- Exposure of unerupted tooth
- Alveoloplasty
- Vestibuloplasty
- Removal of Lateral Exostosis
- Reduction of Osseous Tuberosity
- Incision and drainage of Abscess
- Suture recent small wounds
- Bone replacemement
- Surgical Replacement of Fibrous Tuberosity
- Excision of pericoronal gingiva

General Anesthesia, Intravenous Conscious Sedation and IV Sedation – Covered when administered with covered surgical service.

ORTHODONTIC CARE SERVICES

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your orthodontist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront of the treatment and costs. You or your orthodontist should send your pretreatment estimate to Alliant so we can help you understand how much is covered by your benefits.

Dentally Necessary Orthodontia – These services are available when Dentally Necessary. Only those services medically necessary as evidenced by a severe and handicapping malocclusion are covered and qualify for orthodontic care. Orthodontic procedures are a benefit only when it meets one or more of the qualifying conditions and claims are submitted with appropriate CDT and ICD-10 codes, listed below. All services must be provided by a licensed orthodontist. Medical records may be requested and/or required for Alliant to determine if the service is Dentally Necessary.

Qualifying Conditions:

- Cleft Palate
- Deep Impinging Overbite
- Anterior Impactions
- Severe Traumatic Deviations
- Overjet greater than 9mm
- Severe Maxillary Anterior Crowding, greater than 8mm

Cosmetic Orthodontic Care – These services are not covered.

Orthodontic Treatment may include:

- Limited Treatment – A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment) –This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.

- Comprehensive or Complete Treatment – A full kind of treatment that includes all radiographs, diagnostic cast and modes, orthodontic appliances, and office visits.
- Removable Appliance Therapy – Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy – Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures – Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth or repositioning of the teeth.

What Orthodontic Care does NOT include – The following is not covered as a part of your orthodontic treatment:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost, broken or stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service);
- Provisional splinting, temporary procedures, or interim stabilization of teeth.

How We Pay for Orthodontic Care – Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of your treatment. In order for Alliant to continue to pay for your orthodontic care, you must have continuous coverage under your Plan's policy.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your orthodontist should submit the necessary forms telling us when your appliance is installed. Payments are then made in six-month intervals until the treatment is finished or coverage under your Plan's policy ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this policy, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under your Plan's policy. We will not pay for any portion of your treatment that was given before your effective date under your Plan's policy.

Accidental Dental – Limit once per episode (see definitions).

Adult Dental Benefits

The following services are available to adult Members who are 19 years of age and older. Once you have met your Deductible, dental services will be covered at the listed Coinsurance amounts up to the Maximum Allowed Amount as determined by the issuer for each Covered Service. Preventive care services are covered and reimbursable prior to meeting your Deductible. Deductible requirements are stated in your Summary of Benefits and Coverage.

PREVENTIVE CARE

Oral Exams – Two oral exams are covered each calendar year. If you get two comprehensive exams by the same dentist, the second is covered as the periodic oral exam.

- Periodic and comprehensive oral evaluations
- Limited, problem focused oral evaluations

Periodontal Evaluations – Limit 2 per year. Service covered for Member who has symptoms of periodontal disease and for patients who have risk factors such as smoking, diabetes, or other issues. Not payable when prophylaxis or comprehensive oral evaluation is performed.

Radiographs – The following radiographs are covered:

- Bitewing X-Rays: Limit 2 per year
- Full Mouth X-Rays: Limit 1 series per 3 years
- Panoramic X-Rays: Limit 1 series per 5 years

Dental Cleaning (prophylaxis) – Limit 2 per year. Includes scaling and polishing procedures to remove plaque, tartar, and stain.

BASIC AND RESTORATIVE SERVICES

Fillings (restorations) – Covered for primary or permanent teeth. Limit once per tooth surface per 2 years. 2 types are covered:

- Composite restorations are covered for anterior teeth only. Molar or Bicuspid teeth restorations will be alternative services and paid up to the maximum allowed for an Amalgam filling. Any remaining expenses incurred is the Member's responsibility. One surface having multiple restorations is counted as one restoration.
- Amalgam restorations are a mixture of metals formed to fill cavities that resulted from tooth decay; also known as "silver fillings". One surface having multiple restorations is counted as one restoration.

Brush Biopsy – Limit once per 3 years per Member aged 20-39; limit once per year age 40 and above.

Emergency Treatment – Service covered for infection or temporary pain relief only if no other services outside of the exam and x-rays were performed on the same date of service.

Radiographs – The following radiograph is covered:

- Other X-Rays (intra-oral periapical and occlusal and extra-oral x-rays): As needed to diagnose specific treatment.

MAJOR AND COMPLEX SERVICES

Pre-fabricated Stainless Steel Crowns – Covered on primary or permanent teeth that cannot be restored with Composite or Amalgam restorations. Limit 1 per tooth per 7 years.

Resin Crown, Anterior – Covered on primary or permanent teeth that cannot be restored with Composite or Amalgam restorations. Limit 1 per tooth per 7 years.

Initial placements for permanent teeth: Covered when tooth cannot be repaired with direct placement filling material as a result of decay or injury. Includes onlays, crowns, veneers, core build-ups, and posts and implant supported crowns and abutments. Limit to 1 per tooth per 7 years.

Replacement of inlays, onlays, crowns or other restorations of permanent teeth – Treatment covered if:

- 5 years have passed since initial placement and is not/cannot be made serviceable.
- Accidental injury has caused damage beyond repair while restoration was in the oral cavity.
  Or
- Extraction of functioning teeth (with the exception of third molars or teeth not in full occlusion with an opposing tooth or prosthesis requires replacement).

Restorative cast post and core build-up – Includes 1 post per tooth and 1 pin per surface. Limit once per 5 years when it is necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Pin Retention – Limit 1 time per 5 years. Covered as an addition to a restoration that is not combined with core build-up.

Endodontic Therapy and Services – Covered on primary or permanent teeth. Limit all root canal treatment to once per tooth/root per lifetime.

- Root Canal therapy and retreatment: includes treatment and fillings. Tests, labs, x-rays, intraoperative, tests, or other follow-up care is considered fundamental to the therapy.
- Periradicular surgical procedures: refers to surgery to the external root surface and includes root amputation, tooth reimplementation, apicoectomy, and/or surgical isolation.
- Partial pulpotomy for apexogenesis
- Vital pulpotomy
- Pulp debridement, pulp therapy
- Apexification/recalcification

Periodontic Services

- Scaling and Root Planning: limit 1 per quadrant per 3 years when tooth pocket is 4 millimeters or deeper.
- Full mouth debridement: limit 1 time per lifetime.
- Maintenance: any combination of periodontal maintenance and prophylaxis is covered 2 times per year for Members who have completed a previous periodontal treatment (removal of bacteria from gum pockets, scaling/polishing teeth, periodontal evaluation, gum pocket measurements).
- Periodontics Surgical - The most inclusive procedure will be considered if more than one surgical procedure is administered on the same day.
    - One type of periodontal surgical procedure per area of mouth (quadrant) every three years
    - One Gingivectomy (gum surgery) procedure per single tooth (or multiple teeth within the same quadrant) per 3 years
    - One Gingival flap (gum surgery) procedure per single tooth (or multiple teeth within the same quadrant) per 3 years
    - One bone surgery per single tooth (or multiple teeth within the same quadrant) per 3 years
    - One type of tissue graft per tooth (does not exceed two teeth) per year
- Covered Services
        - Gingivectomy/gingivoplasty
        - Gingival flap
        - Apically positioned flap
        - Osseous surgery
        - Bone replacement graft
        - Pedicle soft tissue graft
        - Free soft tissue graft
        - Subepithelial connective tissue graft
        - Soft tissue allograft
        - Combined connective tissue and double pedicle graft
        - Distal/proximal wedge – Covered on natural teeth only

Prosthodontic Services

- Initial placement of Bridges, Complete Dentures, and Partial Dentures: Limit 1 per 7 years for replacement of extracted permanent teeth.

Replacements/Repairs and Adjustments

- Replacement of bridges, Complete Dentures, and Partial Dentures. Treatment covered if:

- If there is an existing denture or partial, 7 years must pass, and it cannot be repaired or adjusted to be eligible for replacement.
- Accidental injury has caused damage beyond repair while restoration was in the oral cavity;

or

- Extraction of functioning teeth (with the exception of third molars or teeth not in full occlusion with an opposing tooth or prosthesis requires replacement).
- For bridge to be covered, the following must apply:
    - A natural and healthy tooth is available to serve as the anterior and posterior retainer.
    - All teeth are present within the same arch that has been replaced with removable partial denture.
    - The individual teeth of the bridge have not been treated with a crown or cast restoration covered under your Plan within the past 7 years. Denture adjustments covered once it has been 6 months since initial installation, or adjustment performed by a dental Provider, who is not the one who provided the denture. Limit twice per year.

- Repair/Replacement of broken artificial teeth/broken clasp(s) covered twice per 2 years if the appliance is the permanent appliance. Six (6) months must have passed since initial placement and the narrative from the treating Dentist supports the procedure.
- Partial and Bridge adjustments covered twice per 2 years if the appliance is the permanent appliance. Six (6) months must have passed since initial placement and the narrative from the treating Dentist supports the procedure.

Single Tooth Implant Body, Abutment and Crown – Covered once per 5 years. Includes the surgical placement of the implant body, abutment, and supported crown. Your Plan recommends a pretreatment estimate prior to this service.

Recementation of Bridge – Limit once per 5 years.

Tissue Conditioning – Covered once per 2 years.

Relines or Rebases – Covered after 6 months of installation of permanent appliance. Limit 1 time per 3 years.

ORAL SURGERY SERVICES

Simple Extraction – Covered Services include:

- Extraction of coronal remnants of a deciduous tooth.
- Extraction of erupted tooth or exposed root for permanent and primary teeth

Surgical Extraction – Any combination of the following are covered once every 6 years. Covered Services include:

- Surgical Removal of Erupted tooth requiring removal of bone
- Removal of residual tooth roots
- Coronectomy
- Tooth reimplant
- Tooth Transplantation
- Exposure of unerupted tooth
- Alveoloplasty
- Vestibuloplasty
- Removal of Lateral Exostosis
- Reduction of Osseous Tuberosity
- Incision and drainage of Abscess

- Suture recent small wounds
- Bone replacemement
- Surgical Replacement of Fibrous Tuberosity – Covered once per 6 months.
- Excision of pericoronal gingiva

General Anesthesia, Intravenous Conscious Sedation and IV Sedation – Covered when administered with covered surgical service.

ORTHODONTIC CARE SERVICES

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your orthodontist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront of the treatment and costs. You or your orthodontist should send your pretreatment estimate to Alliant so we can help you understand how much is covered by your benefits.

Dentally Necessary Orthodontia – These services are available when Dentally Necessary. Only those services medically necessary as evidenced by a severe and handicapping malocclusion are covered and qualify for orthodontic care. Orthodontic procedures are a benefit only when it meets one or more of the qualifying conditions and claims are submitted with appropriate CDT and ICD-10 codes, listed below. All services must be provided by a licensed orthodontist. Medical records may be requested and/or required for Alliant to determine if the service is Dentally Necessary.

Qualifying Conditions:

- Cleft Palate
- Deep Impinging Overbite
- Anterior Impactions
- Severe Traumatic Deviations
- Overjet greater than 9mm
- Severe Maxillary Anterior Crowding, greater than 8mm

Cosmetic Orthodontic Care – These services are not covered.

Orthodontic Treatment may include:

- Limited Treatment – A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment) –This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment – A full kind of treatment that includes all radiographs, diagnostic cast and modes, orthodontic appliances, and office visits.
- Removable Appliance Therapy – Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy – Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures – Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth or repositioning of the teeth.

What Orthodontic Care does NOT include – The following is not covered as a part of your orthodontic treatment:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost, broken or stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;

- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service);
- Provisional splinting, temporary procedures, or interim stabilization of teeth.

How We Pay for Orthodontic Care – Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of your treatment. In order for Alliant to continue to pay for your orthodontic care, you must have continuous coverage under your Plan's policy.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your orthodontist should submit the necessary forms telling us when your appliance is installed. Payments are then made in six-month intervals until the treatment is finished or coverage under your Plan's policy ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this policy, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under your Plan's policy. We will not pay for any portion of your treatment that was given before your effective date under your Plan's policy.

Accidental Dental – Limit once per episode (see definitions).

DENTAL INSURANCE: EXCLUSIONS

Alliant will not pay Dental Insurance benefits for charges incurred for:

1. Services that are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which Alliant deems experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn child;
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth;
   - fluoride treatments.
6. Services or appliances which restore or alter occlusion of vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion, or erosion, unless caused by disease.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition, and tobacco.
10. Personal supplies or devices including, but not limited to, water picks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown, or other dental work.
12. Missed or cancelled appointments.
13. Services:
    - covered under any workers' compensation or occupational disease law;

- covered under any employer liability law;
- for which the employer of the person receiving such services is not required to pay;
- received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Performed via Teledentistry.

14. Temporary or provisional restorations.
15. Temporary or provisional appliances.
16. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies;
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
    - Dental services arising out of accidental injury (accidental dental) to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
17. Caries susceptibility tests.
18. Initial installation of a fixed and permanent Denture to replace teeth which were missing before such person was insured by Plan, except for congenitally missing natural teeth.
19. Other fixed Denture prosthetic services not described elsewhere in this Schedule of Dental Benefits.
20. Precision attachments, except when the precision attachment is related to implant prosthetics.
21. Initial installation or replacement of a full or removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
22. Addition of teeth to a partial removable Denture to replace teeth that were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
23. Addition of teeth to a fixed and permanent Denture to replace teeth that were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
24. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
25. Implants to replace teeth that were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
26. Implants supported prosthetics to replace teeth that were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
27. Fixed and removable appliances for correction of harmful habits.
28. Diagnosis and treatment of temporomandibular joint (TMJ) disorders and cone beam imaging.
29. Repair or replacement of an orthodontic device.
30. Duplicate prosthetic devices or appliances.
31. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
32. Intra and extraoral photographic images.

Entire Contract

Your Plan's Certificate of Coverage, the application, any riders, endorsements or attachments, this Schedule of Dental Benefits, and the individual applications of the subscriber and dependents, if any, constitute the entire contract between your Plan and the Member and as of the effective date, supersede all other agreements between the parties. Any and all statements made to your Plan by the Member and any and all statements made to the Member by your Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under your Plan's certificate, shall be used in defense to a claim under your Plan's certificate.

Relationship of Parties (Plan - Dentists)
The relationship between your Plan and Dentists is an independent contractor relationship. Dentists are not agents or employees of your Plan, nor is your Plan, or any employee of your Plan, an employee or agent of Dentists.

Your Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Dentists or in any Dentists' facilities.

Not Liable for Provider Acts or Omissions
Your Plan is not responsible for the actual care you receive from any person. Your Plan's Certificate of Coverage does not give anyone any claim, right, or cause of action against your Plan based on what a Provider of dental care, services or supplies, does or does not do.

Circumstances Beyond the Control of your Plan
In the event of circumstances not within the control of your Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of your Plan, disability of a significant part of a Dentists' personnel or similar causes, or the rendering of dental care services provided under your Plan's Certificate of Coverage is delayed or rendered impractical, your Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, your Plan and Dentists shall render dental care services provided under your Plan's Certificate of Coverage insofar as practical, and according to their best judgment; but your Plan and Dentists shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits
Refer to your SoloCare Certificate of Coverage.

COVERED DENTAL SERVICES

The Annual Benefit Maximum is $1000 for all services. Please refer to the Covered Services section of the Schedule of Dental Benefits for a more complete explanation of the specific services covered. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of your Plan, including any attachments or riders.

The following list includes Covered Dental Services and the Maximum Allowed Amount Alliant will reimburse for these services.

	Preventive	**Allowed Amount**
D0120	PERIODIC ORAL EVALUATION ESTABLISHED PATIENT	$65.91
D0150	COMPREHENSIVE ORAL EVALUATION - NEW/ESTABLISHED PATIENT	$116.00
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUS	$110.00
D0145	ORAL EVALUATION PATIENT< 3 YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	$105.64
D0160	DETAILED & EXTENSIVE ORAL EVALUATION - PROBLEM FOCUS REPORT	$234.75
D0170	RE-EVALUATION - LIMITED PROBLEM FOCUSED	$81.26
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW/ESTABLISHED PATIENT	$130.01
D0210	INTRAORAL-COMPLETE SERIES RADIOGRAPH IMAGES	$185.00
D0270	BITEWING - SINGLE RADIOGRAPHC IMAGE	$38.00
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	$61.00
D0273	BITEWINGS-THREE RADIOGRAPHIC IMAGES	$74.00
D0274	BITEWINGS - FOUR RADIOGRAPHC IMAGES	$85.00
D0277	VERTICAL BITEWNGS - 7-8 RADIOGRAPH IMAGES	$92.13
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$167.03
D1110	PROPHYLAXIS - ADULT	$120.99
D1120	PROPHYLAXIS - CHILD	$80.36
D1206	TOPICAL APPLICATION FLUORIDE VARNISH	$76.74
D1208	TOPICAL APPLICATION OF FLUORIDE	$61.40
D1351	SEALANT - PER TOOTH	$73.13
D1352	PREVENTIVE RESIN RESTORATION MODERATE/HIGH CARIES RISK	$218.50
D2940	PROTECTIVE RESTORATION	$361.15
D2990	RESIN FILL OF TOOH SURFACE	$101.12
D1353	SEALANT REPAIR - PER TOOTH	$51.47
D1510	SPACE MAINTAINER-FIXED UNILATERAL - PER QUADRANT	$450.54
D1516	SPACE MAINTAINER-FIXED-BILATERAL MAXILLARY	$648.27
D1517	SPACE MAINTAINER-FIXED BILATERAL MANDIBULAR	$645.56
D1520	SPACE MAINTAINER - REMOVABLE UNILATERAL - PER QUADRANT	$442.32
D1526	SPACE MAINTAINER- REMOVE-BILATERAL, MAXILLARY	$684.38
D1527	SPACE MAINTAINER- REMOVE- BILATERAL, MANDIBULAR	$684.38
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED UNILATERAL-QUADRANT	$500.20
D1551	RE-CEMENT/RE-BOND BILATERAL SPACE MAINTAINER-MAXILLARY	$100.22
D1552	RE-CEMENT/RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR	$99.32
D1553	RE-CEMENT/RE-BOND UNILATERAL SPACE MAINTAINER-QUADRANT	$99.32
D1556	REMOVAL OF UNILATERAL SPACE MAINTAINER - PER QUADRANT	$82.16
D1557	REMOVAL FIXED BILATERAL SPACE MAINTAINER - MAXILLARY	$82.16
D1558	REMOVAL FIXED BILATERAL SPACE MAINTAINER - MANDIBULAR	$83.97
	Basic	**Allowed Amount**
D0171	RE-EVALUATION-POST-OP OFFICE VISIT	$57.83

D0220	INTRAORAL-PERIAPICAL 1ST RADIOGRAPHC IMAGE	$37.02
D0230	INTRAORAL-PERIAPICAL EACH ADDITIONAL RADIOGRPH IMAG	$34.31
D0240	INTRAORAL-OCCLUSAL RADIOGRAPH IMAGE	$52.37
D0250	EXTRA-ORAL - 2D PROJECTION X-RAY	$70.42
D0251	EXTRA-ORAL POSTERIOR DENTAL X-RAY	$50.06
D0460	PULP VITALITY TESTS	$57.78
D2140	AMALGAM-ONE SURFACE PRIMARY/PERMANENT	$156.20
D2150	AMALGAM-TWO SURFACES PRIMARY/PERMANENT	$213.08
D2160	AMALGAM-3 SURFACES PRIMARY/PERMANENT	$254.61
D2161	AMALGAM-FOUR/MORE SURFACES PRIMARY/PERMANENT	$292.53
D2330	RESIN-BASED COMPOSITE ONE SURFACE ANTERIOR	$219.40
D2331	RESIN-BASED COMPOSITE 2 SURFACE ANTERIOR	$283.50
D2332	RESIN-BASED COMPOSITE 3 SURFACE ANTERIOR	$337.68
D2335	RESIN COMPOSITE 4/> SURFACE INCISAL ANGLE	$393.66
D2391	RESIN COMPOSITE - 1 SURFACE POSTERIOR	$237.00
D2392	RESIN COMPOSITE - 2 SURFACES POSTERIOR	$310.00
D2393	RESIN COMPOSITE - 3 SURFACES POSTERIOR	$385.00
D2394	RESIN COMPOSITE - 4/MORE SURFACES POSTERIOR	$490.26
D9110	PALLIATVE TREATMENT DENTAL PAIN-MINOR PROCEDURE	$160.00
D2921	REATTACH TOOTH FRAGMENT INCISORAL EDGE/CUSPID	$303.37
D9610	THERAPEUTIC PARENTRAL DRUG 1 ADMINISTRATION	$87.58
D9612	THERAPEUTIC PARENTERAL RX 2/> ADMIN DIFFERENT MEDICATION	$101.80
D9310	CONSULTATION DIAGNOSTIC SERVICES PERFORMED BY DENTIST/PHYSICIAN OTHER THAN PRACTITIONER PROVIDING TREATMENT	$170.47
D9311	CONSULTATION W/MEDICAL HEALTH CARE PROFESSIONAL	$176.91
D9440	OFFICE VISIT-AFTER REGULARLY SCHEDULED HOURS	$183.28
D9930	TREATMENT OF COMPLICATIONS - UNUSUALL CIRCUMSTANCES BY REPORT	$94.45
D3110	PULP CAP - DIRECT	$110.15
D3120	PULP CAP - INDIRECT	$87.58
	Major	**Allowed Amount**
D2510	INLAY - METALLIC - ONE SURFACE	$905.59
D2520	INLAY - METALLIC - TWO SURFACES	$1,181.87
D2530	INLAY - METALLIC - 3/MORE SURFACES	$1,184.58
D2542	ONLAY - METALLIC - TWO SURFACES	$1,164.72
D2543	ONLAY METALLIC THREE SURFACES	$1,245.97
D2544	ONLAY METALLIC FOUR OR MORE SURFACE	$1,326.33
D2610	INLAY - PORCELAIN/CERAMIC - 1 SURFACE	$935.38
D2620	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$1,232.43
D2630	INLAY - PORCELAIN/CERAM - 3/MORE SURFACES	$1,259.52
D2642	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$1,184.58
D2643	ONLAY - PORCELAIN/CERAMIC - 3 SURFACES	$1,204.44
D2644	ONLAY - PORCELAIN/CERAMIC - 4/MORE SURFACES	$1,352.51
D2650	INLAY RESIN COMPOSITE ONE SURFACES	$842.39
D2651	INLAY RESIN COMPOSITE TWO SURFACES	$880.31
D2652	INLAY RESIN COMPOSITE 3/> SURFACES	$939.00
D2662	ONLAY-RESIN COMPOSITE -2 SURFACES	$874.89

D2663	ONLAY-RESIN COMPOSITE -3 SURFACES	$943.51
D2664	ONLAY RESIN COMPOSITE 4/> SURFACES	$1,000.39
D2910	RECEMENT INLAY ONLAY/PARTIAL COVERED REST	$138.14
D2390	RESIN COMPOSITE CROWN ANTERIOR	$469.50
D2710	CROWN - RESIN-BASED COMPOSITE	$542.63
D2712	CROWN - 3/4 RESIN-BASED COMPOSITE	$616.04
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	$1,226.37
D2721	CROWN - RESIN PREDOM BASE METAL	$1,155.12
D2722	CROWN - RESIN WITH NOBLE METAL	$1,182.20
D2740	CROWN - PORCELAIN/CERAMIC	$1,505.10
D2750	CROWN - PORCELAIN FUSED HI NOBLE METAL	$1,542.12
D2751	CROWN-PORCELAIN FUSED PREDOM BASE METAL	$1,110.99
D2752	CROWN - PORCELAIN FUSED NOBLE METAL	$1,621.57
D2753	CROWN - PORCELAIN FUSED TO TITANIUM & TITANIUM ALLOY	$1,154.67
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	$1,441.00
D2781	CROWN - 3/4 CAST PREDOMINATELY BASE METAL	$1,088.83
D2782	CROWN - 3/4 CAST NOBLE METAL	$1,574.62
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$1,351.61
D2790	CROWN - FULL CAST HIGH NOBLE METAL	$1,530.38
D2791	CROWN - FULL CAST PREDOMINATELY BASE METAL	$1,086.28
D2792	CROWN - FULL CAST NOBLE METAL	$1,139.47
D2794	CROWN - TITANIUM AND TITANIUM ALLOY	$1,201.43
D2920	RECEMENT CROWN	$140.85
D2928	PREFABRICATED PORCELAIN/CERAMIC CROWN - PERMANENT TOOTH	$421.52
D2929	PREFABRICATED PORCELAIN/CERAMIC CROWN-PRIMARY TOOTH	$496.58
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY	$383.72
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT	$460.47
D2932	PREFABRICATED RESIN CROWN	$409.91
D2933	PRFABRICATED STAINLESS STEEL CROWN RESIN WNDOW	$386.72
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN	$506.52
D2960	LABIAL VENEER - DIRECT	$920.03
D2961	LABIAL VENEER RESIN LAMINATE - INDIRECT	$1,087.07
D2962	LABIAL VENEER PORCELAIN LAMINATE - INDIRECT	$1,671.23
D2971	ADDITIONAL PROCEDURE TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK	$139.35
D2980	CROWN REPAIR NEC RESTORATIVE MATERIAL FAIL	$257.32
D2951	PIN RETENTION - PER TOOTH ADDITION RESTORATION	$74.94
D2915	RECEMENT CAST/PREFAB POST & CORE	$105.58
D2950	CORE BUILDUP INCLUDING PINS WHEN REQUIRED	$357.54
D2952	POST & CORE ADD CROWN INDIRECT FAB	$1,136.73
D2953	EACH ADDITIONAL INDIRECT FAB POST SAME TOOTH	$230.06
D2954	PREFABRICATED POST & CORE ADDITION CROWN	$406.30
D2955	POST REMOVAL	$353.93
D2957	EACH ADDITIONAL PREFABRICATION POST - SAME TOOTH	$228.43
D3220	THERAPEUTIC PULPOTOMY-CORONAL DENTNOCEMENTL JUNCTION	$225.72
D3221	PULPAL DEBRIDEMENT PRIMARY & PERMANENT TEETH	$247.39
D3222	PARTIAL PULPOTMY APEXOGNEIS PERMANENT TOOTH	$367.47

D3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	$241.07
D3240	PULPAL THERAPY - POST PRIMARY TOOTH	$297.05
D3310	ENDODONTIC THERAPY ANTERIOR TOOTH	$956.15
D3320	ENDODONTIC THERAPY PREMOLAR TOOTH	$1,171.04
D3330	ENDODONTIC THERAPY MOLAR TOOTH	$1,475.31
D3331	TREATMENT ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS	$373.79
D3332	INCOMPLETE ENDO TREATMENT;INOP UNRSTR/FX TOOTH	$549.23
D3333	INTERNAL ROOT REPAIR PERFORATION DEFECTS	$324.13
D3346	RETREATMENT PREVIOUS ROOT CANAL THERAPY - ANTERIOR	$38,525
D3347	RETREATMENT PREVIOUS ROOT CANAL TREATMENT-PREMOLAR	$1,474.40
D3348	RETREATMENT PREVIOUS ROOT CANAL THERAPY - MOLAR	$1,852.71
D3351	APEXIFICATION/RECALCIFICATION INITIAL VISIT	$584.16
D3352	APEXIFICATION/RECALCIFICATION INTERIM MED REPLACE	$260.03
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT	$1,153.88
D3355	PULPAL REGENERATION - INITIAL VISIT	$584.16
D3356	PULPAL REGENERATION - MED REPLACEMENT	$259.13
D3357	PULPAL REGENERATION - COMPLETION TREATMENT	$930.87
D3410	APICOECTOMY - ANTERIOR	$1,173.74
D3421	APICOECTOMY - PREMOLAR	$1,296.54
D3425	APICOECTOMY - MOLAR FIRST ROOT	$1,472.60
D3426	APICOECTOMY	$486.65
D3430	RETROGRADE FILLING - PER ROOT	$371.99
D3920	HEMISECTION NOT INCLUDING ROOT CANAL THERAPY	$790.02
D3950	CANAL PREP&FIT PREFORMED DOWEL/POST	$260.03
D3450	ROOT AMPUTATION - PER ROOT	$789.12
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	$1,032.89
D3472	SURGICAL REPAIR OF ROOT RESORPTION - PM	$1,032.89
D3473	SURGICAL REPAIR OF ROOT RESORPTN - MOLAR	$1,032.89
D3501	SURGICAL EXP RS NO APCECTMY/REPR RR-ANT	$1,032.89
D3502	SURGICAL EXP RS NO APCECTOMY/REPR RR-PM	$1,032.89
D3503	SURGICAL EXP RS NO APICOECT/RPR RR - MOL	$1,032.89
D3428	BONE GRAFT PERIRADICULR SURG 1 SITE	$777.65
D3429	BONE GRAFT PERIRADICULR SURG EA ADD	$736.26
D4263	BN REPL GR-RET NAT TT-1ST SITE QUAD	$714.18
D4264	BRG-RET NAT TOOTH-EA ADD SITE QUAD	$697.02
D6103	BONE GRAFT REPAIR PERI-IMPL DEFECT	$690.70
D6104	BONE GRAFT TIME IMPLANT PLACEMENT	$510.13
D7949	LEFORT II/LEFORT III - W/BONE GRAFT	$2,109.89
D7953	BONE REPLCMT GRAFT RIDGE PRES -SITE	$517.35
D4210	GINGIVECT/PLSTY 4/>CNTIG TEETH QUAD	$1,124.09
D4211	GINGIVECT/PLSTY 1-3CNTIG TEETH QUAD	$604.93
D4212	GING/GINGIVOPLASTY RES PROC-TOOTH	$386.43
D4240	GINGL FLP 4/>CNTIG/TOOTH BOUND QUAD	$1,503.30
D4241	GINGL FLP 1-3 CNTIG/TOOTH BND QUAD	$915.52
D4245	APICALLY POSITIONED FLAP	$1,089.78
D4249	CLIN CROWN LEN - HARD TISSUE	$1,543.02
D4260	OSSEOUS SURG 4/> CNTIG TEETH QUAD	$2,363.74

D4261	OSSEOUS SURG 1-3 CNTIG TEETH QUAD	$1,358.83
D4268	SURGICAL REVISION PROC PER TOOTH	$457.38
D4274	MESIAL/DISTAL WEDGE PROC 1 TOOTH	$1,245.97
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$1,682.07
D4273	AUTOGEN CONNECTIVE TISS GRAFT PROC	$1,862.64
D4275	NON-AUTOGENOUS CONNECTIVE TISS GRFT	$1,837.36
D4276	COMB CNCTIV TISS&PED GRFT PER TOOTH	$1,102.31
D4277	FREE SFT TSS GFT 1ST T/EDNTULOUS T	$36,929.00
D4278	FREE ST GFT EA CNTG T/EDNT T SAME S	$1,020.25
D4283	AUTOGEN CONNECTIVE TISS GRAFT PROC	$939.00
D4285	NON-AUTOGEN CNCT TISSUE GRAFT PROC	$943.51
D4266	GUID TISS REGEN-RESORB BARRIER-SITE	$650.98
D4267	GUID TISS REGEN-NONRESORB BARRIER	$778.28
D4341	PRDNTL SCAL&ROOT PLAN 4/>TEETH-QUAD	$449.63
D4342	PRDONTAL SCAL&ROOT PLAN 1-3 TEETH	$333.16
D4346	SCALING PRES GEN MOD/SEV GING INF	$210.37
D6080	IMPL MAINT PROC REMV REINSRT CLEAN	$295.24
D6081	SCAL&DEB INF/MUCST 1 IMPL NO F EN&C	$124.84
D4355	FM DEBR ENBL COMP OR E&DX SUBQ VST	$232.04
D4910	PERIODONTAL MAINTENANCE	$206.76
D5110	COMPLETE DENTURE - MAXILLARY	$2,798.93
D5120	COMPLETE DENTURE - MANDIBULAR	$2,792.61
D5130	IMMEDIATE DENTURE - MAXILLARY	$2,814.28
D5140	IMMEDIATE DENTURE - MANDIBULAR	2792.61
D5211	MAXILLARY PARTIAL DENTUR RESIN BASE	$1,712.00
D5212	MANDIB PARTIAL DENTURE RESIN BASE	$32,825.00
D5213	MAX PRTL DENTURE- CAST METAL FW	$2,830.53
D5214	MAND PRTL DENTURE - CAST METAL FW	$2,830.53
D5221	IMMED MAX PRTL DENTURE - RESIN BASE	$1,154.21
D5222	IMMED MAND PRTL DENTURE - RESN BASE	$1,274.77
D5223	IMMED MAX PRTL D - CAST METAL FW	$1,633.69
D5224	IMMED MAND PRTL D - CAST MTL FW	$1,668.91
D5225	MAXILLARY PART DENTURE - FLEX BASE	$1,675.75
D5226	MANDIBULAR PART DENTURE - FLEX BASE	$1,675.75
D5282	REMV UNI PRT D - 1 PC CAST METL MAX	$878.50
D5283	REMV UNI PRT D - 1 PC C METL MAND	$878.50
D5284	REMV UNI PD-1 PECE FLEX BS-PER QUAD	$876.70
D5286	REMV UNI PD - 1 PECE RESIN-PER QUAD	$800.86
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	$139.00
D5411	ADJUST COMPLETE DENTUR - MANDIBULAR	$139.00
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	$139.00
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	$139.00
D5863	OVERDENTURE - COMPLETE MAXILLARY	$2,818.79
D5864	OVERDENTURE - PARTIAL MAXILLARY	$2,818.79
D5865	OVERDENTURE - COMPLETE MANDIBULAR	$2,882.90
D5866	OVERDENTURE - PARTIAL MANDIBULAR	$2,818.79
D5511	REPAIR BKN CMPL DENTURE BASE MAND	$281.70

D5512	REPAIR BKN CMPL DENTURE BASE MAX	$281.70
D5520	REPL MISS/BROKEN TEETH-CMPL DENTUR	$242.87
D5611	REPAIR RESIN PRTL DENTURE BASE MAND	$281.70
D5612	REPAIR RESIN PRTL DENTURE BASE MAX	$281.70
D5621	REPAIR CAST PARTIAL FRAMEWORK MAND	$356.64
D5622	REPAIR CAST PARTIAL FRAMEWORK MAX	$356.64
D5630	REPR/REPLCE BROKEN CLASP-PER TOOTH	$335.87
D5640	REPLACE BROKEN TEETH - PER TOOTH	$247.39
D5650	ADD TOOTH EXISTING PARTIAL DENTURE	$325.94
D5660	ADD CLASP XST PRT DENTURE-PER TOOTH	$395.46
D5670	REPL ALL TEETH&ACRYLC FRMEWRK MAX	$815.30
D5671	REPL ALL TEETH&ACRYLC FRMEWRK MAND	$775.57
D6980	FXD PRT DNTR REPR NEC RSTRTV MTL FL	$369.28
D5710	REBASE COMPLETE MAXILLARY DENTURE	$957.05
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$957.05
D5720	REBASE MAXILLARY PARTIAL DENTURE	$702.44
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$702.44
D5730	RELINE COMPL MAXILLARY DENTURE DIR	$525.48
D5731	RELINE COMPL MANDIBULAR DENTURE DIR	$525.48
D5740	RELINE MAXILLARY PART DENTURE DIR	$455.05
D5741	RELINE MANDIBULAR PART DENTURE DIR	$455.05
D5750	RELINE COMPL MAXILLARY DENTUR INDIR	$795.44
D5751	RELINE CMPL MANDIBULAR DENTUR INDIR	$795.44
D5760	RELINE MAXILLARY PART DENTURE INDIR	$710.57
D5761	RELINE MANDIBULAR PART DENTUR INDIR	$710.57
D5850	TISSUE CONDITIONING MAXILLARY	$235.65
D5851	TISSUE CONDITIONING MANDIBULAR	$235.65
D6010	SURG PLCMT IMPL BODY: ENDOSTEAL	$2,756.49
D6012	SURG PLCMT INTERIM IMPL PROS: ENDOS	$1,812.05
D6013	SURGICAL PLACEMENT OF MINI IMPLANT	$2,789.00
D6040	SURG PLACEMENT: EPOSTEAL IMPLANT	$6,092.39
D6050	SURG PLACEMENT: TRANSOSTEAL IMPLANT	$10,313.60
D6051	INTERIM IMPLANT ABUTMENT PLACEMENT	$652.78
D6055	CONNECTING BAR IMPLANT/ABUT SUPPORT	$1,465.42
D6056	PREFAB ABUTMENT-INCL MOD & PLCMNT	$783.70
D6057	CUSTOM FAB ABUTMENT-INCL PLACEMENT	$904.69
D6058	ABUT SUPP PORCELN/CERAMIC CROWN	$1,895.15
D6059	ABUT PORCLN TO MTL CRWN HI NOBL MTL	$1,473.50
D6060	ABUT PORCLN TO METL CROWN BASE METL	$1,330.27
D6061	ABUT PORCLN TO MTL CROWN NOBLE MTL	$1,586.36
D6062	ABUT SUPP CAST MTL CRWN HI NOBL MTL	$1,844.58
D6063	ABUT SUPP CAST METL CROWN BASE METL	$1,321.13
D6064	ABUT SUPP CAST METL CROWN NOBL METL	$1,306.97
D6065	IMPLANT SUPP PORCELAIN/CERAMIC CROWN	$2,282.48
D6066	IMPLANT SUPP CR-PORCELAIN FU HI NBL ALY	$2,156.98
D6067	IMPLANT SUPP CROWN-HI NOBLE ALLOYS	$2,188.58
D6068	ABUTMENT SUPP RETAINER PORCELAIN/CERAM FPD	$1,437.38

D6069	ABUTMENT RETAINER PORCELAIN METAL FPD HI NOBL MT	$1,908.69
D6070	ABUTMENT RETAINER PORCELAIN METAL FPD BASE METAL	$1,803.05
D6071	ABUTMENT SUPP RETAINER PORCELAIN FUSED METAL FPD	$1,552.05
D6072	ABUTMENT SUPP RETAINER CAST METAL FPD	$1,512.32
D6073	ABUTMENT RETAINER CAST METAL FPD BASE METAL	$1,379.21
D6074	ABUTMENT RETAINER CAST METAL FPD NOBL METAL	$1,360.74
D6075	IMPLANT SUPPORTED RETAINER CERAMIC FPD	$2,240.05
D6076	IMPLANT SUPPORTED RETAINER FPD-PORCELAIN F HI NBL ALY	$2,174.14
D6077	IMPLANT SUPPORTED RETAINER METAL FPD-HI NBL ALY	$2,115.45
D6082	IMPLANT SUPPORTED CROWN-PORCELAIN FUSED PREDOMINANTLY BASE ALLOY	$1,515.77
D6083	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED NOBLE ALLOYS	$1,950.22
D6084	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM	$33,225
D6086	IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOY	$1,285.17
D6087	IMPLANT SUPPORTED CROWN - NOBLE ALLOYS	$33,325.00
D6088	IMPLANT SUPPORTED CROWN - TI & TI ALLOYS	$1,930.36
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS BY REPORT	$190.17
D6091	REPL RP ATT IMPLANT/ABUTMENT SUPPORTED PROSTHESIS PER	$463.18
D6092	RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN	$148.98
D6093	RECEMENT IMPLANT/ABUTMENT FIX PART DENTURE	$224.82
D6094	ABUTMENT SUPPORTED CROWN - TI & TI ALLOY	$1,046.74
D6095	REPAIR IMPLANT ABUTMENT BY REPORT	$266.12
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$467.69
D6097	ABUTMENT SUPPORTED CROWN-PORCELAIN FU TI & TI ALY	$1,442.28
D6098	IMPLANT SUPPORTED RETAINER - PORCELAIN FU PDMT B ALY	$1,141.94
D6099	IMPLANT SUPPORTED RETAINER FPD-PORCELAIN FU NBL ALY	$1,950.22
D6100	SURGICAL REMOVAL OF IMPLANT BODY	$754.81
D6101	DEBR PRIIMPL DEF CLN EXPSD IMPL FLP	$915.52
D6102	DEBR&OSS CNTR PRIIMPL DEF;CLN SURF	$1,353.42
D6110	IMPLANT/ABUTMENT SUPPORTED RMV D EDENT ARCH-MAX	$2,512.72
D6111	IMPLANT/ABUTMENT SUPPORTED RMV D EDENT ARCH-MND	$2,512.72
D6112	IMPLANT/ABUTMENT SUPPORTED RMV D PR EDNT ARCH-MX	$2,581.33
D6113	IMPLANT/ABUTMENT SUPPORTED RMV D PR EDNT ARCH-MND	$2,576.82
D6114	IMPLANT/ABUTMENT SUPPORTED FIXED D EDENT ARCH-MAX	$8,801.27
D6115	IMPLANT/ABUTMENT SUPPORTED FIXD D EDENT ARCH-MND	$8,859.06
D6116	IMPLANT/ABUTMENT SUPPORTED F D PR EDENT ARCH-MAX	$4,323.89
D6117	IMPLANT/ABUTMENT SUPPORTED FIXD D PR EDENT ARCH-M	$4,323.89
D6118	IMPLANT/ABUTMENT SUPPORTED INT D EDENT ARCH-M	$1,788.63
D6119	IMPLANT/ABUTMENT SUPPORTED INT F D EDNT ARCH-MAX	$1,788.63
D6120	IMPLANT SUPPORTED RETAINER PORCELAIN FU TIT & TIT ALY	$1,565.38
D6121	IMPLANT SUPPORTED RETAINER METAL FPD PREDM BASE ALY	$1,950.22
D6122	IMPLANT SUPPORTED RETAINER METAL FPD - NOBLE AL	$1,452.59
D6123	IMPLANT SUPPORTED RETAINER METAL FPD TIT & TIT ALY	$1,930.36
D6190	RADIOGRAPHIC/SURG IMPLANT INDX RPT	$587.77
D6191	SEMI-PRECISION ABUTMENT - PLACEMENT	$1,394.05
D6192	SEMI-PRECISION ATTACHMENT - PLACEMENT	$1,394.05
D6194	ABUTMENT SUPPORTED RETAINER CROWN FPD TIT & TIT ALY	$1,399.46

D6195	ABUTMENT SUPPORTED RETAINER-PORCELAIN FU TIT & TIT ALY	$1,439.19
D6198	REMOVE INTERIM IMPLANT COMPONENT	$68.34
D6205	PONTIC INDIRECT RESIN BASED COMPOSITE	$818.01
D6210	PONTIC - CAST HIGH NOBLE METAL	$1,505.10
D6211	PONTIC - CAST PREDOM BASE METAL	$1,060.25
D6212	PONTIC - CAST NOBLE METAL	$1,117.16
D6214	PONTIC - TITANIUM & TITANIUM ALLOYS	$1,094.33
D6240	PONTIC-PORCELAIN FUSED HI NOBLE METAL	$1,498.78
D6241	PONTIC-PORCELAIN FUSED PREDOM BASE METAL	$1,470.79
D6242	PONTIC - PORCELAIN FUSED NOBLE METAL	$1,417.52
D6243	PONTIC - PORCELAIN FU TIT & TIT ALY	$1,332.65
D6245	PONTIC - PORCELAIN/CERAMIC	$1,533.09
D6250	PONTIC - RESIN W/HIGH NOBLE METAL	$1,145.09
D6251	PONTIC RESIN W/PREDOM BASE METAL	$1,055.93
D6252	PONTIC RESIN W/NOBLE METAL	$1,107.96
D6253	INTRM PONTIC-TREATMENT/CMPL DX NEC B4 F IMP	$405.30
D6545	RETAINER-CAST METAL RESIN BOND FIX PROSTHESIS	$899.27
D6548	RETAINER-PORCELAIN/CERAMIC RESIN BOND PROSTHESIS	$1,007.61
D6549	RETAINER - RESIN BONDED FIXED PROS	$367.47
D6601	RETAINER INLAY-PORCELAIN/CERAMIC 3/MOR SRF	$786.61
D6602	RETAINER INLAY-CAST HI NOBLE METAL 2 SURF	$911.20
D6603	RETAINER INLAY-CAST HI NOBL METAL 3/MORE SRF	$877.14
D6604	RETAINER INLAY-CAST PDMT BASE METAL 2 SRF	$646.67
D6605	RETAINER INLAY-CST PDMT BSE METAL 3/MOR SRF	$853.20
D6606	RETAINER INLAY-CAST NOBLE METAL 2 SURF	$755.62
D6607	RETAINER INLAY-CAST NOBLE METAL 3/MRE SRF	$850.77
D6608	RETAINER ONLAY-PORCELAIN/CERAM 2 SURF	$1,008.19
D6609	RETAINER ONLAY-PORCELAIN/CERAMIC 3/MORE SRF	$1,080.97
D6610	RETAINER ONLAY-CAST HI NOBLE METAL 2 SURFACE	$839.39
D6611	RETAINER ON-CST HI NOBLE METL 3/MORE SRF	$1,138.20
D6612	ONLAY-CAST PREDOM BASE METL 2 SURF	$1,032.48
D6613	RETAINER ON-CST PDMT BSE METL 3/MORE SRF	$1,072.54
D6614	RETAINER ONLAY-CAST NOBLE METAL 2 SURF	$1,020.11
D6615	RETAINER ONLAY-CST NOBLE METL 3/MORE SRF	$1,044.51
D6624	RETAINER INLAY - TITANIUM	$962.46
D6634	RETAINER ONLAY - TITANIUM	$1,005.47
D6710	RETAINER CROWN-INDIR RESIN BASED COMPOS	$864.94
D6720	RETAINER CROWN-RESIN HI NOBLE METAL	$1,044.78
D6721	RETAINER CROWN-RESIN PDMT BASE METL	$1,061.67
D6722	RETAINER CROWN-RESIN W/NOBLE METAL	$1,071.86
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	$1,538.51
D6750	RETAINER CROWN-PORCELAIN FUSED HI NOBLE METAL	$1,561.08
D6751	RETAINER CROWN-PORCELAIN FUSED PDMT BASE METAL	$1,101.11
D6752	RETAINER CROWN-PORCELAIN FUSED NOBLE METAL	$1,450.93
D6753	RETAINER CROWN - PORCELAIN FU TIT & TIT ALY	$1,444.61
D6780	RETAINER CROWN-3/4 CAST HI NOBLE METL	$1,205.63
D6781	RETAINER CRWN-3/4 CAST PDMT BASE METAL	$971.30

D6782	RETAINER CROWN-3/4 CAST NOBLE METAL	$947.36
D6783	RETAINER CROWN-3/4 PORCELAIN/CERAMC	$1,049.03
D6784	RETAINER CROWN 3/4 - TI & TI ALLOYS	$1,141.81
D6790	RETAINER CRWN-FULL CAST HI NOBLE METAL	$1,505.10
D6791	RETAINER CRWN-FULL CAST PDMT BASE METL	$1,074.37
D6792	RETAINER CROWN-FULL CAST NOBLE METL	$1,118.18
D6793	INTRM RET CROWN-TREATMENT/CMPL DX B4 FNL IMP	$332.63
D6794	RETAINER CROWN - TI & TI ALLOYS	$1,293.09
D6920	CONNECTOR BAR	$409.91
D9120	FIXED PARTIAL DENTURE SECTIONING	$235.65
D6930	RECEMENT FIXED PARTIAL DENTURE	$201.34
D7310	ALVEOLOPLASTY W/EXT 4/> TEETH/SPACE	$474.01
D7311	ALVEOLOPLSTY CONJNC XTRCT 1-3 TEETH	$390.04
D7320	ALVEOLOPLASTY NO EXT 4/> TEETH/SPAC	$689.80
D7321	ALVEOLOPLSTY NOT W/XTRCT 1-3 TEETH	$548.95
D7340	VESTIBULOPLASTY RIDGE EXT SEC EPITH	$3,388.51
D7350	VESTBULPLSTY RIDGE EXT SFT TISS GFT	$5,260.17
D7471	REMOVAL OF LATERAL EXOSTOSIS	$1,454.54
D7485	REDUCTION OF OSSEOUS TUBEROSITY	$1,402.17
D7510	INCISION & DRAINAGE ABSCESS-INTRAORAL SOFT TISSUE	$479.00
D7511	INCISION & DRAINAGE ABSCESS INTRAORAL SOFT TISSUE COMPLICATED	$1,692.90
D7520	INCISION & DRAINAGE ABSCESS EXTRAORAL SOFT TISSUE	$406.08
D7521	INCISION & DRAINAGE ABSCESS XTRAORAL SOFT TISSUE COMPLICATED	$2,144.34
D7910	SUTURE RECENT SMALL WOUNDS UP 5 CM	$862.25
D7971	EXCISION OF PERICORONAL GINGIVA	$267.25
D7972	SURGICAL RDUC FIBROUS TUBEROSITY	$984.14
	Orthodontia	**Allowed Amount**
D0340	2D CEPHALOMET X-RAY-ACQN MSR&ANALY	$167.03
D0470	DIAGNOSTIC CASTS	$124.60
D8010	LTD ORTHODONTIC TREATMENT PRIMARY DENTITION	$3,160.25
D8020	LTD ORTHODONTIC TREATMENT TRNSITIONL DENTITN	$3,390.56
D8030	LTD ORTHODONTIC TREATMENT ADOLES DENTITION	$2,341.92
D8040	LTD ORTHODONTIC TREATMENT ADULT DENTITION	$4,285.07
D8070	COMP ORTHODONTIC TREATMENT TRNSITNL DENTITN	$6,722.08
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	$6,809.19
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT ADULT DENTITION	$6,782.50
D8210	REMOVABLE APPLIANCE THERAPY	$851.92
D8220	FIXED APPLIANCE THERAPY	$921.54
D8660	PREORTHODONTIC TREATMENT VISIT	$269.59
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	$436.44
D8680	ORTHODONTIC RETENTION	$593.71
D8698	RE-CEMENT/RE-BOND FIX RETAIN - MAX	$154.39
D8699	RE-CEMENT/RE-BOND FIX RETAIN - MAND	$154.39

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-403-2785 (TTY: 711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-403-2785 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-403-2785 (TTY: 711)

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-403-2785 (TTY: 711)번으로 전화해 주십시 h 오.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-403-2785（TTY：711）。

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-403-2785 (TTY: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-403-2785 (ATS : 711).

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-403-2785 (መስማት ለተሳናቸው: 711).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-403-2785 (TTY: 711) पर कॉल करें।

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-403-2785 (TTY: 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-403-2785 (телетайп: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-403-2785 (رقم هاتف الصم والبكم: 711 TTY).

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-403-2785 (TTY: 711).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-403-2785 (TTY: 711) تماس بگیرید.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-403-2785 (TTY: 711).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-403-2785（TTY:711）まで、お電話にてご連絡ください。