



Monthly Premiums
 Self - \$15.06
 Self & 1 - \$27.76
 Family - \$33.94
Effective 1/1/27

Schedule of Benefits

Benefits provided by SafeGuard Health Plans, Inc., a MetLife company

Direct Referral Dental Plan*

MET290

This SCHEDULE OF BENEFITS lists the Covered Services available to You and Your Dependents under Your dental plan, as well as Your and Your Dependent's costs for each Covered Service. Your and Your Dependent's costs may include Co-Payments for a Covered Service.

*Care under this plan is provided through a network of Selected General Dentists. Your Selected General Dentist is responsible for determining when the services of a Specialty Care Dentist are needed, and facilitating any necessary referral. You and Your Dependents will be advised of the name, address and telephone number of the Specialty Care Dentist in Your or Your Dependent's Service Area.

Missed Appointments: If You or Your Dependents need to cancel or reschedule an appointment, please notify the Selected General Dental Office as far in advance as possible. This will allow the Selected General Dental Office to accommodate another person in need of attention. If You or Your Dependents fail to do this in a timely fashion, You or Your Dependents may be charged a missed appointment fee.

Code	Service	Your and Your Dependent's Co-Payment
	• Office visit - per visit (<i>including all fees for sterilization and/or infection control</i>)	\$5
Code	Service	Your and Your Dependent's Co-Payment
Diagnostic Treatment		
D0120	Periodic oral evaluation - established patient. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient. Report additional diagnostic procedures separately. Limited oral evaluation - problem focused	\$0
D014	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$0
D014	Comprehensive oral evaluation - new or established patient	\$0
D015	Detailed and extensive oral evaluation - problem focused, by report	\$0
D015	Re-evaluation - limited, problem focused (<i>established patient; not post-operative visit</i>)	\$0
D016	Re-evaluation - post-operative office visit	\$0
D017	Comprehensive periodontal evaluation - new or established patient. This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history, and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships.	\$0
D018	Screening of a patient	\$0
D019	Assessment of a patient	\$0
D019		\$0
D019	Radiographs / Diagnostic Imaging (<i>X-rays</i>)	\$
D021	A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all.	\$0
D021	Intraoral - periapical first radiographic image	\$0

Code	Service	Your and Your Dependent's Co-Payment
D023	Intraoral – periapical each additional radiographic image	\$0
0	Intraoral – occlusal radiographic image	\$0
D024	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	\$0
D0251	Extra-oral posterior dental radiographic image	\$0
D027	Bitewing – single radiographic image	\$0
D027	Bitewings – two radiographic images	\$0
0	Bitewings – three radiographic images	\$0
D027	Bitewings – four radiographic images	\$0
D027	Vertical bitewings – 7 to 8 radiographic images	\$0
4	Panoramic radiographic image	\$0
D027	2D cephalometric radiographic image – acquisition, measurement and analysis	\$0
D033	2D oral/facial photographic image obtained intra-orally or extra-orally	\$180
0		
D034	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	
D035		
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	\$180
D036		
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	\$180
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	\$180
D0372	A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. Comprehensive series of radiographic images.	\$0
D037	Intraoral tomosynthesis- bitewing radiographic image	\$0
3	Intraoral tomosynthesis – periapical radiographic image	\$0
D037	Cone beam CT image capture with limited field of view – less than one whole jaw	\$180
4	Cone beam CT image capture with field of view of one full dental arch – mandible	\$180
D038		\$180
0	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	
D038		
D038	Cone beam CT image capture with field of view of both jaws, with or without cranium	\$180
D0383		
D039	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	\$0
1	3D printing of a 3D dental surface scan	\$0

Tests and Examinations

D041	Collection of microorganisms for culture and sensitivity	\$0
5	Caries susceptibility tests	\$0
D042	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	\$50
D0431		
D046	Pulp vitality tests	\$
0	Diagnostic casts	0
D047		\$
0		

Code	Service	Your and Your Dependent's Co-Payment
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	\$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	\$0
D048	Laboratory accession of transepithelial cytologic sample, microscopic examination preparation and transmission of written report Other oral pathology procedures, by report	\$0
6		\$0

Preventive Services

D050	Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.	\$5
D1110	• Additional-adult prophylaxis (<i>maximum of 2 additional per year</i>)	\$45
D1120	Removal of plaque, calculus and stains from the tooth structures and implants in the primary and transitional dentition. It is intended to control local irritational factors.	\$5
	• Additional-child prophylaxis (<i>maximum of 2 additional per year</i>)	\$35
D120	Topical application of fluoride varnish	\$0
6	Topical application of fluoride – excluding varnish	\$0
D120	Nutritional counseling for control of dental disease	\$0
8	Tobacco counseling for the control and prevention of oral disease	
D131	Oral hygiene instructions	
0	• Includes periodontal hygiene instruction	
D132	Sealant – per tooth	\$0
D135	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	\$0
D135	Sealant repair - per tooth	\$0
2	Application of caries arresting medicament – per tooth. Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	\$0
D135	Caries preventive medicament application – per tooth	\$0
5	Space maintainer – fixed, unilateral – per quadrant Excludes a distal shoe space maintainer	\$25
D151	Space maintainer – fixed – bilateral, maxillary	\$25
0	Space maintainer – fixed – bilateral, mandibular	\$25
D151	Space maintainer – removable, unilateral – per quadrant	\$35
6	Space maintainer – removable – bilateral, maxillary	\$35
D151	Space maintainer – removable – bilateral, mandibular	\$35
7	Re-cement or re-bond bilateral space maintainer – maxillary	\$15
D152		

Code	Service	Your and Your Dependent's Co-Payment
D155	Re-cement or re-bond bilateral space maintainer – mandibular	\$15
2	Re-cement or re-bond unilateral space maintainer – per quadrant	\$15
D155	Removal of fixed unilateral space maintainer – per quadrant	\$15
3	Removal of fixed bilateral space maintainer – maxillary	\$15
D155	Removal of fixed bilateral space maintainer – mandibular	\$15
6	Distal shoe space maintainer – fixed, unilateral – per quadrant	
D155 D1575 7	Fabrication and delivery of fixed appliance extending subgingivally and distally to guide the eruption of the first permanent molar. Does not include ongoing follow-up or adjustments, or replacement appliance, once the tooth had erupted	\$25
D155 8	Restorative Treatment	
D214	Amalgam – one surface, primary or permanent	\$12
0	Amalgam – two surfaces, primary or permanent	\$20
D215	Amalgam – three surfaces, primary or permanent	\$23
0	Amalgam – four or more surfaces, primary or permanent	\$25
D216	Resin-based composite – one surface, anterior	\$12
0	Resin-based composite – two surfaces, anterior	\$20
D216	Resin-based composite – three surfaces, anterior	\$23
1	Resin-based composite – four or more surfaces (<i>anterior</i>)	\$25
D233	Resin-based composite crown, anterior	\$30
0	Resin-based composite – one surface, posterior	\$30
D233	Resin-based composite – two surfaces, posterior	\$45
1	Resin-based composite – three surfaces, posterior	\$65
D233	Resin-based composite – four or more surfaces, posterior	\$65
2		
D233	Crowns	
5	An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a \$75 Co-Payment per molar, for the use of porcelain.	
0	Cases involving seven (7) or more Crowns, implants and/or fixed Bridge units in the same treatment plan require an additional \$125 Co-Payment per unit in addition to the specified Co-Payment for each Crown, Implant or Bridge unit.	
D251	Inlay – metallic – one surface	\$27
D239	Inlay – metallic – two surfaces	0
D252	Inlay – metallic – three or more surfaces	\$27
D239	Onlay – metallic – two surfaces	0
D253	Onlay – metallic – three surfaces	\$27
D239	Onlay – metallic – four or more surfaces	0
D254	Inlay – porcelain/ceramic – one surface	\$27
2	Inlay – porcelain/ceramic – two surfaces	0
D254	Inlay – porcelain/ceramic – three or more surfaces	\$27
3	Onlay – porcelain/ceramic – two surfaces	0
D254	Onlay – porcelain/ceramic – three surfaces	\$27
4	Onlay – porcelain/ceramic – four or more surfaces	0
D261	Inlay – resin-based composite – one surface	\$29
0	Inlay – resin-based composite – two surfaces	0
D262	Inlay – resin-based composite – three or more surfaces	\$29
0	Onlay – resin-based composite – two surfaces	0
D263	Onlay – resin-based composite – three surfaces	\$29
0		0
D264		\$29
2		
D264		
3		
D264		

Code	Service	Your and Your Dependent's Co-Payment
D266	Onlay – resin-based composite – four or more surfaces	\$29
4	Crown – resin-based composite (<i>indirect</i>)	0
D271	Crown – ¾ resin-based composite (<i>indirect</i>)	\$29
0	Crown – resin with high noble metal	0
D271	Crown – resin with predominantly base metal	\$29
2	Crown – resin with noble metal	0
D272	Crown – porcelain/ceramic	\$29
0	Crown – porcelain fused to high noble metal	0
D272	Crown – porcelain fused to predominantly base metal	\$29
1	Crown – porcelain fused to noble metal	0
D272	Crown – porcelain fused to titanium and titanium alloys	\$29
2	Crown – ¾ cast high noble metal	0
D274	Crown – ¾ cast predominantly base metal	\$31
0	Crown – ¾ cast noble metal	0
D275	Crown – ¾ porcelain/ceramic	\$29
0	Crown – full cast high noble metal	0
D275	Crown – full cast predominantly base metal	\$29
1	Crown – full cast noble metal	0
D275	Crown – titanium and titanium alloys	\$29
2	Interim crown – further treatment or completion of diagnosis necessary prior to final	0
D275	impression. Further treatment or completion of diagnosis necessary prior to final	\$
3	impression. Not to be used as a temporary crown for a routine prosthetic	0\$2895
D2799	restoration.	\$29
D278	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$0
0	Re-cement or re-bond indirectly fabricated or prefabricated post and core	0
D298	Re-cement or re-bond crown	\$ \$2
0	Prefabricated porcelain/ceramic crown – permanent tooth	09
5	Prefabricated stainless steel crown – primary tooth	0\$0
D298	Prefabricated stainless steel crown – permanent tooth	\$
9	Prefabricated resin crown	12
D299	Prefabricated stainless steel crown with resin window	59 5
6	Protective restoration	0\$2
D299	Interim therapeutic restoration - primary dentition	5
0	Core buildup, including any pins when required	\$22
D299	Pin retention – per tooth, in addition to restoration	95
1	Post and core in addition to crown, indirectly fabricated	0\$4
D299	Each additional indirectly fabricated post – same tooth	5
4	Prefabricated post and core in addition to crown	\$24
D293	Post removal	95
3	Each additional prefabricated post – same tooth	0\$0
D294	Labial veneer (<i>resin laminate</i>) – chairside	\$ \$2
0	Labial veneer (<i>resin laminate</i>) – laboratory	09
D294	Labial veneer (<i>porcelain laminate</i>) – laboratory	0\$7
1		5
D295		\$21
0		90
D295		0\$5
1		0
D295		0\$5
0		0
D295		0\$3
3		0

Code	Service	Your and Your Dependent's Co-Payment
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework. This procedure is in addition to the separate a crown procedure documented with its own code.	\$50
D297	Band stabilization – per tooth	\$7
6	Crown repair necessitated by restorative material failure	\$0
D298	Inlay repair necessitated by restorative material failure	\$0
0	Onlay repair necessitated by restorative material failure	\$0
D298	Veneer repair necessitated by restorative material failure	\$0
1	Excavation of a tooth resulting in the determination of non-restorability	\$0
D298	Resin infiltration of incipient smooth surface lesions	\$0
2		
Endodontics		
D298	All procedures exclude final restoration.	
3		
D3110	Pulp cap – direct (<i>excluding final restoration</i>)	\$5
D298	Pulp cap – indirect (<i>excluding final restoration</i>)	
D3120		\$5
D299	Therapeutic pulpotomy (<i>excluding final restoration</i>) – removal of pulp coronal to the dentinocemental junction and application of medicament	\$40
D3220		
D3221	Pulpal debridement, primary and permanent teeth	\$55
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$40
D3230	Pulpal therapy (<i>resorbable filling</i>) – anterior, primary tooth (<i>excluding final restoration</i>)	\$40
D3240	Pulpal therapy (<i>resorbable filling</i>) – posterior, primary tooth (<i>excluding final restoration</i>)	\$40
D3310		\$115
D3320	Endodontic therapy, anterior tooth (<i>excluding final restoration</i>)	\$185
D3330	Endodontic therapy, premolar tooth (<i>excluding final restoration</i>)	\$265
D3331	Endodontic therapy, molar tooth (<i>excluding final restoration</i>)	\$85
D3332	Treatment of root canal obstruction; non-surgical access	\$110
	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$85
D3333	Internal root repair of perforation defects: Non-surgical seal of perforation caused by resorption and/or decay but not iatrogenic by same provider.	\$230
D3346	Retreatment of previous root canal therapy – anterior	\$280
D3347	Retreatment of previous root canal therapy – premolar	\$325
D3348	Retreatment of previous root canal therapy – molar	
D3351	Apexification/recalcification – initial visit (<i>apical closure / calcific repair of perforations, root resorption, etc.</i>)	\$70
D3352		\$70
D3353	Apexification/recalcification – interim medication replacement	\$70
D3355		
D3356	Apexification/recalcification – final visit (<i>includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.</i>)	\$70
D3357		
D3410	Pulpal regeneration - initial visit	\$35
D3421	Pulpal regeneration - interim medication replacement	\$70
D3425	Pulpal regeneration - completion of treatment	\$95
	Apicoectomy – anterior	\$95
	Apicoectomy – premolar (<i>first root</i>)	\$95
	Apicoectomy – molar (<i>first root</i>)	

Code	Service	Your and Your Dependent's Co-Payment
D342	Apicoectomy (<i>each additional root</i>)	\$80
6	Bone graft in conjunction with periradicular surgery - per tooth, single site	\$180
D342	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	\$95
8	Retrograde filling – per root	\$60
D342	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	\$95
D343	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	\$215
D343	Root amputation – per root	\$110
D343	Endodontic endosseous implant	\$555
D345	Surgical repair of root resorption – anterior	\$72
D346	Surgical repair of root resorption – premolar	\$72
D346	Surgical repair of root resorption – molar	\$72
D347	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	\$54
D347	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	\$54
D347	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	\$54
D350	Surgical procedure for isolation of tooth with rubber dam	\$0
D391	Hemisection (<i>including any root removal</i>), not including root canal therapy	\$90
D392	Decoronation or submergence of an erupted tooth	\$41
D392	Decoronation or submergence of an erupted tooth	\$15
D392	Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply to You or Your Dependent or Us.	
D395	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	\$150
D421	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	\$100
D421	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$30
D421	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant: A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth or fractured root. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.	\$170
D4240		

Code	Service	Your and Your Dependent's Co-Payment
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant: A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth or fractured root. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.	\$130
	Apically positioned flap	
D424	Clinical crown lengthening – hard tissue	\$16
5	Osseous surgery (<i>including elevation of a full thickness flap and closure</i>) – four or	5
D424	more contiguous teeth or tooth bounded spaces per quadrant	\$16
9	Osseous surgery (<i>including elevation of a full thickness flap and closure</i>) – one to	0
	three contiguous teeth or tooth bounded spaces per quadrant	\$
D426	Bone replacement graft – retained natural tooth – first site in quadrant	23
0	Bone replacement graft – retained natural tooth – each additional site in quadrant	\$95
D426	Biologic materials to aid in soft and osseous tissue regeneration, per site. Biologic	\$95
1	materials may be used alone or with other regenerative substrates such as bone	
D426	and barrier membranes, depending upon their formulation and the presentation of	\$18
3	the periodontal defect. This procedure does not include surgical entry and closure,	00
D4265	wound debridement, osseous contouring, or the placement of graft materials and/or	\$95
4	barrier membranes. Other separate procedures may be required concurrent to D4265 and should be reported using their own unique codes.	
D4266	Guided tissue regeneration, natural teeth – resorbable barrier, per site: This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.	\$215
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site: This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for	\$255
D426	periodontal defects around natural teeth.	\$0
8	Surgical revision procedure, per tooth	\$250
D427	Pedicle soft tissue graft procedure	\$75
0	Autogenous connective tissue graft procedure (<i>including donor and recipient surgical sites</i>) first tooth, implant, or edentulous tooth position in graft	\$100
D427	Mesial/distal wedge procedure, single tooth (<i>when not performed in conjunction with surgical procedures in the same anatomical area</i>)	\$380
3	Non-autogenous connective tissue graft (<i>including recipient site and donor material</i>) first tooth, implant, or edentulous tooth position in graft	\$75
D427	Combined connective tissue and pedicle graft, per tooth. Advanced gingival	\$26
D427	recession often cannot be corrected with a single procedure. Combined tissue grafting procedures are needed to achieve the desired outcome.	0
7	Free soft tissue graft procedure (<i>including recipient and donor surgical sites</i>) first tooth, implant or edentulous tooth position in graft	\$13
D427	Free soft tissue graft procedure (<i>including recipient and donor surgical sites</i>) each additional contiguous tooth, implant or edentulous tooth position in same graft site	0

Code	Service	Your and Your Dependent's Co-Payment
D4283	Autogenous connective tissue graft procedure (<i>including donor and recipient surgical sites</i>) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$38
D4285	Non-autogenous connective tissue graft procedure (<i>including recipient surgical site and donor material</i>) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$190
D432	Splint - intracoronar; natural teeth or prosthetic crowns	\$95
2	Splint - extracoronar; natural teeth or prosthetic crowns	\$85
D432	Periodontal scaling and root planing – four or more teeth per quadrant	\$50
3	Periodontal scaling and root planing – one to three teeth per quadrant	\$38
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	\$5
D435	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.	\$50
3	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	\$65
D438	Periodontal maintenance	\$40
1	Unscheduled dressing change (<i>by someone other than treating dentist or their staff</i>)	\$0
D491	Additional periodontal maintenance procedure (per 20 minutes, 12 months)	\$55
Delivery of removable and fixed Prosthodontics includes up to 3 adjustments within 6 months of delivery date of service.		
D4920	Complete denture – maxillary	\$44
D5120	Complete denture – mandibular	\$44
D5130	Immediate denture – maxillary	\$44
D5140	Immediate denture – mandibular	\$44
D5211	Maxillary partial denture – resin base (<i>including, retentive/clasping materials, rests, and teeth</i>)	\$44
D5212	Mandibular partial denture – resin base (<i>including, retentive/clasping materials, rests, and teeth</i>)	\$44
D5213	Maxillary partial denture - cast metal framework with resin denture bases (<i>including retentive/clasping materials, rests and teeth</i>)	\$48
D5214	Mandibular partial denture - cast metal framework with resin denture bases (<i>including retentive/clasping materials, rests and teeth</i>)	\$48
D5221	Immediate maxillary partial denture - resin base (<i>including retentive/clasping materials, rests and teeth</i>) Includes limited follow-up care only; does not include future rebasing/relining procedure(s) Immediate mandibular partial denture - resin base (<i>including retentive/clasping materials, rests and teeth</i>) Includes limited follow-up care only; does not include future rebasing/relining procedure(s) Immediate maxillary partial denture - cast metal framework with resin denture bases (<i>including retentive/clasping materials, rests and teeth</i>) Includes limited follow-up care only; does not include future rebasing/relining procedure(s) Immediate mandibular partial denture - cast metal framework with resin denture bases (<i>including retentive/clasping materials, rests and teeth</i>) Includes limited follow-up care only; does not include future rebasing/relining procedure(s)	\$405
D5222	Maxillary partial denture – flexible base (<i>including any clasps, rests and teeth</i>)	\$48
D5225	Mandibular partial denture – flexible base (<i>including any clasps, rests and teeth</i>)	\$48
D5226		\$48

Code	Service	Your and Your Dependent's Co-Payment
D5227	Immediate maxillary partial denture – flexible base (<i>including any clasps, rests and teeth</i>)	\$405
D5228	Immediate mandibular partial denture – flexible base (<i>including any clasps, rests and teeth</i>)	\$405
D528 2	Removable unilateral partial denture – one piece cast metal (<i>including clasps and teeth</i>), maxillary	\$360
D528 3	Removable unilateral partial denture – one piece cast metal (<i>including clasps and teeth</i>), mandibular	\$360
D528 4	Removable unilateral partial denture – one piece flexible base (<i>including clasps and teeth</i>) – per quadrant	\$180
D528 6	Removable unilateral partial denture – one piece resin (<i>including clasps and teeth</i>) – per quadrant	\$180
D541 0	Adjust complete denture – maxillary	\$20
D541 1	Adjust complete denture – mandibular	\$50
D541 1	Adjust partial denture – maxillary	\$50
D542 1	Adjust partial denture – mandibular	\$40
D542 1	Repair broken complete denture base, mandibular	\$50
D542 2	Repair broken complete denture base, maxillary	\$50
D551 1	Replace missing or broken teeth – complete denture (<i>each tooth</i>)	\$50
D551 2	Repair resin partial denture base, mandibular	\$50
D551 2	Repair resin partial denture base, maxillary	\$70
D551 2	Repair cast partial framework, mandibular	\$40
D552 0	Repair cast partial framework, maxillary	\$60
D561 1	Repair or replace broken retentive clasping materials – per tooth	\$70
D561 2	Replace broken teeth – per tooth	\$165
D561 2	Add tooth to existing partial denture	\$165
D562 1	Add clasp to existing partial denture – per tooth	\$125
D562 2	Replace all teeth and acrylic on cast metal framework (<i>maxillary</i>)	\$125
D562 2	Replace all teeth and acrylic on cast metal framework (<i>mandibular</i>)	\$125
D562 1	Rebase complete maxillary denture	\$125
D562 2	Rebase complete mandibular denture	\$125
D563 0	Rebase maxillary partial denture	\$100
D564 0	Rebase mandibular partial denture	\$100
D565 0	Rebase hybrid prosthesis	\$90
D566 0	Reline complete maxillary denture (<i>chairside</i>)	\$90
D567 0	Reline complete mandibular denture (<i>chairside</i>)	\$130
D571 1	Reline maxillary partial denture (<i>chairside</i>)	\$130
D571 1	Reline mandibular partial denture (<i>chairside</i>)	\$130
D572 1	Reline complete maxillary denture (<i>laboratory</i>)	\$130
D572 1	Reline complete mandibular denture (<i>laboratory</i>)	\$130
D572 1	Reline maxillary partial denture (<i>laboratory</i>)	\$230
D572 1	Reline mandibular partial denture (<i>laboratory</i>)	\$230
D572 1	Soft liner for complete or partial removable denture – indirect	\$160
D572 1	Interim complete denture (<i>maxillary</i>)	\$170
D572 1	Interim complete denture (<i>mandibular</i>)	
D572 1	Interim partial denture (<i>maxillary</i>)	
D572 1	Interim partial denture (<i>mandibular</i>)	

Code	Service	Your and Your Dependent's Co-Payment
D585	Tissue conditioning, maxillary	\$40
0	Tissue conditioning, mandibular	\$40
D585	Precision attachment, by report. Each pair of components is one precision attachment. Describe the type of attachment used.	\$160
1 D5876 D586	Add metal substructure to acrylic full denture (<i>per arch</i>). Use of metal substructure in removable complete dentures without a framework	\$110
Implant Services		
Pre-Surgical Services		
D6190	Radiographic/surgical implant index, by report	\$130
Surgical Services		
D601	Surgical placement of implant body: endosteal implant	\$1,005
0		\$770
D601	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	\$1,005
2		\$1,860
D601	Surgical placement of mini implant	\$1,170
3	Surgical placement: eposteal implant	\$123
D604	Surgical placement: transosteal implant	\$240
0	Interim implant abutment placement. A healing cap is not an interim abutment.	
D605	Surgical removal of implant body	
0		
D6101 D605	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	\$39
1	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	\$75
D610 D6102	Bone graft for repair of peri-implant defect – does not include flap entry and closure	
D610	Bone graft at time of implant placement	\$10
3	Removal of implant body not requiring bone removal nor flap elevation	0
D610	Guided tissue regeneration – resorbable barrier, per implant. This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	\$10
4		0
D610 D6106	Guided tissue regeneration – non-resorbable barrier, per implant. This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	\$24 \$215
D6107		\$255

Implant Supported Prosthetics

- An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a \$75 Co-Payment per molar, for the use of porcelain.
- Cases involving seven (7) or more Crowns, implants and/or fixed Bridge units in the same treatment plan require an additional \$125 Co-Payment per unit in addition to the specified Co-Payment for each Crown, implant or Bridge unit.

D605	Connecting bar – implant supported or abutment supported	\$34
5	Prefabricated abutment – includes modification and placement	5
D605	Custom fabricated abutment – includes placement	\$24
6	Abutment supported porcelain/ceramic crown	5

D605

\$33

7

Page 11 of 21

GCERT2012-DHMO-SOB

MET290_SOB_TX (01/24) Fs/f

D605

\$68

8

5

Code	Service	Your and Your Dependent's Co-Payment
D605	Abutment supported porcelain fused to metal crown (<i>high noble metal</i>)	\$66
9	Abutment supported porcelain fused to metal crown (<i>predominantly base metal</i>)	0
D606	Abutment supported porcelain fused to metal crown (<i>noble metal</i>)	\$64
0	Abutment supported cast metal crown (<i>high noble metal</i>)	0
D606	Abutment supported cast metal crown (<i>predominantly base metal</i>)	\$64
1	Abutment supported cast metal crown (<i>noble metal</i>)	5
D606	Implant supported porcelain/ceramic crown	\$65
2	Implant supported crown – porcelain fused to high noble alloys.	5
D606	A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant	\$76
D606	Implant supported crown - high noble alloys. A single metal crown restoration that is retained, supported and stabilized by an implant	04 0
D606	Abutment supported retainer for porcelain/ceramic FPD	\$72
5	Abutment supported retainer for porcelain fused to metal FPD (<i>high noble metal</i>)	\$72
D606	Abutment supported retainer for porcelain fused to metal FPD (<i>predominantly base metal</i>)	\$56
8	Abutment supported retainer for porcelain fused to metal FPD (<i>noble metal</i>)	8
D606	Abutment supported retainer for cast metal FPD (<i>high noble metal</i>)	0\$5
D607	Abutment supported retainer for cast metal FPD (<i>predominantly base metal</i>)	95
0	Abutment supported retainer for cast metal FPD (<i>noble metal</i>)	0\$6
D607	Implant supported retainer for ceramic FPD	8\$6
D607	Implant supported retainer for FPD - porcelain fused to high noble alloys. A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant	35
D607	Implant supported retainer for metal FPD - high noble alloys. A metal retainer for a fixed partial denture that gains retention, support and stability from an implant	\$62
D607	Implant supported retainer for metal FPD - high noble alloys. A metal retainer for a fixed partial denture that gains retention, support and stability from an implant	5
D607	Implant supported retainer for metal FPD - high noble alloys. A metal retainer for a fixed partial denture that gains retention, support and stability from an implant	\$44
D607	Implant supported retainer for metal FPD - high noble alloys. A metal retainer for a fixed partial denture that gains retention, support and stability from an implant	\$510
D607	Implant supported retainer for metal FPD - high noble alloys. A metal retainer for a fixed partial denture that gains retention, support and stability from an implant	\$64
D607	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prosthesis and abutments	0
D608	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	\$20
D608	Implant supported crown – porcelain fused to predominantly base alloys	\$70
2	Implant supported crown – porcelain fused to noble alloys	\$640
D608	Implant supported crown – porcelain fused to titanium and titanium alloys	\$645
3	Implant supported crown – predominantly base alloys	\$650
D608	Implant supported crown – noble alloys	\$640
4	Implant supported crown – titanium and titanium alloys	\$720
D608	Accessing and retorquing loose implant screw – per screw	\$650
6	Repair implant supported prosthesis, by report	\$0
D608	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	\$190
7	Re-cement or re-bond implant/abutment supported crown	\$170
D608	Re-cement or re-bond implant/abutment supported fixed partial denture	\$50
8		\$70
D608		
9		
D609		
0		
D609		

Code	Service	Your and Your Dependent's Co-Payment
D609	Abutment supported crown - titanium and titanium alloys. A single crown restoration that is retained, supported and stabilized by an abutment on an implant	\$650
4	Repair implant abutment, by report	\$140
		\$24
D609	Remove broken implant retaining screw	\$700
5	Abutment supported crown – porcelain fused to titanium and titanium alloys	\$595
D609	Implant supported retainer – porcelain fused to predominantly base alloys	\$635
6	Implant supported retainer for FPD – porcelain fused to noble alloys	\$995
D609	Implant/abutment supported removable denture for edentulous arch-maxillary	\$995
7	Implant/abutment supported removable denture for edentulous arch-mandibular	\$945
D609	Implant/abutment supported removable denture for partially edentulous arch-maxillary	
D609	Implant/abutment supported removable denture for partially edentulous arch-mandibular	\$945
D611	Implant/abutment supported fixed denture for edentulous arch-maxillary	\$2,380
D611	Implant/abutment supported fixed denture for edentulous arch-mandibular	\$2,380
D611	Implant/abutment supported fixed denture for partially edentulous arch-maxillary	\$1,410
D611	Implant/abutment supported fixed denture for partially edentulous arch-mandibular	\$1,410
D611	Implant supported retainer – porcelain fused to titanium and titanium alloys	\$520
D611	Implant supported retainer for metal FPD – predominantly base alloys	\$445
6	Implant supported retainer for metal FPD – noble alloys	\$640
D611	Implant supported retainer for metal FPD – titanium and titanium alloys	\$520
7	Semi-precision abutment – placement	\$335
D612	Semi-precision attachment – placement	\$252
0	Abutment supported retainer crown for FPD – titanium and titanium alloys. A	
D612	retainer for a fixed partial denture that gains retention, support and stability from an	
1	abutment on an implant	\$520
D6194	Abutment supported retainer – porcelain fused to titanium and titanium alloys	
D612	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.	\$510
D6195		\$30
D6197		
3		

D619 Crowns/Fixed Bridges - Per Unit

1 An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal. There is a \$75 Co-Payment per molar, for the use of porcelain.

2 Cases involving seven (7) or more Crowns, implants and/or fixed Bridge units in the same treatment plan require an additional \$125 Co-Payment per unit in addition to the specified Co-Payment for each Crown, implant or Bridge unit.

D620	Pontic – indirect resin based composite	\$29
5	Pontic – cast high noble metal	0
D621	Pontic – cast predominantly base metal	\$29
0	Pontic – cast noble metal	0
D621	Pontic – titanium and titanium alloys	\$29
1	Pontic – porcelain fused to high noble metal	0
D621	Pontic – porcelain fused to predominantly base metal	\$29
2	Pontic – porcelain fused to noble metal	0
D621	Pontic – porcelain fused to titanium and titanium alloys	\$29
4	Pontic – porcelain/ceramic	0
D624	Pontic – resin with high noble metal	\$29
0		0

D624

1 GCERT2012-DHMO-SOB

D624

2

D624

Code	Service	Your and Your Dependent's Co-Payment
D625	Pontic – resin with predominantly base metal	\$290
1	Pontic – resin with noble metal Further treatment or completion of diagnosis	\$290
D625	necessary prior to final impression.	\$85
2	Not to be used as a temporary pontic for a routine prosthetic restoration.	\$120
D625	Retainer – cast metal for resin bonded fixed prosthesis	\$120
3	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	\$90
D654	Resin retainer – for resin bonded fixed prosthesis	\$290
5	Retainer inlay – porcelain/ceramic, two surfaces	\$290
D654	Retainer inlay – porcelain/ceramic, three or more surfaces	\$290
8	Retainer inlay – cast high noble metal, two surfaces	\$290
D654	Retainer inlay – cast high noble metal, three or more surfaces	\$290
9	Retainer inlay – cast predominantly base metal, two surfaces	\$290
D660	Retainer inlay – cast predominantly base metal, three or more surfaces	\$290
0	Retainer inlay – cast noble metal, two surfaces	\$290
D660	Retainer inlay – cast noble metal, three or more surfaces	\$290
1	Retainer onlay – porcelain/ceramic, two surfaces	\$290
D660	Retainer onlay – porcelain/ceramic, three or more surfaces	\$290
2	Retainer onlay – cast high noble metal, two surfaces	\$290
D660	Retainer onlay – cast high noble metal, three or more surfaces	\$290
3	Retainer onlay – cast predominantly base metal, two surfaces	\$290
D660	Retainer onlay – cast predominantly base metal, three or more surfaces	\$290
4	Retainer onlay – cast noble metal, two surfaces	\$290
D660	Retainer onlay – cast noble metal, three or more surfaces	\$290
5	Retainer inlay – titanium	\$290
D660	Retainer onlay – titanium	\$290
6	Retainer crown – indirect resin based composite	\$290
D660	Retainer crown – resin with high noble metal	\$290
7	Retainer crown – resin with predominantly base metal	\$290
D660	Retainer crown – resin with noble metal	\$290
8	Retainer crown – porcelain/ceramic	\$290
D660	Retainer crown – porcelain fused to high noble metal	\$290
9	Retainer crown – porcelain fused to predominantly base metal	\$290
D661	Retainer crown – porcelain fused to noble metal	\$290
0	Retainer crown – porcelain fused to titanium and titanium alloys	\$290
D661	Retainer crown – $\frac{3}{4}$ cast high noble metal	\$290
1	Retainer crown – $\frac{3}{4}$ cast predominantly base metal	\$290
D661	Retainer crown – $\frac{3}{4}$ cast noble metal	\$290
2	Retainer crown – $\frac{3}{4}$ porcelain/ceramic	\$290
D661	Retainer crown – $\frac{3}{4}$ titanium and titanium alloys	\$290
3	Retainer crown – full cast high noble metal	\$290
D661	Retainer crown – full cast predominantly base metal	\$290
4	Retainer crown – full cast noble metal	
D661	Interim pontic. Further treatment or completion of diagnosis necessary prior to final	
5	impression. Not to be used as a temporary retainer crown for a routine prosthetic	
D662	restoration.	
4		
D6783		\$85
4		

Code	Service	Your and Your Dependent's Co-Payment
D679	Retainer crown – titanium and titanium alloys	\$290
4	Re-cement or re-bond fixed partial denture	\$0
D693	Stress breaker	\$110
0	Precision attachment. A pair of components constitutes one precision attachment, that is separate from the prosthesis.	\$195
D694	Fixed partial denture repair necessitated by restorative material failure	\$45
0		
Oral Surgery		
0	Includes routine post operative visits/treatment.	
0	The removal of asymptomatic third molars is not a Covered Service unless pathology (disease) exists.	
D698	Extraction, coronal remnants – primary tooth	\$5
D711	Extraction, erupted tooth or exposed root (<i>elevation and/or forceps removal</i>)	\$5
0		
D714	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	\$50
0	Removal of impacted tooth – soft tissue	\$50
D721	Removal of impacted tooth – partially bony	\$65
0	Removal of impacted tooth – completely bony	\$135
D722	Removal of impacted tooth – completely bony, with unusual surgical complications	\$150
0	Removal of residual tooth roots (<i>cutting procedure</i>)	\$40
D723	Coronectomy – intentional partial tooth removal, impacted teeth only: Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire tooth is removed.	\$135
0	Oroantral fistula closure	
D724	Primary closure of a sinus perforation	\$270
D726	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$275
D7261	Exposure of an unerupted tooth	\$80
D725		
D7270	Mobilization of erupted or malpositioned tooth to aid eruption	\$100
0		\$90
D7282	Placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.	\$90
D7283	Incisional biopsy of oral tissue – hard (<i>bone, tooth</i>)	\$150
D7285	Incisional biopsy of oral tissue – soft	\$60
D7286	Exfoliative cytological sample collection	\$50
D7287	Brush biopsy – transepithelial sample collection	\$50
D7288	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$40
D7291	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$40
D7310	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$25
D7311	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$190
D7320	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$65
D732	Vestibuloplasty – ridge extension (<i>secondary epithelialization</i>)	
1		\$370

Code	Service	Your and Your Dependent's Co-Payment
D7350	Vestibuloplasty – ridge extension (<i>including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue</i>)	\$990
D7450		\$130
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	\$335
D7471	Removal of benign odontogenic cyst or tumor – lesion diameter greater than	\$80
D7472	1.25 cm	\$60
D7473	Removal of lateral exostosis (<i>maxilla or mandible</i>)	\$60
D7485	Removal of torus palatinus	\$60
D7510	Removal of torus mandibularis	\$35
D7511	Reduction of osseous tuberosity	\$35
D7520	Incision and drainage of abscess – intraoral soft tissue	\$35
D7521	Incision and drainage of abscess – intraoral soft tissue – complicated (<i>includes drainage of multiple fascial spaces</i>)	\$35
D7550		\$125
D7560	Incision and drainage of abscess – extraoral soft tissue	\$505
D7910		\$25
D7921	Incision and drainage of abscess – extraoral soft tissue – complicated (<i>includes drainage of multiple fascial spaces</i>)	\$95
D7950		\$600
D7951	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$825
D7952	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$825
D7953	Suture of recent small wounds up to 5 cm	\$100
D7961	Collection and application of autologous blood concentrate product	\$90
D7962	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous	\$90
D7963	or nonautogenous, by report	\$90
D7970	Sinus augmentation with bone or bone substitutes via a lateral open approach	\$55
D7971	Sinus augmentation via a vertical approach	\$40
D7972	Bone replacement graft for ridge preservation – per site	\$125
	Buccal / labial frenectomy (<i>frenulectomy</i>)	
	lingual frenectomy (<i>frenulectomy</i>)	
	Frenuloplasty	
	Excision of hyperplastic tissue – per arch	
	Excision of pericoronal gingiva	
	Surgical reduction of fibrous tuberosity	

Orthodontics

- Benefits cover twenty-four (24) months of usual & customary Orthodontic treatment and an additional twenty four (24) months of retention.
 - Comprehensive Orthodontic benefits include all phases of treatment and fixed/removable appliances.
- | | | |
|------|---|---------|
| D801 | Limited orthodontic treatment of the primary dentition | \$1,095 |
| 0 | Limited orthodontic treatment of the transitional dentition | \$1,095 |
| D802 | Limited orthodontic treatment of the adolescent dentition | \$1,095 |
| 0 | Limited orthodontic treatment of the adult dentition | \$1,095 |
| D803 | Comprehensive orthodontic treatment of the transitional dentition | \$2,095 |
| 0 | Comprehensive orthodontic treatment of the adolescent dentition | \$2,095 |
| D804 | Comprehensive orthodontic treatment of the adult dentition | \$2,095 |
| 0 | Pre-orthodontic treatment examination to monitor growth and development | \$35 |
| D807 | Periodic orthodontic treatment visit | \$35 |
| 0 | | |

Code	Service	Your and Your Dependent's Co-Payment
D8680	Orthodontic retention (<i>removal of appliances, construction and placement of retainer(s)</i>)	\$300
D8681	Removable orthodontic retainer adjustment	\$0
D8698	Re-cement or re-bond fixed retainer – maxillary	\$0
D8699	Re-cement or re-bond fixed retainer – mandibular	\$0
D8701	Repair of fixed retainer, includes reattachment – maxillary	\$0
D8702	Repair of fixed retainer, includes reattachment – mandibular	\$0

- • There is a Co-Payment of \$250 for Orthodontic treatment planning and records (*pre/post x-rays (cephalometric, panoramic, etc.), photos, study models*).
- There is a Co-Payment of \$25 per visit for Orthodontic visits beyond twenty-four (24) months of active treatment or retention.

Adjunctive General Services		
D9110	Palliative treatment of dental pain per visit: Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes. This is typically reported on a “per-visit” basis for emergency treatment of dental pain. Fixed partial denture sectioning	\$10
D9120	denture sectioning	\$0
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0
D9211	Regional block anesthesia	\$0
D9212	Trigeminal division block anesthesia	\$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	\$0
D9222	Deep sedation/general anesthesia – first 15 minutes	\$60
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	\$60
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis Intravenous moderate (<i>conscious</i>)	\$15
D9239	sedation/analgesia- first 15 minutes	\$60
D9243	Intravenous moderate (<i>conscious</i>) sedation/analgesia – each subsequent 15 minute	\$60
D9248	increment	\$15
D9310	Non-intravenous conscious sedation	\$0
D9311	Consultation – diagnostic service provided by dentist or physician other than	\$0
D9430	requesting dentist or physician	\$30
D9440	Consultation with a medical health care professional	\$0
D9450	Office visit for observation (<i>during regularly scheduled hours</i>) – no other services	\$15
D9610	performed	\$25
D9630	Office visit – after regularly scheduled hours	\$15
D9910	Case presentation, subsequent to detailed and extensive treatment planning.	\$15
D9930	Therapeutic parenteral drug, single administration	\$0
D9932	Therapeutic parenteral drugs, two or more administrations, different medications	\$55
D9933	Drugs or medicaments dispensed in the office for home use	\$55
D9934	Application of desensitizing medicament	\$55
D9935	Treatment of complication (<i>post-surgical</i>) – unusual circumstances, by report	\$55
D9942	Cleaning and inspection of removable complete denture, maxillary	\$40
D9943	Cleaning and inspection of removable complete denture, mandibular	\$10
D9944	Cleaning and inspection of removable partial denture, maxillary	\$85
	Cleaning and inspection of removable partial denture, mandibular	
	Repair and/or reline of occlusal guard	
	Occlusal guard adjustment	
	Occlusal guard – hard appliance, full arch	

Code	Service	Your and Your Dependent's Co-Payment
D994	Occlusal guard – soft appliance, full arch	\$85
5	Occlusal guard – hard appliance, partial arch	\$64
D994	Occlusal adjustment – limited	\$30
6	Occlusal adjustment – complete	\$100
D995	Infiltration of sustained release therapeutic drug, per quadrant. Infiltration of a sustained release pharmacologic agent for long acting surgical site pain control. Not for local anesthesia purposes.	\$15
D995	Fabrications and delivery of oral appliance therapy (OAT) morning repositioning device	\$16
D961	Oral appliance therapy (OAT) titration visit	\$10
3	Missed appointment (<i>less than 24-hr notice</i>)	Not to exceed \$25
D995	Cancelled appointment (<i>if less than 24-hr notice, see D9986</i>)	\$0
5	Current Dental Terminology © American Dental Association	
D998		

6

D998

7

Dental benefits: Limitations and additional charges

General

1. Specialty Care Dentists will accept the contracted fee for all Covered Services.
2. General anesthesia or IV sedation is a Covered Service only if it is provided in a Selected General Dental Office, administered by the Selected General Dentist or Specialty Care Dentist, and is in conjunction with covered oral and periodontal surgical procedures or when deemed necessary by the Selected General Dentist or Specialty Care Dentist.
3. Sterilization and infection control are not billable to Us or You or Your Dependent and are included within the charges for other services provided on that date of service.
 - a. Local Anesthetic is included in all restorative and surgical procedure fees.
 - b. All adhesives, liners, bases and occlusal adjustments are included as a part of the restorative procedure.

Diagnostic

1. Panoramic or full mouth x-rays (*including bitewings*): once every three (3) years, unless Dentally Necessary for a specific dental problem.
2. All costs for additional periapical and bitewing x-rays provided on the same day that a full mouth x-ray is provided to You or Your Dependent are included in the costs for the full mouth x-ray.

Preventive

1. Routine cleanings (*oral Prophylaxis*), periodontal maintenance services (*following active periodontal therapy*) and fluoride treatments are limited to twice a year. Two (2) additional cleanings (*routine and periodontal*) are available at the Co-Payment listed in the SCHEDULE OF BENEFITS. Additional Prophylaxis are available, if Dentally Necessary.
2. Sealants and/or preventive resin restorations: Plan benefit applies to primary and permanent molar teeth, limited to age 19, one (1) per tooth, per thirty-six (36) months, unless Dentally Necessary.
3. Space maintainers are covered to age 14 once per area, per lifetime. Replacement of lost space maintainers are not a Covered Service.

Restorative Treatment

Crowns, Implants and Fixed Bridges

1. An additional charge, not to exceed \$150 per unit, will be applied for any procedure using noble, high noble or titanium metal.
2. Cases involving seven (7) or more Crowns, implants and/or fixed Bridge units in the same treatment plan require an additional \$125 Co-Payment per unit in addition to the specified Co-Payment for each Crown, implant or Bridge unit.
3. There is a \$75 Co-Payment per molar, for the use of porcelain.
4. Prefabricated stainless steel Crowns or prefabricated resin Crowns are limited to no more than one (1) replacement for the same tooth surface within five (5) years.
5. Charges for temporary Crowns/restorations are included within the costs of the permanent Crown/restoration.
6. Provisional Crowns/restorations are to be used for an interim of at least six (6) months duration. Interim Crowns/restorations are to be used for a period of at least two (2) months duration. These procedures are to be utilized during restorative treatment to allow adequate time for healing or completion of other procedures. They are not to be used as temporary restorations.
7. Replacement of any Cast Restorations with the same or a different type of Cast Restoration are limited to no more than once every five (5) years.
8. Core buildups are limited to no more than once per tooth in a period of five (5) years.
9. Post and cores are limited to no more than once per tooth in a period of five (5) years.
10. Labial veneers are limited to no more than once per tooth in a period of five (5) years.

Prosthodontics

1. Relinings and rebasings are limited to one (1) every twelve (12) months.
2. Dentures (*full or partial*): Replacement only after five (5) years have elapsed following any prior provision of such Dentures under a SafeGuard Plan, unless due to the loss of a natural tooth which cannot be added to the existing partial. Replacements will be a benefit under this Plan only if the existing Denture is unsatisfactory and cannot be made satisfactory as determined by the treating Selected General Dentist or Specialty Care Dentist.
3. Replacement of an immediate full Denture with a permanent full Denture if the immediate full Denture cannot be made permanent and such replacement is done within twelve (12) months of the installation of the immediate full Denture.
4. Adjustments of Dentures if at least six (6) months have passed since the installation of the existing removable Denture.
5. Delivery of removable and fixed Prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
6. Tissue conditioning eligible one (1) per appliance each twenty-four (24) months.

7. Provisional prostheses are to be used for an interim of at least six (6) months duration. Interim prostheses are to be used for a period of at least two (2) months duration. These procedures are to be utilized during restorative treatment to allow adequate time for healing or completion of other procedures. They are not to be used as temporary restorations.

Implant Services

1. Implants are limited to no more than once for the same tooth position in a five (5) year period.
2. Repairs of implants are limited to not more than once in a twelve (12) month period.
3. Implant supported prosthetics are limited to no more than once for the same tooth position in a five (5) year period:
 - when needed to replace congenitally missing teeth; or
 - when needed to replace natural teeth.
4. The following are limited to no more than two (2) each per year: Implants, Implant supported prosthetics, and Implant abutments.

Endodontics

1. The Co-Payments listed for Endodontic procedures do not include the cost of the final restoration.
2. Materials used for canal irrigation are included in the Endodontic procedure fees.

Oral Surgery

1. The removal of asymptomatic third molars is not a Covered Service. Pathology (*disease*) must exist for it to be covered by the program.
2. Includes routine post operative visits/treatments.

Periodontics

1. Irrigation (*such as Chlorhexidine*), is included with the other services rendered that day.
2. Local chemotherapeutic agents are limited to no more than six (6) teeth per arch. Treatment plans involving more than six (6) teeth per arch, require prior Plan approval.
3. Periodontal maintenance is eligible following active periodontal therapy, which includes scaling and root planing, surgery, etc.
4. Periodontal scaling and root planing, is limited to not more than once per Quadrant in any twenty-four (24) month period.
5. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, is limited to no more than one surgical procedure per Quadrant in any thirty-six (36) month period.
6. Periodontal charting for planning treatment of periodontal disease is included as part of overall diagnosis and treatment. No additional charge will apply to You or Your Dependent or Us.

Orthodontics

1. If You or Your Dependent require the services of an orthodontist, a referral must first be facilitated by Your Selected General Dentist. If a referral is not obtained before the Orthodontic treatment begins, You will be responsible for all costs associated with any Orthodontic treatment.
2. If You or Your Dependent terminate coverage from the SafeGuard Plan after the start of Orthodontic treatment, You will be responsible for any additional charges incurred for the remaining Orthodontic treatment.
3. Orthodontic treatment must be provided by a Selected General Dentist or Specialty Care Dentist whose specialty is orthodontics or pediatric dentistry for the Co-Payments listed in this SCHEDULE OF BENEFITS to apply.
4. Plan benefits shall cover twenty-four (24) months of usual and customary Orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a charge of \$25 per visit.
5. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.
6. If You or Your Dependent started orthodontic treatment before Your coverage for Yourself or that Dependent started under this group contract, Continuing Orthodontic treatment is available under this group contract for You or Your Dependent under any of the following circumstances:
 - a. You were covered under the terms of a dental plan provided by SafeGuard and, due to an acquisition, are now covered under the terms of this group contract;
 - b. You were covered under the terms of a dental plan provided by a carrier other than SafeGuard and are now covered under the terms of this group contract because the Contractholder subsequently contracts with SafeGuard;
 - c. You become eligible for DHMO benefits under the terms of this group contract because of Your status as a new employee; or
 - d. You were covered under the terms of a dental plan and received orthodontic services which were not covered because that dental plan did not offer orthodontic coverage.

Upon receipt of a completed Continuing Orthodontic Form by Us, with all supporting documentation, We will accept liability for continuing payment of the remaining balance owed, up to a maximum of \$1,500 times the percentage of the total treatment remaining as of this group contract's Effective Date, subject to the section titled DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES and DENTAL BENEFITS: EXCLUSIONS. Continuing Orthodontic treatment will be available if You enroll within 30 days of the date You become eligible for benefits under the terms of this group contract.

Dental benefits: Exclusions

1. Any procedures not specifically listed as a Covered Service in this SCHEDULE OF BENEFITS or dental procedures or services performed solely for Cosmetic purposes (*unless specifically listed as a Covered Service in this SCHEDULE OF BENEFITS*), are not covered.
2. Covered Services must be performed by Your Selected General Dental Office or a SafeGuard Specialty Care Dentist to whom You are referred in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS. Services performed by any Dentist not contracted with SafeGuard are not Covered Services, without prior approval by SafeGuard or Your Selected General Dentist, in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS (*except for out-of-area emergency services*).
3. Dental procedures started prior to Your or Your Dependent's eligibility under this SCHEDULE OF BENEFITS or started after Your or Your Dependent's benefits have ended. For example, teeth prepared for Crowns, root canals in progress (*the tooth has been opened into the pulp (nerve chamber)*), or full or partial Dentures for which an impression has been taken.
4. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Selected General Dentist, and Us based on generally accepted dental standards of care.
5. Orthognathic surgery.
6. Inpatient/outpatient hospital charges of any kind, including prescriptions or medications, except for palliative care for an Emergency Dental Condition. General anesthesia or IV sedation is not covered for any reason if rendered in an out patient facility or hospital. Dental charges will be covered, if the procedure performed is covered by the Plan.
7. Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
8. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in the SCHEDULE OF BENEFITS. Any services related to pathology laboratory fees.
9. Procedures, appliances, or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital malformation, developmental, or medically induced dental disorders including, but not limited to, treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a Covered Service in this SCHEDULE OF BENEFITS.
10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
11. Dental services required while serving in the armed forces of any country or international authority.
12. Dental services considered Experimental or Investigational in nature. If We make a determination that a Dental service is Experimental or Investigational in nature, this Adverse Determination may be appealed as described in the section titled APPEAL OF ADVERSE DETERMINATION in Your Evidence of Coverage.
13. Treatment required due to an accident from an external force, unless otherwise listed as Covered Service in this SCHEDULE OF BENEFITS.
14. The following are not included as Orthodontic benefits:
 - Repair or replacement of lost or broken appliances;
 - Retreatment of Orthodontic cases;
 - Treatment involving:
 - Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
 - Hormonal imbalances or other factors affecting growth or developmental abnormalities;
 - Treatment related to temporomandibular joint disorders;
 - Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or
 - Cosmetic alternatives to standard fixed and removable Orthodontic appliances.Invisalign services are excluded.