VIII: Dental procedure guidelines

Dental procedure guidelines

A detailed description of the covered services and levels of copayment by plan code for DMO plans is available on the secure website, **www.aetnadental.com**. Each procedure is listed by CDT code* and nomenclature, along with guidelines for coverage and the level of copayment.

For any plan code not included, please call the National Dentist Line at **1-800-451-7715**.

Coverage for any service not specifically listed on the applicable charts will be as determined by Aetna in its sole discretion. Furthermore, additional codes may be added and codes may be deleted at our discretion. Except as specified otherwise, "codes" refer to codes of the American Dental Association ("ADA"). The appropriate code must be designated when billing or when submitting claims or encounter information.

Your participating provider agreement requires your office to comply with Aetna policies and procedures. This includes the guidelines for dental procedures as shown on the DMO plan code charts available at **www.aetnadental.com**.

Dental Procedure Guidelines
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ADA CODE[1]	NOMENCLATURE	GUIDELINES	E	F	G	H	I	J	K	L -LM Li	M Mi	Q	U Ui	UAB	UNJ
	Office Visit Copay	Check Roster When an Office Visit copay applies, the DMO Patient Roster will show the amount under column "Office Copay" (i.e. 000 = $0.00; 005 = $5.00). When submitted, use ADA code D0999.													
	Infection Control	May not bill patient for infection control procedures													
		Frequency limits on Preventive and Diagnostic services are waived in Arizona, California and Texas if medically necessary.													
D0120	Periodic Oral Evaluation - Established Patient	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0140	Limited Oral Evaluation - Problem Focused	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0145	Oral Evaluation for a Patient under Three Years of Age and Counseling with a Primary Caregiver	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0150	Comprehensive Oral Evaluation - New or Established Patient	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, by Report	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0170	Re-Evaluation - Limited, Problem Focused (Established Patient; not Post-Operative Visit)	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0171	Re-Evaluation - Post-Operative Office Visit	Inclusive to surgery. Patient cannot be billed.	0	0	0	0	0	0	0	0	0	0	0	0	0
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0190-D0191[2]	Screening / Assessment of a Patient	Inclusive to oral evaluation Patient cannot be billed	0	0	0	0	0	0	0	0	0	0	0	0	0
D0210	Intraoral - Complete Series of Radiographic Images	FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0220-D0230	Intraoral - Periapical Image		0	0	0	0	0	0	0	0	0	0	0	0	0
D0240	Intraoral - Occlusal Radiographic Image		0	0	0	0	0	0	0	0	0	0	0	0	0
D0250-D0251	Extra-Oral Image		0	0	0	0	0	0	0	0	0	0	0	0	0
D0270-D0274	Bitewing Radiographic Image	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	0	0	0	0	0	0	0	0	0	0	0	0	0
D0277	Vertical Bitewings - 7 to 8 Radiographic Images	1 series every 3 years	0	0	0	0	0	0	0	0	0	0	0	0	0
D0310	Sialography	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0320-D0321	Temporomandibular Joint Image	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0322	Tomographic Survey	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0330	Panoramic Radiographic Image	FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0340	2D Cephalometric Radiographic Image – Acquisition, Measurement and Analysis	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0350	2D Oral/Facial Photographic Image Obtained Intra-orally or Extra-orally	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D0364-D0368	Cone Beam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0369-D0371	Capture and Interpretation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0372	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0373	Intraoral Tomosynthesis – Bitewing Radiographic Image	Pre Nov 2000 Plans (*) — 1 Bitewing series 2x per year DMO Standard Plans (#) — 1 Bitewing series per year	0	0	0	0	0	0	0	0	0	0	0	0	0
D0374	Intraoral Tomosynthesis – Periapical Radiographic Image		0	0	0	0	0	0	0	0	0	0	0	0	0
D0387	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images – Image Capture Only	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0	N/C	N/C	N/C	N/C
D0388	Intraoral Tomosynthesis – Bitewing Radiographic Image – Image Capture Only	Pre Nov 2000 Plans (*) — 1 Bitewing series 2x per year DMO Standard Plans (#) — 1 Bitewing series per year	0	0	0	0	0	0	0	0	0	N/C	N/C	N/C	N/C
D0389	Intraoral Tomosynthesis – Periapical Radiographic Image – Image Capture Only		0	0	0	0	0	0	0	0	0	0	0	0	0
D0380-D0384	Cone Beam CT Image Capture	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	0	0	0	0
D0385-D0386	Cone Beam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	0	0	0	0
D0391	Interpretation of Diagnostic Image by Practitioner Not Associated with Capture of the Image, Including Report		0	0	0	0	0	0	0	0	0	0	0	0	0
D0393-D0395	3D Images	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0396	3D printing of a 3D dental surface scan	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0411	HbA1c In-office Point of Service Testing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0412	Blood Glucose Level Test – In-office Using a Glucose Meter	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0415	Collection of Microorganisms	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0416	Viral Culture	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0417	Collection & Preparation of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0418	Analysis of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0419	Assessment of Salivary Flow by Measurement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0422	Collection and Preparation of Genetic Sample Material for Laboratory Analysis and Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0423	Genetic Test for Susceptibility to Diseases – Specimen Analysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0425	Caries Susceptibility Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D0431	Adjunctive Pre-Diagnostic Test	The use of any tools and/or devices that assist in a diagnosis to be an adjunctive technique that is part of the oral evaluation or primary service. Members cannot be billed for this service.	0	0	0	0	0	0	0	0	0	0	0	0	0
D0460	Pulp Vitality Tests	Inclusive to oral evaluation Patient cannot be billed	0	0	0	0	0	0	0	0	0	0	0	0	0
D0470	Diagnostic Casts		0	0	0	0	0	0	0	0	0	0	0	0	0
D0472-D0474	Accession of Tissue		0	0	0	0	0	0	0	0	0	0	0	0	0
D0475-D0502	Oral Pathology Laboratory Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0601-D0603[2]	Caries Risk Assessment	Inclusive to oral evaluation	0	0	0	0	0	0	0	0	0	0	0	0	0
D0604	Antigen testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0605	Antibody testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0606	Molecular testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0701	panoramic radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0330. FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0	0	0	0	0
D0702	2-D cephalometric radiographic image – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0705	extra-oral posterior dental radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0251.	0	0	0	0	0	0	0	0	0	0	0	0	0
D0706	intraoral – occlusal radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0240.	0	0	0	0	0	0	0	0	0	0	0	0	0
D0707	intraoral – periapical radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0220.	0	0	0	0	0	0	0	0	0	0	0	0	0
D0708	intraoral – bitewing radiographic image – image capture only	Only eligible when submitted with D0391 Inclusive when submitted with D0270 Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	0	0	0	0	0	0	0	0	0	0	0	0	0
D0709	intraoral – complete series of radiographic images – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0210. FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0	0	0	0	0

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D0801	3D Intraoral Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0802	3D Dental Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0803	3D Facial Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0804	3D Facial Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0999	Unspecified Diagnostic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1110	Prophylaxis – Adult	Limited to 2 per year. (Some pre-1991 plans may have 6 per year.) Plan UAB = 3 per year	0	0	0	0	0	0	0	0	0	0	0	0	0
D1120	Prophylaxis – Child	Limited to 2 per year. (Some pre-1991 plans may have 6 per year.) Plan UAB = 3 per year	0	0	0	0	0	0	0	0	0	0	0	0	0
D1206	Topical Application of Fluoride Varnish	1x per year Pre Nov 2000 Plans (*) - Age Limit = 18 DMO Standard Plans (#) – Age Limit = 16	0	0	0	0	0	0	0	0	0	0	0	0	0
D1208	Topical Application of Fluoride – Excluding Varnish	1x per year Pre Nov 2000 Plans (*) - Age Limit = 18 DMO Standard Plans (#) – Age Limit = 16	0	0	0	0	0	0	0	0	0	0	0	0	0
D1301	Immunization Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1310-D1321	Nutritional or Tobacco Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1330	Oral Hygiene Instruction		0	0	0	0	0	0	0	0	0	0	0	0	0
D1351	Sealant – per Tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years for permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children). Plan UAB - Permanent molars only (up to age 19)	0	0	0	0	0	0	0	0	0	0	0	0	0
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years for permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	0	0	0	0	0	0	0	0	0	0	0	0	0
D1353	Sealant Repair - per Tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to permanent molars and to covered persons under age 16 (not limited to dependent children).	0	0	0	0	0	0	0	0	0	0	0	0	0

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D1354	Application of Caries Arresting Medicament – per Tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years for permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children). Plan UAB - Permanent molars only (up to age 19)	0	0	0	0	0	0	0	0	0	0	0	0	0
D1355	Caries preventive medicament application – per tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years for permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	0	0	0	0	0	0	0	0	0	0	0	0	0
		Space Maintainers – Covered as a Major Service under "Pre November 2000 plans" (*) and a Preventive Service under "DMO Standard Plans" (#). First Copayment = "Pre Nov 2000 Plan" Second Copayment = "DMO Standard Plan"													
D1510	Space Maintainer - Fixed, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	0 0	0 0	0 0	0 0
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	0 0	0 0	0 0	0 0
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	0 0	0 0	0 0	0 0
D1520	Space Maintainer - Removable, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	25% 0	0 0	0 0	0 0
D1526	Space Maintainer – Removable – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	25% 0	0 0	0 0	0 0
D1527	Space Maintainer – Removable – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	25% 0	0 0	0 0	0 0
D1551	Re-cement or re-bond bilateral space maintainer – maxillary		0	0	0	0	0	0	0	0	0	0	0	0	0
D1552	Re-cement or re-bond bilateral space maintainer – mandibular		0	0	0	0	0	0	0	0	0	0	0	0	0
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant		0	0	0	0	0	0	0	0	0	0	0	0	0

Plan Code - The symbol shown on the roster before the plan code indicates the applicable plan provisions.
* Pre November 1, 2000 Plan
# DMO Standard Plan

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D1556	Removal of fixed unilateral space maintainer – per quadrant		0	0	0	0	0	0	0	0	0	0	0	0	0
D1557	Removal of fixed bilateral space maintainer – maxillary		0	0	0	0	0	0	0	0	0	0	0	0	0
D1558	Removal of fixed bilateral space maintainer – mandibular		0	0	0	0	0	0	0	0	0	0	0	0	0
D1575	Distal shoe space maintainer – fixed, unilateral - per quadrant	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	30% 0	10% 0	20% 0	25% 0	30% 0	40% 0	50% 0	0 0	0 0	0 0	0 0
D1701 - D1714	Covid-19 vaccine administration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1781 - D1783	Vaccine Administration – Human Papillomavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		<u>Effective 11/1/2020</u> - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is considered part of the primary service done on the same day. Member cannot be charged. **<u>Prior to 11/1/2020</u> - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is not covered. The member will be responsible for the charge.**													
D1999	Unspecified Preventive Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2140	Amalgam – 1 Surface, Primary or Permanent		0	0	0	0	0	0	0	0	0	0	0	0	0
D2150	Amalgam – 2 Surfaces, Primary or Permanent		0	0	0	0	0	0	0	0	0	0	0	0	0
D2160	Amalgam – 3 Surfaces, Primary or Permanent		0	0	0	0	0	0	0	0	0	0	0	0	0
D2161	Amalgam – 4+ Surfaces, Primary or Permanent		0	0	0	0	0	0	0	0	0	0	0	0	0
D2330	Resin-Based Composite – 1 Surface, Anterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D2331	Resin-Based Composite – 2 Surfaces, Anterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D2332	Resin-Based Composite – 3 Surfaces, Anterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D2335	Resin-Based Composite – 4+ Surfaces or Involving Incisal Angle, Anterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D2390	Resin-Based Composite Crown, Anterior		0	0	0	0	0	0	0	0	0	0	0	0	0
		<u>Effective 1/1/2024</u>, <u>posterior resin/composite restorations will no longer be subject to an upgrade</u>. DMO patients are only responsible for the applicable copayment based on the service performed. For percentage-based co-insurance plans, Aetna will pay a supplemental benefit to your office for posterior composite restorations (refer to the Network Bulletin October 2023). You must submit an encounter/claim to receive the procedure based supplemental payment. **<u>Prior to 1/1/2024</u> -** If you first offer an amalgam restoration and the patient elects to have a resin restoration on a molar or on the stress-bearing surfaces of a premolar, the patient is responsible for the copayment, if any, for an amalgam restoration plus the difference between your Usual and Customary fees for the resin restoration and the amalgam restoration. (Refer to Elective Services/Optional Treatment Plans.) If the office does not have an amalgam fee, use the corresponding resin fee reduced by 20%. **Plan Code UAB - Alternate benefit does not apply.**													
D2391	Resin-Based Composite – 1 Surface, Posterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D2392	Resin-Based Composite – 2 Surfaces, Posterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D2393	Resin-Based Composite – 3 Surfaces, Posterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D2394	Resin-Based Composite – 4+ Surfaces, Posterior		0	0	0	0	0	0	0	0	0	0	0	0	0

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	E	F	G	H	I	J	K	L -LM Li	M Mi	Q	U Ui	UAB	UNJ
D2410 - D2430	Gold Foil	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Crowns/Inlays Procedure Codes: **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Eligible for plan benefit when tooth cannot be restored with a filling. Plan benefit available for one crown once every 5 years per tooth.** **Facings on molar crowns and pontics will always be considered cosmetic.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)**													
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.												
D2510	Inlay – Metallic - 1 Surface		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2520	Inlay – Metallic - 2 Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2530	Inlay – Metallic - 3 or More Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2542	Onlay – Metallic - 2 Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2543	Onlay – Metallic - 3 Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2544	Onlay - Metallic – 4 or More Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2610	Inlay, Porcelain/Ceramic – 1 Surface		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2620	Inlay, Porcelain/Ceramic – 2 Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2630	Inlay, Porcelain/Ceramic – 3 or More Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2642	Onlay, Porcelain/Ceramic – 2 Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2643	Onlay, Porcelain/Ceramic – 3 Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2644	Onlay, Porcelain/Ceramic – 4 or More Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2650	Inlay, Resin Based Composite – 1 Surface		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2651	Inlay, Resin Based Composite – 2 Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2652	Inlay, Resin Based Composite – 3 or more Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2662	Onlay, Resin Based Composite – 2 Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2663	Onlay, Resin Based Composite – 3 Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2664	Onlay, Resin Based Composite – 4 or More Surfaces		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2710	Crown – Resin-Based Composite, Indirect		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2712	Crown – 3/4 Resin-Based Composite, Indirect		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2720	Crown – Resin with High Noble Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2721	Crown – Resin with Predominantly Base Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2722	Crown – Resin with Noble Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2740	Crown – Porcelain/ Ceramic		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2750	Crown – Porcelain Fused to High Noble Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	E	F	G	H	I	J	K	L -LM Li	M Mi	Q	U Ui	UAB	UNJ
D2751	Crown – Porcelain Fused to Predominantly Base Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2752	Crown – Porcelain Fused to Noble Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2753	Crown - porcelain fused to titanium and titanium alloys		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2780	Crown – 3/4 Cast High Noble Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2781	Crown – 3/4 Cast Predominantly Base Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2782	Crown – 3/4 Cast Noble Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2783	Crown – 3/4 Cast Porcelain/Ceramic		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2790	Crown – Full Cast High Noble Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2791	Crown – Full Cast Predominantly Base Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2792	Crown – Full Cast Noble Metal		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2794	Crown – Titanium and Titanium Alloys		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2799	Interim Crown – Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	0	0	0	0	0	0	0	0	0	0	0	0	0
D2910	Re-cement Or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration		0	0	0	0	0	0	0	0	0	0	0	0	0
D2915	Re-Cement or Re-Bond Indirectly Fabricated or Prefabricated Post and Core		0	0	0	0	0	0	0	0	0	0	0	0	0
D2920	Re-Cement or Re-Bond Crown		0	0	0	0	0	0	0	0	0	0	0	0	0
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp		0	0	0	0	0	0	0	0	0	0	0	0	0
D2928	Prefabricated Porcelain/Ceramic Crown – Permanent Tooth	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	0	0	0	0	0	0	0	0	0	0	0	0	0
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	Alternate benefit based on D2930 Plan UAB - Alternate benefit does not apply.	0	0	0	0	0	0	0	0	0	0	0	0	0
D2930	Prefabricated Stainless Steel Crown – Primary Tooth		0	0	0	0	0	0	0	0	0	0	0	0	0
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	When used as permanent crown, subject to permanent tooth crown frequency limit. Eligible as temp only when used as temp restoration until adult dentition formed or when used due to accident away from home. Otherwise, temp is included in final restoration and not separately eligible.	0	0	0	0	0	0	0	0	0	0	0	0	0
D2932	Prefabricated Resin Crown	Alternate benefit based on D2930 or D2931 Plan UAB - Alternate benefit does not apply.	0	0	0	0	0	0	0	0	0	0	0	0	0
D2933	Prefabricated Stainless Steel Crown with Resin Window	Alternate benefit based on D2930 or D2931 Plan UAB - Alternate benefit does not apply.	0	0	0	0	0	0	0	0	0	0	0	0	0
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	Alternate benefit based on D2930 Plan UAB - Alternate benefit does not apply.	0	0	0	0	0	0	0	0	0	0	0	0	0
D2940	Placement of Interim Direct Restoration		0	0	0	0	0	0	0	0	0	0	0	0	0

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D2941	Interim Therapeutic Restoration – Primary Dentition		0	0	0	0	0	0	0	0	0	0	0	0	0
D2949[2]	Restorative Foundation for an Indirect Restoration	Inclusive to permanent restoration	0	0	0	0	0	0	0	0	0	0	0	0	0
D2950	Core Buildup, Including Any Pins When Required		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2951	Pin Retention – Per Tooth, In Addition to Restoration		0	0	0	0	0	0	0	0	0	0	0	0	0
D2952	Post & Core In Addition to Crown, Indirectly Fabricated		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2953	Each Additional Indirectly Fabricated Post – Same Tooth		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2954	Prefabricated Post & Core In Addition To Crown		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2955	Post Removal	Included in cost of replacement post	0	0	0	0	0	0	0	0	0	0	0	0	0
D2956	Removal of an Indirect Restoration on a Natural Tooth	Not to be used as a temporary or provisional restoration. Inclusive to any restorative service.	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2957	Each Additional Prefabricated Post - Same Tooth		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2960	Labial Veneer (Resin Laminate) – Chairside	Not covered when done solely for Cosmetic or aesthetic reasons and without the presence of decay or other pathologic condition.	40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2961	Labial Veneer (Resin Laminate) – Laboratory	Not covered when done solely for Cosmetic or aesthetic reasons and without the presence of decay or other pathologic condition.	40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2962	Labial Veneer (Porcelain Laminate) – Laboratory	Not covered when done solely for Cosmetic or aesthetic reasons and without the presence of decay or other pathologic condition.	40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2971	Additional Procedures to Customize a Crown to Fit under an Existing Partial Denture Framework		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2975	Coping	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2976	Band Stabilization – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2980	Crown Repair Necessitated by Restorative Material Failure		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2981	Inlay Repair Necessitated by Restorative Material Failure		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2982	Onlay Repair Necessitated by Restorative Material Failure		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2983	Veneer Repair Necessitated by Restorative Material Failure		40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D2989	Excavation of a Tooth Resulting in the Determination of Non-restorability	Restorations, endodontics, and/or D4249 on same day/same tooth will be denied.	0	0	0	0	0	0	0	0	0	0	0	0	0

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D2990	Resin Infiltration of Incipient Smooth Surface Lesions	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years and to covered persons under age 16 (not limited to dependent children). Plan UAB - Permanent molars only (up to age 19)	0	0	0	0	0	0	0	0	0	0	0	0	0
D2991	Application of Hydroxyapatite Regeneration Medicament – per Tooth	One application per tooth, regardless of the number of appointments required to complete the full application. Once tooth application is completed, limited to once every 3 years for permanent teeth (1-32).	0	0	0	0	0	0	0	0	0	0	0	0	0
D2999	Unspecified Restorative Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3110	Pulp Cap – Direct (Excluding Final Restoration)		0	0	0	0	0	0	0	0	0	0	0	0	0
D3120	Pulp Cap – Indirect (Excluding Final Restoration)		0	0	0	0	0	0	0	0	0	0	0	0	0
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	If done in conjunction with root canal therapy, included in cost of RCT	0	0	0	0	0	0	0	0	0	0	0	0	0
D3221	Pulpal Debridement, Primary And Permanent Teeth	Considered inclusive with the Endodontic treatment when completed on the same day	0	0	0	0	0	0	0	0	0	0	0	0	0
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development		0	0	0	0	0	0	0	0	0	0	0	0	0
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)		0	0	0	0	0	0	0	0	0	0	0	0	0
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)		0	0	0	0	0	0	0	0	0	0	0	0	0
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)		0	0	0	0	0	0	0	0	0	0	0	0	0
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)		0	0	0	0	0	0	0	0	0	0	0	0	0
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)		0	0	0	10%	20%	25%	30%	40%	50%	25%	0	0	0
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access		0	0	0	0	0	0	0	0	0	0	0	0	0
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth		0	0	0	0	0	0	0	0	0	0	0	0	0
D3333	Internal Root Repair of Perforation Defects		0	0	0	0	0	0	0	0	0	0	0	0	0
D3346	Retreatment of Previous Root Canal Therapy – Anterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D3347	Retreatment of Previous Root Canal Therapy – Premolar		0	0	0	0	0	0	0	0	0	0	0	0	0
D3348	Retreatment of Previous Root Canal Therapy – Molar		0	0	0	10%	20%	25%	30%	40%	50%	25%	0	0	0

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D3351	Apexification/Recalcification – Initial Visit		0	0	0	0	0	0	0	0	0	0	0	0	0
D3352	Apexification/Recalcification – Interim Medication Replacement		0	0	0	0	0	0	0	0	0	0	0	0	0
D3353	Apexification/ Recalcification – Final Visit		0	0	0	0	0	0	0	0	0	0	0	0	0
D3355	Pulpal Regeneration - Initial Visit		0	0	0	0	0	0	0	0	0	0	0	0	0
D3356	Pulpal Regeneration – Interim Medication Replacement		0	0	0	0	0	0	0	0	0	0	0	0	0
D3357	Pulpal Regeneration – Completion of Treatment		0	0	0	0	0	0	0	0	0	0	0	0	0
D3410	Apicoectomy – Anterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D3421	Apicoectomy – Premolar (First Root)		0	0	0	0	0	0	0	0	0	0	0	0	0
D3425	Apicoectomy – Molar (First Root)		0	0	0	0	0	0	0	0	0	0	0	0	0
D3426	Apicoectomy – Each Additional Root		0	0	0	0	0	0	0	0	0	0	0	0	0
D3428	Bone Graft In Conjunction With Periradicular Surgery - per Tooth, Single Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3429	Bone Graft in Conjunction with Periradicular Surgery - Each Additional Contiguous Tooth in the Same Surgical Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3430	Retrograde Filling – per Root		0	0	0	0	0	0	0	0	0	0	0	0	0
D3431	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction With Periradicular Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3432	Guided Tissue Regeneration, Resorbable Barrier, per Site, In Conjunction with Periradicular Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3450	Root Amputation – per Root		0	0	0	0	0	0	0	0	0	0	0	0	0
D3460	Endodontic Endosseous Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3470	Intentional Re-Implantation (Including Necessary Splinting)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3471	Surgical repair of root resorption - anterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D3472	Surgical repair of root resorption – premolar		0	0	0	0	0	0	0	0	0	0	0	0	0
D3473	Surgical repair of root resorption – molar		0	0	0	0	0	0	0	0	0	0	0	0	0
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior		0	0	0	0	0	0	0	0	0	0	0	0	0
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar		0	0	0	0	0	0	0	0	0	0	0	0	0
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar		0	0	0	0	0	0	0	0	0	0	0	0	0
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	If done in conjunction with root canal therapy, included in cost of RCT	0	0	0	0	0	0	0	0	0	0	0	0	0

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D3911	Intraorifice Barrier	Inclusive to root canals	0	0	0	0	0	0	0	0	0	0	0	0	0
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy		0	0	0	0	0	0	0	0	0	0	0	0	0
D3921	Decoronation or Submergence of an Erupted Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	If done in conjunction with root canal therapy, included in cost of RCT, unless performed by dentist other than who performed RCT or crown.	0	0	0	0	0	0	0	0	0	0	0	0	0
D3999	Unspecified Endodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4210	Gingivectomy or Gingivoplasty – 4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	0	0	0	0	0	0	0	0	0	0	0	0	0
D4211	Gingivectomy or Gingivoplasty – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	0	0	0	0	0	0	0	0	0	0	0	0	0
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	DMO Standard Plans (#) – 1 per quadrant every 3 years	0	0	0	0	0	0	0	0	0	0	0	0	0
D4230	Anatomical Crown Exposure - 4 or More Contiguous Teeth per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4231	Anatomical Crown Exposure - 1 to 3 Teeth or Bounded Tooth Spaces per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4240	Gingival Flap Procedure, Including Root Planing – 4 or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	0	0	0	0	0	0	0	0	0	0	0	0	0
D4241	Gingival Flap Procedure, Including Root Planing – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	0	0	0	0	0	0	0	0	0	0	0	0	0
D4245	Apically Positioned Flap		0	0	0	0	0	0	0	0	0	0	0	0	0
D4249	Clinical Crown Lengthening – Hard Tissue		0	0	0	10%	20%	25%	30%	40%	50%	25%	0	0	0
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	0	0	0	10%	20%	25%	30%	40%	50%	25%	0	0	0
D4261	Osseous Surgery (Including Elevation of a Full Thickness Flap And Closure) – One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	0	0	0	10%	20%	25%	30%	40%	50%	25%	0	0	0
D4263	Bone Replacement Graft – retained natural tooth - First Site in Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D4264	Bone Replacement Graft – retained natural tooth - Each Additional Site in Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4265	Biologic Materials to Aid in Soft And Osseous Tissue Regeneration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4266	Guided Tissue Regeneration – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4267	Guided Tissue Regeneration – Non-Resorbable Barrier, per Site (Includes Membrane Removal)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4268	Surgical Revision Procedure, per Tooth		0	0	0	0	0	0	0	0	0	0	0	0	0
		Soft Tissue Graft Procedures – Covered as Basic under "Pre Nov 2000 Plans" (*) and as a Major Service under "DMO Standard Plans" (#)." First copayment shown = "Pre November 1, 2000 Plan" (*) Second copayment = "DMO Standard Plan" (#)													
D4270	Pedicle Soft Tissue Graft Procedure		0 40%	0 50%	0 10%	0 10%	0 20%	0 25%	0 30%	0 40%	0 50%	0 25%	0 0	0 0	0 0
D4273	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) First Tooth, Implant or Edentulous Tooth Position		0 40%	0 50%	0 10%	0 10%	0 20%	0 25%	0 30%	0 40%	0 50%	0 25%	0 0	0 0	0 0
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft		0 40%	0 50%	0 10%	0 10%	0 20%	0 25%	0 30%	0 40%	0 50%	0 25%	0 0	0 0	0 0
D4276	Combined Connective Tissue and Pedicle Graft, per Tooth		0 40%	0 50%	0 10%	0 10%	0 20%	0 25%	0 30%	0 40%	0 50%	0 25%	0 0	0 0	0 0
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft		0 40%	0 50%	0 10%	0 10%	0 20%	0 25%	0 30%	0 40%	0 50%	0 25%	0 0	0 0	0 0
D4278	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) Each Additional Contiguous Tooth, Implant, or Edentulous Tooth Position in Same Graft Site		0 40%	0 50%	0 10%	0 10%	0 20%	0 25%	0 30%	0 40%	0 50%	0 25%	0 0	0 0	0 0
D4283	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		0 40%	0 50%	0 10%	0 10%	0 20%	0 25%	0 30%	0 40%	0 50%	0 25%	0 0	0 0	0 0

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D4285	Non Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site And Donor Material) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		0 40%	0 50%	0 10%	0 10%	0 20%	0 25%	0 30%	0 40%	0 50%	0 25%	0 0	0 0	0 0
D4286	Removal of Non-resorbable Barrier	Inclusive with D7957 - Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	0	0	0	0	0	0	0	0	0	0	0	0	0
D4322	Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4323	Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4341	Periodontal Scaling and Root Planing, 4 or More Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	0	0	0	0	0	0	0	0	0	0	0	0	0
D4342	Periodontal Scaling and Root Planing – 1-3 Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	0	0	0	0	0	0	0	0	0	0	0	0	0
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		0	0	0	0	0	0	0	0	0	0	0	0	0
D4355	Full Mouth Debridement to Enable Comprehensive Oral Evaluation and Diagnosis on a Subsequent Visit	Once per lifetime when covered under Aetna dental plans •D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355. •D1110, D1120, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.	40%	50%	10%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D4381	Localized Delivery of Antimicrobial Agents via a Controlled Release Vehicle Into Diseased Crevicular Tissue, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Special Note for D4910: **Periodontal Maintenance Procedures are covered twice per year only when there is a history of periodontal surgery. (Effective 04/01/2023, D4341 and D4342 have been added to the DMO list of procedure codes that will allow for future D4910.) If there is no history of periodontal surgery, an allowance for D1110 applies, provided the prophy frequency of 2 per year (pre-1991 plans = 6 per year) has not been met. Dentist may charge the difference between their Usual and Customary fees for D1110 and D4910.** **If prophy frequency met or there has been a combination of any two D1110 or D4910 done, the procedure is not covered. The patient is responsible for dentist's Usual and Customary fee for the service.**													
D4910	Periodontal Maintenance	(See Special Note above)	0	0	0	0	0	0	0	0	0	0	0	0	0
D4920	Unscheduled Dressing Change (by Someone Other than Treating Dentist or Their Staff)		0	0	0	0	0	0	0	0	0	0	0	0	0
D4921	Gingival Irrigation – per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

Plan Code - The symbol shown on the roster before the plan code indicates the applicable plan provisions.
* Pre November 1, 2000 Plan
# DMO Standard Plan

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		Special Note for D4999: **Laser may <u>not</u> be submitted as D4999. The use of laser is not a procedure in and of itself; therefore, the patient may not be charged separately for this. Laser is considered inclusive with the service performed.**													
D4999	Unspecified Periodontal Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Removable Prosthetic Codes **<u>Effective 1/1/2024, the "initial placement rule" is removed.</u>** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **<u>Prior to 1/1/2024</u> -** Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does <u>not</u> apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. **Note – Benefit includes all adjustments, relines and rebases occurring within 6 months of insertion (exception D5130 & D5140).** **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.**													
D5110	Complete Denture – Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5120	Complete Denture – Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5130	Immediate Denture – Maxillary	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5140	Immediate Denture – Mandibular	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5211	Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5212	Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5221	Immediate Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5222	Immediate Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5223	Immediate Maxillary Partial Denture – Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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D5224	Immediate Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5225	Maxillary Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5226	Mandibular Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5227	Immediate Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5228	Immediate Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5282	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5283	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5284	Removable unilateral partial denture – one-piece flexible base (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5286	Removable unilateral partial denture – one-piece resin (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5410	Adjust Complete Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5411	Adjust Complete Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5421	Adjust Partial Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5422	Adjust Partial Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5511	Repair Broken Complete Denture Base, Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5512	Repair Broken Complete Denture Base, Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5520	Replace Missing or Broken Teeth – Complete Denture - per Tooth		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5611	Repair Resin Partial Denture Base, Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5612	Repair Resin Partial Denture Base, Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5621	Repair Cast Partial Framework, Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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D5622	Repair Cast Partial Framework, Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5630	Repair or Replace Broken Retentive/Clasping Materials - per Tooth		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5640	Replace Missing or Broken Teeth – Partial Denture - per Tooth		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5650	Add Tooth to Existing Partial Denture - per Tooth		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5660	Add Clasp to Existing Partial Denture - per Tooth		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5670 - D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary or Mandibular)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5710 - D5711	Rebase Complete Maxillary or Mandibular Denture	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5720 - D5721	Rebase Maxillary or Mandibular Partial Denture	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5725	Rebase Hybrid Prosthesis		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5730	Reline Complete Maxillary Denture (Direct)	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5731	Reline Complete Mandibular Denture (Direct)	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5740	Reline Maxillary Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5741	Reline Mandibular Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5750	Reline Complete Maxillary Denture (Indirect)	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5751	Reline Complete Mandibular Denture (Indirect)	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5760	Reline Maxillary Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5761	Reline Mandibular Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5765	Soft Liner for Complete or Partial Removable Denture – Indirect		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5810 - D5811	Interim Complete Denture (Maxillary or Mandibular)	Plan benefit and patient copay for permanent to include all interim provisional charges	0	0	0	0	0	0	0	0	0	0	0	0	0
D5820	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Maxillary	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5821	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Mandibular	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5850 - D5851	Tissue Conditioning, Maxillary or Mandibular	Inclusive with prosthesis within 6 months after insertion	0	0	0	0	0	0	0	0	0	0	0	0	0
D5862	Precision Attachment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5863	Overdenture – Complete Maxillary	Not covered – Alternate benefit based on D5110	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5864	Overdenture – Partial Maxillary	Not covered – Alternate benefit based on D5211	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5865	Overdenture – Complete Mandibular	Not covered – Alternate benefit based on D5120	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5866	Overdenture – Partial Mandibular	Not covered – Alternate benefit based on D5212	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5875	Modification of Removable Prosthesis Following Implant Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5876	Add Metal Substructure to Acrylic Full Denture (per Arch)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D5899	Unspecified Removable Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5911 - D5993	Maxillofacial Prosthetics	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5994	Periodontal Medicament Carrier with Peripheral Seal – Laboratory Processed	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5999	Unspecified Maxillofacial Prosthesis, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Fixed Prosthetic Codes **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Effective 1/1/2024, the "initial placement rule" is removed.** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **Prior to 1/1/2024** - Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does not apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. **Facings on molars are not covered.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)**													
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.													
D6010	Surgical Placement of Implant Body: Endosteal Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C N/C 40%	N/C 50%	N/C	N/C 0	N/C	N/C
D6011	Second Stage Implant Surgery	Not covered unless plan covers implants. For plans covering implants, this is inclusive to surgical placement of implant.	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C N/C $0	N/C $0	N/C	N/C 0	N/C	N/C
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6013	Surgical Placement of Mini Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C N/C 40%	N/C 50%	N/C	N/C 0	N/C	N/C
D6040	Surgical Placement: Eposteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6050	Surgical Placement: Transosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D6051	Placement of Interim Implant Abutment	For plans covering implants, plan benefit and patient copay for permanent restoration includes all interim charges.	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C N/C $0	N/C $0	N/C	N/C 0	N/C	N/C
D6052	Semi-Precision Attachment Abutment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6055	Connecting Bar - Implant Supported or Abutment Supported	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6056	Prefabricated Abutment - Includes Modification and Placement	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C N/C 40%	N/C 50%	N/C	N/C 0	N/C	N/C
D6057	Custom Fabricated Abutment – Includes Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6058	Abutment Supported Porcelain/Ceramic Crown		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6064	Abutment Supported Cast Metal Crown (Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6065	Implant Supported Porcelain/Ceramic Crown		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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D6075	Implant Supported Retainer for Ceramic FPD		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6080	Implant Maintenance Procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	Not covered unless plan covers implants.	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C N/C 40%	N/C 50%	N/C	N/C 0	N/C	N/C
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths: includes cleaning of the implant surfaces, without flap entry and closure	Not covered unless plan covers implants.	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C N/C 40%	N/C 50%	N/C	N/C 0	N/C	N/C
D6082	Implant supported crown – porcelain fused to predominantly base alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6083	Implant supported crown – porcelain fused to noble alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6085	Provisional implant crown	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6086	Implant supported crown – predominantly base alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6087	Implant supported crown – noble alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6088	Implant supported crown – titanium and titanium alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6089	Accessing and Retorquing Loose Implant Screw - per Screw		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6090	Repair of Implant/Abutment Supported Prosthesis		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6091	Replacement of Semi-Precision or Precision Attachment of Implant/Abutment Supported Prosthesis, per Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6092	Re-cement Or Re-bond Implant/Abutment Supported Crown		0	0	0	0	0	0	0	0	0	0	0	0	0
D6093	Re-cement Or Re-bond Implant/Abutment Supported Fixed Partial Denture		0	0	0	0	0	0	0	0	0	0	0	0	0
D6094	Abutment Supported Crown (Titanium)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6095	Repair Implant Abutment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6096	Remove Broken Implant Retaining Screw		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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D6098	Implant supported retainer – porcelain fused to predominantly base alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6100	Implant Removal, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6102	Debridement and osseous contouring of a periimplant defect: includes surface cleaning of exposed implant surfaces and flap entry and closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6104	Bone graft at time of implant placement		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6105	Removal of Implant Body not Requiring Bone Removal or Flap Elevation		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6106	Guided Rissue Regeneration – Resorbable Barrier, per Implant		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6107	Guided Rissue Regeneration – Non-resorbable Barrier, per Implant		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6110	Implant /Abutment Supported Removable Denture for Edentulous Arch – Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6111	Implant /Abutment Supported Removable Denture for Edentulous Arch – Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6112	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6113	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6114	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6115	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6116	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6117	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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D6118	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Mandibular		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6119	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Maxillary		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6121	Implant supported retainer for metal FPD – predominantly base alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6122	Implant supported retainer for metal FPD – noble alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	This procedure includes active debriding of the implant(s) and prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s). Only covered if Plan has implant coverage.	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C 40%	N/C 50%	N/C	N/C 0	N/C	N/C
D6190	Radiographic / Surgical Implant Index, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6191	Semi-precision abutment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6192	Semi-precision attachment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6193	Replacement of an Implant Screw	If D6193 is eligible, D6096 on same day is inclusive (not separately eligible).	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6194	Abutment Supported Retainer Crown for FPD (Titanium)		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6197	Replacement of Restorative Material Used to Close an Access Opening of a Screw-retained Implant Supported Prosthesis, per Implant	Not Covered for molars or stress-bearing surfaces of premolars – Alternate Benefit D2140 (See Elective Services/ Optional Treatment Plans) Plan UAB - Alternate benefit does not apply.	0	0	0	0	0	0	0	0	0	0	0	0	0
D6198	Remove Interim Implant Component	Inclusive to permanent restoration	0	0	0	0	0	0	0	0	0	0	0	0	0
D6199	Unspecified Implant Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6205	Pontic – Indirect Resin Based Composite		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6210	Pontic – Cast High Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6211	Pontic – Cast Predominantly Base Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6212	Pontic – Cast Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6214	Pontic – Titanium		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6240	Pontic – Porcelain Fused to High Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6241	Pontic – Porcelain Fused to Predominantly Base Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6242	Pontic – Porcelain Fused to Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6243	Pontic – porcelain fused to titanium and titanium alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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D6245	Pontic – Porcelain/Ceramic		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6250	Pontic – Resin with High Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6251	Pontic – Resin with Predominantly Base Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6252	Pontic – Resin with Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6253	Provisional Pontic– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan Benefit and patient copay for permanent to include all provisional charges	0	0	0	0	0	0	0	0	0	0	0	0	0
D6545	Retainer – Cast Metal for Resin-Bonded Fixed Prosthesis		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6548	Retainer – Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6549	Resin Retainer – for Resin Bonded Fixed Prosthesis		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6600	Retainer Inlay – Porcelain/Ceramic, 2 Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6601	Retainer Inlay – Porcelain/Ceramic, 3 or More Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6602	Retainer Inlay – Cast High Noble Metal, 2 Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6603	Retainer Inlay – Cast High Noble Metal, 3 or More Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6604	Retainer Inlay – Cast Predominantly Base Metal, 2 Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6605	Retainer Inlay – Cast Predominantly Base Metal, 3 or More Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6606	Retainer Inlay – Cast Noble Metal, 2 Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6607	Retainer Inlay – Cast Noble Metal, 3 or More Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6608	Retainer Onlay – Porcelain/Ceramic, 2 Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6609	Retainer Onlay – Porcelain/Ceramic, 3 or More Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6610	Retainer Onlay – Cast High Noble Metal, 2 Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6611	Retainer Onlay – Cast High Noble Metal, 3 or More Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6612	Retainer Onlay – Cast Predominantly Base Metal, 2 Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6613	Retainer Onlay – Cast Predominantly Base Metal, 3 or More Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6614	Retainer Onlay – Cast Noble Metal, 2 Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6615	Retainer Onlay – Cast Noble Metal, 3 or More Surfaces		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6624	Retainer Inlay – Titanium		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6634	Retainer Onlay – Titanium		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6710	Retainer Crown – Indirect Resin Based Composite		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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D6720	Retainer Crown – Resin with High Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6721	Retainer Crown – Resin with Predominantly Base Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6722	Retainer Crown – Resin with Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6740	Retainer Crown – Porcelain/Ceramic		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6750	Retainer Crown – Porcelain Fused to High Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6751	Retainer Crown – Porcelain Fused to Predominantly Base Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6752	Retainer Crown – Porcelain Fused to Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6753	Retainer crown – porcelain fused to titanium and titanium alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6780	Retainer Crown – 3/4 Cast High Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6781	Retainer Crown – 3/4 Cast Predominantly Based Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6782	Retainer Crown – 3/4 Cast Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6783	Retainer Crown – 3/4 Porcelain/Ceramic		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6784	Retainer crown 3/4 – titanium and titanium alloys		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6790	Retainer Crown – Full Cast High Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6791	Retainer Crown – Full Cast Predominantly Base Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6792	Retainer Crown – Full Cast Noble Metal		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6793	Provisional Retainer Crown– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan Benefit and patient copay for permanent to include all provisional charges	0	0	0	0	0	0	0	0	0	0	0	0	0
D6794	Retainer Crown – Titanium		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6920	Connector Bar	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6930	Re-cement or Re-bond Fixed Partial Denture		0	0	0	0	0	0	0	0	0	0	0	0	0
D6940	Stress Breaker		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6950	Precision Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	0	0	0
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6985	Pediatric Partial Denture, Fixed	Eligible for anterior teeth. Not Covered for teeth other than anterior.	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D6999	Unspecified Fixed Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7111	Extraction, Coronal Remnants – Primary Tooth	Includes extractions for orthodontic purposes.	0	0	0	0	0	0	0	0	0	0	0	0	0
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	Includes extractions for orthodontic purposes.	0	0	0	0	0	0	0	0	0	0	0	0	0
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth and Including Elevation of Mucoperiosteal Flap if Indicated	Includes extractions for orthodontic purposes.	0	0	0	0	0	0	0	0	0	0	0	0	0

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D7220	Removal of Impacted Tooth – Soft Tissue	Includes extractions for orthodontic purposes.	0	0	0	0	0	0	0	0	0	0	0	0	0
D7230	Removal of Impacted Tooth – Partially Bony	Extractions of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	0	0	0	10%	20%	25%	30%	40%	50%	25%	0	0	0
D7240	Removal of Impacted Tooth – Completely Bony	Extractions of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	0	0	0	10%	20%	25%	30%	40%	50%	25%	0	0	0
D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications	Extractions of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	0	0	0	10%	20%	25%	30%	40%	50%	25%	0	0	0
D7250	Removal of Residual Tooth Roots (Cutting Procedure)		0	0	0	0	0	0	0	0	0	0	0	0	0
D7251	Coronectomy - Intentional Partial Tooth Removal	Extractions of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	0	0	0	10%	20%	25%	30%	40%	50%	25%	0	0	0
D7252	Partial Extraction for Immediate Implant Placement	Only covered if implants are covered.	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C 40%	N/C 50%	0	0	0	0
D7259	Nerve Dissection		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7260	Oroantral Fistula Closure		0	0	0	0	0	0	0	0	0	0	0	0	0
D7261	Primary Closure of a Sinus Perforation		0	0	0	0	0	0	0	0	0	0	0	0	0
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7272	Tooth Transplantation (Includes Reimplantation from One Site to Another & Splinting and/or Stabilization)		0	0	0	0	0	0	0	0	0	0	0	0	0
D7280	Exposure of an Unerupted Tooth		0	0	0	0	0	0	0	0	0	0	0	0	0
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption		0	0	0	0	0	0	0	0	0	0	0	0	0
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth		0	0	0	0	0	0	0	0	0	0	0	0	0
D7284	Excisional Biopsy of Minor Salivary Glands		0	0	0	0	0	0	0	0	0	0	0	0	0
D7285	Incisional Biopsy of Oral Tissue – Hard (Bone, Tooth)		0	0	0	0	0	0	0	0	0	0	0	0	0
D7286	Incisional Biopsy of Oral Tissue – Soft		0	0	0	0	0	0	0	0	0	0	0	0	0
D7287	Exfoliative Cytological Sample Collection		0	0	0	0	0	0	0	0	0	0	0	0	0
D7288	Brush Biopsy – Transepithelial Sample Collection	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7290	Surgical Repositioning of Teeth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7291	Transseptal Fiberotomy/ Supra Crestal Fiberotomy, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7292	Placement of Temporary Anchorage Device [Screw Retained Plate] Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7293	Placement of Temporary Anchorage Device Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7294	Placement of Temporary Anchorage Device Without Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7295	Harvest of Bone for Use in Autogenous Grafting Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7296	Corticotomy - One to Three Teeth or Tooth Spaces, per Quadrant		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7297	Corticotomy – Four or More Teeth or Tooth Spaces, per Quadrant		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7298	Removal of Temporary Anchorage Device [Screw Retained Plate], Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	0	0	0	0	0	0	0	0	0	0	0	0	0
D7299	Removal of Temporary Anchorage Device, Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	0	0	0	0	0	0	0	0	0	0	0	0	0
D7300	Removal of Temporary Anchorage Device Without Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	0	0	0	0	0	0	0	0	0	0	0	0	0
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	0	0	0	0	0	0	0	0	0	0	0	0	0
D7311	Alveoloplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		0	0	0	0	0	0	0	0	0	0	0	0	0
D7320	Alveoloplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	0	0	0	0	0	0	0	0	0	0	0	0	0
D7321	Alveoloplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		0	0	0	0	0	0	0	0	0	0	0	0	0
D7340	Vestibuloplasty – Ridge Extension (Secondary Epithelialization)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7350	Vestibuloplasty – Ridge Extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7410	Excision of Benign Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7411	Excision of Benign Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7412	Excision of Benign Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7413	Excision of Malignant Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7414	Excision of Malignant Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7415	Excision of Malignant Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7440	Excision Malignant Tumor - Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7441	Excision Malignant Tumor Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7450	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm		0	0	0	0	0	0	0	0	0	0	0	0	0
D7451	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm		0	0	0	0	0	0	0	0	0	0	0	0	0
D7460	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7461	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7465	Destruction of Lesion(s) by Physical or Chemical Method, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)		0	0	0	0	0	0	0	0	0	0	0	0	0
D7472	Removal of Torus Palatinus		0	0	0	0	0	0	0	0	0	0	0	0	0
D7473	Removal of Torus Mandibularis		0	0	0	0	0	0	0	0	0	0	0	0	0
D7485	Reduction of Osseous Tuberosity		0	0	0	0	0	0	0	0	0	0	0	0	0
D7490	Radical Resection of Maxilla or Mandible	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7509	Marsupialization of Odontogenic Cyst		0	0	0	0	0	0	0	0	0	0	0	0	0
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue		0	0	0	0	0	0	0	0	0	0	0	0	0
D7511	Incision and Drainage of Abscess – Intraoral Soft Tissue - Complicated		0	0	0	0	0	0	0	0	0	0	0	0	0
D7520	Incision and Drainage of Abscess – Extraoral Soft Tissue		0	0	0	0	0	0	0	0	0	0	0	0	0
D7521	Incision and Drainage of Abscess – Extraoral Soft Tissue - Complicated		0	0	0	0	0	0	0	0	0	0	0	0	0
D7530	Removal of Foreign Body from Mucosa, Skin or Subcutaneous Alveolar Tissue		0	0	0	0	0	0	0	0	0	0	0	0	0
D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System		0	0	0	0	0	0	0	0	0	0	0	0	0
D7550	Partial Ostectomy/ Sequestrectomy for Removal of Non-Vital Bone		0	0	0	0	0	0	0	0	0	0	0	0	0

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D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7610-D7820	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7830	Manipulation Under Anesthesia	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7840-D7870	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7871	Non-Arthroscopic Lysis and Lavage	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7872-D7877	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7880	Occlusal Orthotic Device, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7881	Occlusal Orthotic Device Adjustment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7899	Unspecified TMD Therapy, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7910	Suture of Recent Small Wound up to 5 cm		0	0	0	0	0	0	0	0	0	0	0	0	0
D7911	Complicated Suture - Up to 5 cm		0	0	0	0	0	0	0	0	0	0	0	0	0
D7912	Complicated Suture - greater than 5 cm		0	0	0	0	0	0	0	0	0	0	0	0	0
D7920-D7921	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Inclusive to the extraction Patient cannot be billed	0	0	0	0	0	0	0	0	0	0	0	0	0
D7939	Indexing for Osteotomy using Dynamic Robotic Assisted or Dynamic Navigation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7940-D7952	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7953	Bone Replacement Graft for Ridge Preservation – Per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7956	Guided Tissue Regeneration, Edentulous Area – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7957	Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7961	Buccal / labial frenectomy (frenulectomy)		0	0	0	0	0	0	0	0	0	0	0	0	0
D7962	Lingual frenectomy (frenulectomy)		0	0	0	0	0	0	0	0	0	0	0	0	0
D7963	Frenuloplasty		0	0	0	0	0	0	0	0	0	0	0	0	0
D7970	Excision of Hyperplastic Tissue – Per Arch		0	0	0	0	0	0	0	0	0	0	0	0	0
D7971	Excision of Pericoronal Gingiva		0	0	0	0	0	0	0	0	0	0	0	0	0
D7972	Surgical Reduction of Fibrous Tuberosity		0	0	0	0	0	0	0	0	0	0	0	0	0
D7979	Non-Surgical Sialolithotomy		0	0	0	0	0	0	0	0	0	0	0	0	0
D7980	Surgical Sialolithotomy		0	0	0	0	0	0	0	0	0	0	0	0	0
D7981	Excision Of Salivary Gland, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7982	Sialodochoplasty	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7983	Closure of Salivary Fistula		0	0	0	0	0	0	0	0	0	0	0	0	0
D7990-D7998	Other Surgical Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

Plan Code - The symbol shown on the roster before the plan code indicates the applicable plan provisions.
* Pre November 1, 2000 Plan
# DMO Standard Plan

Dental Procedure Guidelines
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ADA CODE[1]	NOMENCLATURE	GUIDELINES	E	F	G	H	I	J	K	L -LM Li	M Mi	Q	U Ui	UAB	UNJ
D7999	Unspecified Oral Surgery Procedure, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D8210	Removable Appliance Therapy	Includes appliances for thumb sucking and tongue thrusting. Pre Nov 2000 Plans (*) - Covered at percentage shown. DMO Standard Plans (#) – Covered at Ortho copayment level.	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D8220	Fixed Appliance Therapy	Includes appliances for thumb sucking and tongue thrusting. Pre Nov 2000 Plans (*) - Covered at percentage shown. DMO Standard Plans (#) – Covered at Ortho copayment level.	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D8695	Removal of Fixed Orthodontic Appliances for Reasons other than Completion of Treatment		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	Inclusive when performed on the same date of service as definitive treatment; member cannot be billed. Definitive treatment is the treatment which resolves the pain permanently - this is the final measure taken to eliminate the pain.	0	0	0	0	0	0	0	0	0	0	0	0	0
D9120	Fixed Partial Denture Sectioning		50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9130	Temporomandibular Joint Dysfunction – Non-invasive physical Therapies	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9210	Local Anesthesia, Not in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	0	0	0	0	0	0	0	0	0	0	0	0	0
D9211	Regional Block Anesthesia	Included in cost of underlying procedure	0	0	0	0	0	0	0	0	0	0	0	0	0
D9212	Trigeminal Division Block Anesthesia	Not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	0	0	0	0	0	0	0	0	0	0	0	0	0
D9219[3]	Evaluation For Moderate Sedation, Deep Sedation or General Anesthesia	When rendered by anesthesiologist	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9222	Deep Sedation/General Anesthesia – First 15 Minutes		50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9223	Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia – First 15 Minutes		50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	50%	50%	50%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9248	Non-Intravenous Conscious Sedation	Not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician	For Second Opinions only	0	0	0	0	0	0	0	0	0	0	0	0	0
D9311	Consultation with a medical health care professional		0	0	0	0	0	0	0	0	0	0	0	0	0

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	E	F	G	H	I	J	K	L -LM Li	M Mi	Q	U Ui	UAB	UNJ
D9410	House/Extended Care Facility Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9420	Hospital or Ambulatory Surgical Center Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	Included in cost of underlying procedure	0	0	0	0	0	0	0	0	0	0	0	0	0
D9440	Office Visit - After Regularly Scheduled Hours	Not Covered (Covered in Texas)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)
D9450	Case Presentation, Detailed and Extensive Treatment Planning	Included in Cost of Underlying Procedure	0	0	0	0	0	0	0	0	0	0	0	0	0
D9610	Therapeutic Parenteral Drug, Single Administration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9612	Therapeutic Parenteral Drugs, 2 or more Administrations, Different Medications	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9613	Infiltration of Sustained Release Therapeutic Drug	Eligible when performed in conjunction with procedure codes D7220, D7230, D7240, D7241, or D7251 on third molars (teeth #'s 01, 16, 17, or 32).	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9630	Drugs or Medicaments dispensed in the office for home use	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9910	Application of Desensitizing Medicament	Inclusive with the restoration being performed on the same date of service; member cannot be billed.	0	0	0	0	0	0	0	0	0	0	0	0	0
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9912	Pre-visit Patient Screening	Inclusive with record keeping requirements	0	0	0	0	0	0	0	0	0	0	0	0	0
D9913	Administration of Neuromodulators		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9914	Administration of Dermal Fillers		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9920	Behavior Management, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9930	Treatment of Complications (Post-surgical) – Unusual Circumstances, by Report	Included in cost of underlying procedure	0	0	0	0	0	0	0	0	0	0	0	0	0
D9932	Cleaning and Inspection of Removable Complete Denture, Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9933	Cleaning and Inspection of Removable Complete Denture, Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9934	Cleaning and Inspection of Removable Partial Denture, Maxillary		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9935	Cleaning and Inspection of Removable Partial Denture, Mandibular		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9938	Fabrication of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9939	Placement of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9941	Fabrication of Athletic Mouthguard	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9942	Repair and/or Reline of Occlusal Guard		40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	E	F	G	H	I	J	K	L -LM Li	M Mi	Q	U Ui	UAB	UNJ
D9943	Occlusal Guard Adjustment	Fee for occlusal guard includes adjustments performed within 6 months of placement	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9944	Occlusal Guard – Hard Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9945	Occlusal Guard – Soft Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9946	Occlusal Guard – Hard Appliance, Partial Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	40%	50%	30%	10%	20%	25%	30%	40%	50%	25%	0	0	0
D9947	Custom Sleep Apnea Appliance Fabrication and Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9948	Adjustment of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9949	Repair of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9950	Occlusion Analysis - Mounted Case	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9951	Occlusal Adjustment – Limited	Not separately eligible when performed in conjunction with a restoration, root canal therapy or appliance.	0	0	0	0	0	0	0	0	0	0	0	0	0
D9952	Occlusal Adjustment – Complete		0	0	0	0	0	0	0	0	0	0	0	0	0
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9954	Fabrication and Delivery of Oral Appliance Therapy (OAT) Morning Repositioning Device	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9955	Oral Appliance Therapy (OAT) Titration Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9956	Administration of Home Sleep Apnea Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9957	Screening for Sleep Related Breathing Disorders	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9959	Unspecified Sleep Apnea Services Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9961	Duplicate/Copy Patient's Records	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9970	Enamel Microabrasion	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9972	External Bleaching – per Arch - Performed in Office	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9973	External Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9974	Internal Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9975	External Bleaching for Home Application, per Arch	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9985[2]	Sales Tax	Inclusive to service being taxed	0	0	0	0	0	0	0	0	0	0	0	0	0
D9986	Missed Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9987	Cancelled Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9990	Certified Translation or Sign-language Services per Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	E	F	G	H	I	J	K	L -LM Li	M Mi	Q	U Ui	UAB	UNJ
D9991	Dental case management - addressing appointment compliance barriers	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9992	Dental case management – care coordination	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9993	Dental case management – motivational interviewing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9994	Dental case management – patient education to improve oral health literacy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9995	Teledentistry – Synchronous; Real-Time Encounter		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9996	Teledentistry – Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9997	Dental case management – patients with special health care needs	Inclusive to the primary service Patient cannot be billed	0	0	0	0	0	0	0	0	0	$0	$0	$0	$0
D9999	Unspecified Adjunctive Procedure, by Report	Used for procedure that is not adequately described by a code. Use of this code REQUIRES A WRITTEN NARRATIVE & supporting documentation	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

[1] Current Dental Terminology ©American Dental Association. All rights reserved.
[2] Not separately eligible/inclusive - the patient cannot be billed for these services.
[3] Covered only when performed by anesthesiologist.

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	1 1i	2 2i	2BA	3	8 8i	12	14i	21	22
	Office Visit Copay	Check Roster When an Office Visit copay applies, the DMO Patient Roster will show the amount under column "Office Copay" (i.e. 000 = $0.00; 005 = $5.00). When submitted, use ADA code D0999.									
	Infection Control	May not bill patient for infection control procedures									
		Frequency limits on Preventive and Diagnostic services are waived in Arizona, California and Texas if medically necessary.									
D0120	Periodic Oral Evaluation - Established Patient	Limited to 4x per year Plan 14i limited to 2x per year (as of 01/01/2019). (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0
D0140	Limited Oral Evaluation - Problem Focused	Limited to 4x per year Plan 14i limited to 2x per year (as of 01/01/2019). (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0
D0145	Oral Evaluation for a Patient under Three Years of Age and Counseling with a Primary Caregiver	Limited to 4x per year Plan 14i limited to 2x per year (as of 01/01/2019). (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0
D0150	Comprehensive Oral Evaluation - New or Established Patient	Limited to 4x per year Plan 14i limited to 2x per year (as of 01/01/2019). (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, by Report	Limited to 4x per year Plan 14i limited to 2x per year (as of 01/01/2019). (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0
D0170	Re-Evaluation - Limited, Problem Focused (Established Patient; not Post-Operative Visit)	Limited to 4x per year Plan 14i limited to 2x per year (as of 01/01/2019). (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0
D0171	Re-Evaluation - Post-Operative Office Visit	Inclusive to surgery. Patient cannot be billed.	0	0	0	0	0	0	0	0	0
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	Limited to 4x per year Plan 14i limited to 2x per year (as of 01/01/2019). (All Evaluations Combined D0120 - D0180)	0	0	0	0	0	0	0	0	0
D0190-D0191[2]	Screening / Assessment of a Patient	Inclusive to oral evaluation Patient cannot be billed	0	0	0	0	0	0	0	0	0
D0210	Intraoral - Complete Series of Radiographic Images	FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service) Plan 2BA - once every 60 months	0	0	0	0	0	0	0	0	0
D0220-D0230	Intraoral - Periapical Image		0	0	0	0	0	0	0	0	0
D0240	Intraoral - Occlusal Radiographic Image		0	0	0	0	0	0	0	0	0
D0250-D0251	Extra-Oral Image		0	0	0	0	0	0	0	0	0
D0270-D0274	Bitewing Radiographic Image	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year Plan 2BA - Limitations Adults - 1 series per calendar year Children - 2 series per calendar year	0	0	0	0	0	0	0	0	0

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	1 1i	2 2i	2BA	3	8 8i	12	14i	21	22
D0277	Vertical Bitewings - 7 to 8 Radiographic Images	1 series every 3 years	0	0	0	0	0	0	0	0	0
D0310	Sialography	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0320-D0321	Temporomandibular Joint Image	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0322	Tomographic Survey	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0330	Panoramic Radiographic Image	FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0
D0340	2D Cephalometric Radiographic Image – Acquisition, Measurement and Analysis	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0350	2D Oral/Facial Photographic Image Obtained Intra-orally or Extra-orally	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0364-D0368	Cone Beam CT Capture and Interpretation		N/C	N/C	N/C	N/C	N/C	N/C	40%	N/C	N/C
D0369-D0371	Capture and Interpretation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0372	Intraoral - Complete Series of Radiographic Images	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0
D0373	Intraoral Tomosynthesis – Bitewing Radiographic Image	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year Plan 2BA - Limitations Adults - 1 series per calendar year Children - 2 series per calendar year	0	0	0	0	0	0	0	0	0
D0374	Intraoral Tomosynthesis – Periapical Radiographic Image		0	0	0	0	0	0	0	0	0
D0380-D0384	Cone Beam CT Image Capture		N/C	N/C	N/C	N/C	N/C	N/C	40%	N/C	N/C
D0385-D0386	Cone Beam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0387	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images – Image Capture Only	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0
D0388	Intraoral Tomosynthesis – Bitewing Radiographic Image – Image Capture Only	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year Plan 2BA - Limitations Adults - 1 series per calendar year Children - 2 series per calendar year	0	0	0	0	0	0	0	0	0
D0389	Intraoral Tomosynthesis – Periapical Radiographic Image – Image Capture Only		0	0	0	0	0	0	0	0	0
D0391	Interpretation of Diagnostic Image by Practitioner Not Associated with Capture of the Image, Including Report		0	0	0	0	0	0	0	0	0

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D0393-D0395	3D Images	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0396	3D printing of a 3D dental surface scan	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0411	HbA1c In-office Point of Service Testing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0412	Blood Glucose Level Test – In-office Using a Glucose Meter	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0415	Collection of Microorganisms	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0416	Viral Culture	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0417	Collection & Preparation of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0418	Analysis of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0419	Assessment of Salivary Flow by Measurement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0422	Collection and Preparation of Genetic Sample Material for Laboratory Analysis and Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0423	Genetic Test for Susceptibility to Diseases – Specimen Analysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0425	Caries Susceptibility Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0431	Adjunctive Pre-Diagnostic Test	The use of any tools and/or devices that assist in a diagnosis to be an adjunctive technique that is part of the oral evaluation or primary service. Members cannot be billed for this service.	0	0	0	0	0	0	0	0	0
D0460	Pulp Vitality Tests	Inclusive to oral evaluation Patient cannot be billed	0	0	0	0	0	0	0	0	0
D0470	Diagnostic Casts		0	0	0	0	0	0	0	0	0
D0472-D0474	Accession of Tissue		0	0	0	0	0	0	0	0	0
D0475-D0502	Oral Pathology Laboratory Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0601-D0603[2]	Caries Risk Assessment	Inclusive to oral evaluation	0	0	0	0	0	0	0	0	0
D0604	Antigen testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0605	Antibody testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0606	Molecular testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D0701	panoramic radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0330. FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	0	0	0	0	0	0	0	0	0
D0702	2-D cephalometric radiographic image – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0705	extra-oral posterior dental radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0251.	0	0	0	0	0	0	0	0	0
D0706	intraoral – occlusal radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0240.	0	0	0	0	0	0	0	0	0
D0707	intraoral – periapical radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0220.	0	0	0	0	0	0	0	0	0
D0708	intraoral – bitewing radiographic image – image capture only	Only eligible when submitted with D0391 Inclusive when submitted with D0270 Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year Plan 2BA - Limitations Adults - 1 series per calendar year Children - 2 series per calendar year	0	0	0	0	0	0	0	0	0
D0709	intraoral – complete series of radiographic images – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0210. FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service) Plan 2BA - once every 60 months	0	0	0	0	0	0	0	0	0
D0801	3D Intraoral Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0802	3D Dental Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0803	3D Facial Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0804	3D Facial Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0999	Unspecified Diagnostic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1110	Prophylaxis – Adult	Limited to 2 per year	0	0	0	0	0	0	0	0	0
D1120	Prophylaxis – Child	Limited to 2 per year	0	0	0	0	0	0	0	0	0
D1206	Topical Application of Fluoride Varnish	1x per year Pre Nov 2000 Plans (*) - Age limit = 18 DMO Standard Plans (#) – Age limit = 16	0	0	0	0	0	0	0	0	0

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D1208	Topical Application of Fluoride – Excluding Varnish	1x per year Pre Nov 2000 Plans (*) - Age Limit = 18 DMO Standard Plans (#) – Age Limit = 16	0	0	0	0	0	0	0	0	0
D1301	Immunization Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1310-D1321	Nutritional or Tobacco Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1330	Oral Hygiene Instruction		0	0	0	0	0	0	0	0	0
D1351	Sealant – per Tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years for permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children). Plan Code 14i - limited to 2 treatments per tooth, per lifetime for permanent molars only for covered persons under age 19.	0	0	0	0	0	0	0	0	0
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years for permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children). Plan Code 14i - limited to 2 treatments per tooth, per lifetime for permanent molars only for covered persons under age 19.	0	0	0	0	0	0	0	0	0
D1353	Sealant Repair - per Tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years for permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children). Plan Code 14i - limited to 2 treatments per tooth, per lifetime for permanent molars only for covered persons under age 19.	0	0	0	0	0	0	0	0	0
D1354	Application of Caries Arresting Medicament – per Tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years for permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children). Plan Code 14i - limited to 2 treatments per tooth, per lifetime for permanent molars only for covered persons under age 19.	0	0	0	0	0	0	0	0	0

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D1355	Caries preventive medicament application – per tooth	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years for permanent molars (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children). Plan Code 14i - limited to 2 treatments per tooth, per lifetime for permanent molars only for covered persons under age 19.	0	0	0	0	0	0	0	0	0
		Space Maintainers – Covered as a Major Service under "Pre November 2000 plans" (*) and a Preventive Service under "DMO Standard Plans" (#). First Copayment = "Pre Nov 2000 Plan" Second Copayment = "DMO Standard Plan"									
D1510	Space Maintainer - Fixed, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	0	50% 0	40% 0	50% 0	0	10% 0	20% 0
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	0	50% 0	40% 0	50% 0	0	10% 0	20% 0
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	0	50% 0	40% 0	50% 0	0	10% 0	20% 0
D1520	Space Maintainer - Removable, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	0	50% 0	40% 0	50% 0	0	10% 0	20% 0
D1526	Space Maintainer – Removable – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	0	50% 0	40% 0	50% 0	0	10% 0	20% 0
D1527	Space Maintainer – Removable – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	0	50% 0	40% 0	50% 0	0	10% 0	20% 0
D1551	Re-cement or re-bond bilateral space maintainer – maxillary		20%	20%	20%	50%	10%	0	10%	10%	20%
D1552	Re-cement or re-bond bilateral space maintainer – mandibular		20%	20%	20%	50%	10%	0	10%	10%	20%
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant		20%	20%	20%	50%	10%	0	10%	10%	20%
D1556	Removal of fixed unilateral space maintainer – per quadrant		20%	20%	20%	50%	10%	0	10%	10%	20%
D1557	Removal of fixed bilateral space maintainer – maxillary		20%	20%	20%	50%	10%	0	10%	10%	20%
D1558	Removal of fixed bilateral space maintainer – mandibular		20%	20%	20%	50%	10%	0	10%	10%	20%

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D1575	Distal shoe space maintainer – fixed, unilateral - per quadrant	Includes all adjustments within 6 months after insertion Pre-Nov 2000 Plans (*) = 1st Copay DMO Standard Plans (#) = 2nd Copay	40% 0	50% 0	0	50% 0	40% 0	50% 0	0	10% 0	20% 0
D1701 - D1714	Covid-19 vaccine administration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1781 - D1783	Vaccine Administration – Human Papillomavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		<u>Effective 11/1/2020</u> - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is considered part of the primary service done on the same day. Member cannot be charged. **<u>Prior to 11/1/2020</u> - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is not covered. The member will be responsible for the charge.**									
D1999	Unspecified Preventive Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2140	Amalgam – 1 Surface, Primary or Permanent		20%	20%	20%	50%	10%	0	10%	10%	20%
D2150	Amalgam – 2 Surfaces, Primary or Permanent		20%	20%	20%	50%	10%	0	10%	10%	20%
D2160	Amalgam – 3 Surfaces, Primary or Permanent		20%	20%	20%	50%	10%	0	10%	10%	20%
D2161	Amalgam – 4+ Surfaces, Primary or Permanent		20%	20%	20%	50%	10%	0	10%	10%	20%
D2330	Resin-Based Composite – 1 Surface, Anterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D2331	Resin-Based Composite – 2 Surfaces, Anterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D2332	Resin-Based Composite – 3 Surfaces, Anterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D2335	Resin-Based Composite – 4+ Surfaces or Involving Incisal Angle, Anterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D2390	Resin-Based Composite Crown, Anterior		20%	20%	20%	50%	10%	0	10%	10%	20%
		<u>Effective 1/1/2024, posterior resin/composite restorations will no longer be subject to an upgrade.</u> DMO patients are only responsible for the applicable copayment based on the service performed. For percentage-based co-insurance plans, Aetna will pay a supplemental benefit to your office for posterior composite restorations (refer to the Network Bulletin October 2023). You must submit an encounter/claim to receive the procedure based supplemental payment. **<u>Prior to 1/1/2024</u>** - If you first offer an amalgam restoration and the patient elects to have a resin restoration on a molar or on the stress-bearing surfaces of a premolar, the patient is responsible for the copayment, if any, for an amalgam restoration plus the difference between your Usual and Customary fees for the resin restoration and the amalgam restoration. (Refer to Elective Services/Optional Treatment Plans.) If the office does not have an amalgam fee, use the corresponding resin fee reduced by 20%. **Plan 2BA - Resin restorations are covered for all teeth.**									
D2391	Resin-Based Composite – 1 Surface, Posterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D2392	Resin-Based Composite – 2 Surfaces, Posterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D2393	Resin-Based Composite – 3 Surfaces, Posterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D2394	Resin-Based Composite – 4+ Surfaces, Posterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D2410 - D2430	Gold Foil	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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		Crowns/Inlays Procedure Codes: **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Eligible for plan benefit when tooth cannot be restored with a filling. Plan benefit available for one crown once every 5 years per tooth. (Plan 2BA - Benefit for one crown once every 7 years per tooth.)** **Facings on molar crowns and pontics will always be considered cosmetic.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)**									
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.									
D2510	Inlay – Metallic - 1 Surface		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2520	Inlay – Metallic - 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2530	Inlay – Metallic - 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2542	Onlay – Metallic - 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2543	Onlay – Metallic - 3 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2544	Onlay - Metallic – 4 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2610	Inlay, Porcelain/Ceramic – 1 Surface		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2620	Inlay, Porcelain/Ceramic – 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2630	Inlay, Porcelain/Ceramic – 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2642	Onlay, Porcelain/Ceramic – 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2643	Onlay, Porcelain/Ceramic – 3 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2644	Onlay, Porcelain/Ceramic – 4 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2650	Inlay, Resin Based Composite – 1 Surface		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2651	Inlay, Resin Based Composite – 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2652	Inlay, Resin Based Composite – 3 or more Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2662	Onlay, Resin Based Composite – 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2663	Onlay, Resin Based Composite – 3 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2664	Onlay, Resin Based Composite – 4 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2710	Crown – Resin-Based Composite, Indirect		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2712	Crown – 3/4 Resin-Based Composite, Indirect		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2720	Crown – Resin with High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2721	Crown – Resin with Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2722	Crown – Resin with Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2740	Crown – Porcelain/ Ceramic		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2750	Crown – Porcelain Fused to High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2751	Crown – Porcelain Fused to Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2752	Crown – Porcelain Fused to Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%

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D2753	Crown - porcelain fused to titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2780	Crown – 3/4 Cast High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2781	Crown – 3/4 Cast Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2782	Crown – 3/4 Cast Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2783	Crown – 3/4 Cast Porcelain/Ceramic		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2790	Crown – Full Cast High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2791	Crown – Full Cast Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2792	Crown – Full Cast Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2794	Crown – Titanium and Titanium Alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2799	Interim Crown – Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	0	0	0	0	0	0	0	0	0
D2910	Re-cement Or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration		20%	20%	20%	50%	10%	0	10%	10%	20%
D2915	Re-Cement or Re-Bond Indirectly Fabricated or Prefabricated Post and Core		20%	20%	20%	50%	10%	0	10%	10%	20%
D2920	Re-Cement or Re-Bond Crown		20%	20%	20%	50%	10%	0	10%	10%	20%
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp		20%	20%	20%	50%	10%	0	10%	10%	20%
D2928	Prefabricated Porcelain/Ceramic Crown – Permanent Tooth	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	0	0	0	0	0	0	0	0	0
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	Alternate benefit based on D2930	20%	20%	20%	50%	10%	0	10%	10%	20%
D2930	Prefabricated Stainless Steel Crown – Primary Tooth		20%	20%	20%	50%	10%	0	10%	10%	20%
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	When used as permanent crown, subject to crown frequency limit. Eligible as temp only when used as temp restoration until adult dentition formed or when used due to accident away from home. Otherwise, temp is included in final restoration and not separately eligible	20%	20%	20%	50%	10%	0	10%	10%	20%
D2932	Prefabricated Resin Crown	Alternate benefit based on D2930 or D2931	20%	20%	20%	50%	10%	0	10%	10%	20%
D2933	Prefabricated Stainless Steel Crown with Resin Window	Alternate benefit based on D2930 or D2931	20%	20%	20%	50%	10%	0	10%	10%	20%
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	Alternate benefit based on D2930	20%	20%	20%	50%	10%	0	10%	10%	20%
D2940	Placement of Interim Direct Restoration		20%	20%	20%	50%	10%	0	10%	10%	20%
D2941	Interim Therapeutic Restoration – Primary Dentition		20%	20%	20%	50%	10%	0	10%	10%	20%
D2949[2]	Restorative Foundation for an Indirect Restoration	Inclusive to permanent restoration	0	0	0	0	0	0	0	0	0
D2950	Core Buildup, Including Any Pins When Required		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2951	Pin Retention – Per Tooth, In Addition to Restoration		20%	20%	20%	50%	10%	0	10%	10%	20%
D2952	Post & Core In Addition to Crown, Indirectly Fabricated		40%	50%	50%	50%	40%	50%	40%	10%	20%

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D2953	Each Additional Indirectly Fabricated Post – Same Tooth		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2954	Prefabricated Post & Core In Addition To Crown		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2955	Post Removal	Included in cost of replacement	0	0	0	0	0	0	0	0	0
D2956	Removal of an Indirect Restoration on a Natural Tooth	Not to be used as a temporary or provisional restoration. Inclusive to any restorative service.	40%	50%	50%	50%	40%	0	10%	10%	20%
D2957	Each Additional Prefabricated Post - Same Tooth		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2960	Labial Veneer (Resin Laminate) – Chairside	Not covered when done solely for cosmetic or aesthetic reasons and without the presence of decay or other pathologic condition.	40%	50%	50%	50%	40%	50%	40%	10%	20%
D2961	Labial Veneer (Resin Laminate) – Laboratory	Not covered when done solely for cosmetic or aesthetic reasons and without the presence of decay or other pathologic condition.	40%	50%	50%	50%	40%	50%	40%	10%	20%
D2962	Labial Veneer (Porcelain Laminate) – Laboratory	Not covered when done solely for cosmetic or aesthetic reasons and without the presence of decay or other pathologic condition.	40%	50%	50%	50%	40%	50%	40%	10%	20%
D2971	Additional Procedures to Customize a Crown to Fit under an Existing Partial Denture Framework		40%	50%	50%	50%	40%	50%	40%	10%	20%
D2975	Coping	Not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2976	Band Stabilization – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2980	Crown Repair Necessitated by Restorative Material Failure		40%	50%	50%	50%	40%	50%	10%	10%	20%
D2981	Inlay Repair Necessitated by Restorative Material Failure		40%	50%	50%	50%	40%	50%	10%	10%	20%
D2982	Onlay Repair Necessitated by Restorative Material Failure		40%	50%	50%	50%	40%	50%	10%	10%	20%
D2983	Veneer Repair Necessitated by Restorative Material Failure		40%	50%	50%	50%	40%	50%	10%	10%	20%
D2989	Excavation of a Tooth Resulting in the Determination of Non-restorability	Restorations, endodontics, and/or D4249 on same day/same tooth will be denied.	20%	20%	20%	50%	10%	0	10%	10%	20%
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	Pre Nov 2000 DMO Coinsurance Plans (*) limited to once every 3 years (not limited to dependent children and no age limit). DMO Standard Coinsurance Plans (#) limited to once every 3 years and to covered persons under age 16 (not limited to dependent children).	0	0	0	0	0	0	0	0	0
D2991	Application of Hydroxyapatite Regeneration Medicament – per Tooth	One application per tooth, regardless of the number of appointments required to complete the full application. Once tooth application is completed, limited to once every 3 years for permanent teeth (1-32).	0	0	0	0	0	0	0	0	0
D2999	Unspecified Restorative Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3110	Pulp Cap – Direct (Excluding Final Restoration)		20%	20%	20%	50%	10%	0	10%	10%	20%

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D3120	Pulp Cap – Indirect (Excluding Final Restoration)		20%	20%	20%	50%	10%	0	10%	10%	20%
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	If done in conjunction with root canal therapy, included in cost of RCT	20%	20%	20%	50%	10%	0	10%	10%	20%
D3221	Pulpal Debridement, Primary And Permanent Teeth	Considered inclusive with the Endodontic treatment when completed on the same day	20%	20%	20%	50%	10%	0	10%	10%	20%
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development		20%	20%	20%	50%	10%	0	10%	10%	20%
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)		20%	20%	20%	50%	10%	0	10%	10%	20%
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)		20%	20%	20%	50%	10%	0	10%	10%	20%
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)		20%	20%	20%	50%	10%	0	10%	10%	20%
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)		20%	20%	20%	50%	10%	0	10%	10%	20%
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)		40%	50%	50%	50%	40%	0	10%	10%	20%
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access		20%	20%	20%	50%	10%	0	10%	10%	20%
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth		20%	20%	20%	50%	10%	0	10%	10%	20%
D3333	Internal Root Repair of Perforation Defects		20%	20%	20%	50%	10%	0	10%	10%	20%
D3346	Retreatment of Previous Root Canal Therapy – Anterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D3347	Retreatment of Previous Root Canal Therapy – Premolar		20%	20%	20%	50%	10%	0	10%	10%	20%
D3348	Retreatment of Previous Root Canal Therapy – Molar		40%	50%	50%	50%	40%	0	10%	10%	20%
D3351	Apexification/Recalcification – Initial Visit		20%	20%	20%	50%	10%	0	10%	10%	20%
D3352	Apexification/Recalcification – Interim Medication Replacement		20%	20%	20%	50%	10%	0	10%	10%	20%
D3353	Apexification/ Recalcification – Final Visit		20%	20%	20%	50%	10%	0	10%	10%	20%
D3355	Pulpal Regeneration - Initial Visit		20%	20%	20%	50%	10%	0	10%	10%	20%
D3356	Pulpal Regeneration – Interim Medication Replacement		20%	20%	20%	50%	10%	0	10%	10%	20%
D3357	Pulpal Regeneration – Completion of Treatment		20%	20%	20%	50%	10%	0	10%	10%	20%
D3410	Apicoectomy – Anterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D3421	Apicoectomy – Premolar (First Root)		20%	20%	20%	50%	10%	0	10%	10%	20%
D3425	Apicoectomy – Molar (First Root)		20%	20%	20%	50%	10%	0	10%	10%	20%
D3426	Apicoectomy – Each Additional Root		20%	20%	20%	50%	10%	0	10%	10%	20%
D3428	Bone Graft In Conjunction With Periradicular Surgery - per Tooth, Single Site		N/C	N/C	N/C	N/C	N/C	N/C	10%	N/C	N/C

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D3429	Bone Graft in Conjunction with Periradicular Surgery - Each Additional Contiguous Tooth in the Same Surgical Site		N/C	N/C	N/C	N/C	N/C	N/C	10%	N/C	N/C
D3430	Retrograde Filling – per Root		20%	20%	20%	50%	10%	0	10%	10%	20%
D3431	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction With Periradicular Surgery		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3432	Guided Tissue Regeneration, Resorbable Barrier, per Site, In Conjunction with Periradicular Surgery		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3450	Root Amputation – per Root		20%	20%	20%	50%	10%	0	10%	10%	20%
D3460	Endodontic Endosseous Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3470	Intentional Re-Implantation (Including Necessary Splinting)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3471	Surgical repair of root resorption - anterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D3472	Surgical repair of root resorption – premolar		20%	20%	20%	50%	10%	0	10%	10%	20%
D3473	Surgical repair of root resorption – molar		20%	20%	20%	50%	10%	0	10%	10%	20%
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior		20%	20%	20%	50%	10%	0	10%	10%	20%
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar		20%	20%	20%	50%	10%	0	10%	10%	20%
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar		20%	20%	20%	50%	10%	0	10%	10%	20%
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	If done in conjunction with root canal therapy, included in cost of RCT	20%	20%	20%	50%	10%	0	10%	10%	20%
D3911	Intraorifice Barrier	Inclusive to root canals	0	0	0	0	0	0	0	0	0
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy		20%	20%	20%	50%	10%	0	10%	10%	20%
D3921	Decoronation or Submergence of an Erupted Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	If done in conjunction with root canal therapy, included in cost of RCT, unless performed by dentist other than who performed RCT or crown.	0	0	0	0	0	0	0	10%	20%
D3999	Unspecified Endodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4210	Gingivectomy or Gingivoplasty – 4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	20%	20%	20%	50%	10%	0	10%	10%	20%
D4211	Gingivectomy or Gingivoplasty – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	20%	20%	20%	50%	10%	0	10%	10%	20%

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D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	DMO Standard Plans (#) – 1 per quadrant every 3 years	20%	20%	20%	50%	10%	0	10%	10%	20%
D4230	Anatomical Crown Exposure - 4 or More Contiguous Teeth per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4231	Anatomical Crown Exposure - 1 to 3 Teeth or Bounded Tooth Spaces per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4240	Gingival Flap Procedure, Including Root Planing – 4 or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	20%	20%	20%	50%	10%	0	10%	10%	20%
D4241	Gingival Flap Procedure, Including Root Planing – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	20%	20%	20%	50%	10%	0	10%	10%	20%
D4245	Apically Positioned Flap		20%	20%	20%	50%	10%	0	10%	10%	20%
D4249	Clinical Crown Lengthening – Hard Tissue		40%	50%	50%	50%	40%	0	10%	10%	20%
D4260	Osseous Surgery (Including Elevation of a Full Thickness Flap And Closure) – Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	40%	50%	50%	50%	40%	0	10%	10%	20%
D4261	Osseous Surgery (Including Elevation of a Full Thickness Flap And Closure) – One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	40%	50%	50%	50%	40%	0	10%	10%	20%
D4263	Bone Replacement Graft – retained natural tooth - First Site in Quadrant		N/C	N/C	N/C	N/C	N/C	N/C	10%	N/C	N/C
D4264	Bone Replacement Graft – retained natural tooth - Each Additional Site in Quadrant		N/C	N/C	N/C	N/C	N/C	N/C	10%	N/C	N/C
D4265	Biologic Materials to Aid in Soft And Osseous Tissue Regeneration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4266	Guided Tissue Regeneration – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4267	Guided Tissue Regeneration – Non-Resorbable Barrier, per Site (Includes Membrane Removal)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4268	Surgical Revision Procedure, per Tooth		20%	20%	20%	50%	10%	0	10%	10%	20%
		Soft Tissue Graft Procedures – Covered as Basic under "Pre Nov 2000 Plans" (*) and as a Major Service under "DMO Standard Plans" (#)." First copayment shown = "Pre November 1, 2000 Plan" (*) Second copayment = "DMO Standard Plan" (#)									
D4270	Pedicle Soft Tissue Graft Procedure		20% 40%	20% 50%	50%	50% 50%	10% 40%	0% 0%	10%	10% 10%	20% 20%
D4273	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) First Tooth, Implant or Edentulous Tooth Position		20% 40%	20% 50%	50%	50% 50%	10% 40%	0% 0%	10%	10% 10%	20% 20%

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D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft		20% 50%	20% 50%	50%	50% 50%	10% 40%	0% 0%	10%	10% 10%	20% 20%
D4276	Combined Connective Tissue and Pedicle Graft, per Tooth		20% 50%	20% 50%	50%	50% 50%	10% 40%	0% 0%	10%	10% 10%	20% 20%
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft		20% 40%	20% 50%	50%	50% 50%	10% 40%	0% 0%	10%	10% 10%	20% 20%
D4278	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) Each Additional Contiguous Tooth, Implant, or Edentulous Tooth Position in Same Graft Site		20% 40%	20% 50%	50%	50% 50%	10% 40%	0% 0%	10%	10% 10%	20% 20%
D4283	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		20% 40%	20% 50%	50%	50% 50%	10% 40%	0 0	10%	10% 10%	20% 20%
D4285	Non Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site And Donor Material) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		20% 40%	20% 50%	50%	50% 50%	10% 40%	0 0	10%	10% 10%	20% 20%
D4286	Removal of Non-resorbable Barrier	Inclusive with D7957 - Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	0	0	0	0	0	0	0	0	0
D4322	Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4323	Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4341	Periodontal Scaling and Root Planing, 4 or More Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	20%	20%	20%	50%	10%	0	10%	10%	20%
D4342	Periodontal Scaling and Root Planing – 1-3 Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	20%	20%	20%	50%	10%	0	10%	10%	20%
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		0	0	0	0	0	0	0	0	0

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D4355	Full Mouth Debridement to Enable Comprehensive Oral Evaluation and Diagnosis on a Subsequent Visit	Once per lifetime when covered under Aetna dental plans •D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355. •D1110, D1120, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.	40%	50%	50%	50%	40%	50%	10%	10%	20%
D4381	Localized Delivery of Antimicrobial Agents via a Controlled Release Vehicle Into Diseased Crevicular Tissue, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Special Note for D4910: **Periodontal Maintenance Procedures are covered twice per year only when there is a history of periodontal surgery. (Effective 04/01/2023, D4341 and D4342 have been added to the DMO list of procedure codes that will allow for future D4910.) If there is no history of periodontal surgery, an allowance for D1110 applies, provided the prophy frequency of 2 per year (pre-1991 plans = 6 per year) has not been met. Dentist may charge the difference between their Usual and Customary fees for D1110 and D4910.** **If prophy frequency met or there has been a combination of any two D1110 or D4910 done, the procedure is not covered. The patient is responsible for the dentist's Usual and Customary fee for the service.**									
D4910	Periodontal Maintenance	(See Special Note above)	20%	20%	20%	50%	10%	0	10%	0	20%
D4920	Unscheduled Dressing Change (by Someone Other than Treating Dentist or Their Staff)		20%	20%	20%	50%	10%	0	10%	0	0
D4921	Gingival Irrigation – per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Special Note for D4999: **Laser may not be submitted as D4999. The use of laser is not a procedure in and of itself; therefore, the patient may not be charged separately for this. Laser is considered inclusive with the service performed.**									
D4999	Unspecified Periodontal Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Removable Prosthetic Codes **Effective 1/1/2024, the "initial placement rule" is removed.** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **Prior to 1/1/2024 -** Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does not apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. (Plan 2BA - Eligible for Plan benefit if replacement of an existing prosthesis that is over 7 years old.) **Note – Benefit includes all adjustments, relines and rebases occurring within 6 months of insertion (exception D5130 & D5140).** **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.**									
D5110	Complete Denture – Maxillary		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5120	Complete Denture – Mandibular		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5130	Immediate Denture – Maxillary	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5140	Immediate Denture – Mandibular	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5211	Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		40%	50%	50%	50%	40%	50%	40%	10%	20%

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D5212	Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5221	Immediate Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5222	Immediate Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5223	Immediate Maxillary Partial Denture – Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5224	Immediate Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5225	Maxillary Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5226	Mandibular Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5227	Immediate Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5228	Immediate Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5282	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), maxillary		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5283	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), mandibular		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5284	Removable unilateral partial denture – one-piece flexible base (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5286	Removable unilateral partial denture – one-piece resin (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		40%	50%	50%	50%	40%	50%	40%	10%	20%

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D5410	Adjust Complete Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5411	Adjust Complete Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5421	Adjust Partial Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5422	Adjust Partial Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5511	Repair Broken Complete Denture Base, Mandibular		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5512	Repair Broken Complete Denture Base, Maxillary		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5520	Replace Missing or Broken Teeth – Complete Denture - per Tooth		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5611	Repair Resin Partial Denture Base, Mandibular		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5612	Repair Resin Partial Denture Base, Maxillary		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5621	Repair Cast Partial Framework, Mandibular		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5622	Repair Cast Partial Framework, Maxillary		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5630	Repair or Replace Broken Retentive/Clasping Materials - per Tooth		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5640	Replace Missing or Broken Teeth – Partial Denture - per Tooth		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5650	Add Tooth to Existing Partial Denture - per Tooth		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5660	Add Clasp to Existing Partial Denture - per Tooth		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5670 - D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary or Mandibular)		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5710 - D5711	Rebase Complete Maxillary or Mandibular Denture	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5720 - D5721	Rebase Maxillary or Mandibular Partial Denture	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5725	Rebase Hybrid Prosthesis		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5730	Reline Complete Maxillary Denture (Direct)	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5731	Reline Complete Mandibular Denture (Direct)	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5740	Reline Maxillary Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5741	Reline Mandibular Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5750	Reline Complete Maxillary Denture (Indirect)	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5751	Reline Complete Mandibular Denture (Indirect)	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5760	Reline Maxillary Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5761	Reline Mandibular Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	40%	50%	50%	50%	40%	50%	10%	10%	20%
D5765	Soft Liner for Complete or Partial Removable Denture – Indirect		40%	50%	50%	50%	40%	50%	10%	10%	20%
D5810 - D5811	Interim Complete Denture (Maxillary or Mandibular)	Plan benefit and patient copay for permanent to include all interim provisional charges	0	0	0	0	0	0	0	0	0

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D5820	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Maxillary	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5821	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Mandibular	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5850 - D5851	Tissue Conditioning, Maxillary or Mandibular	Inclusive with prosthesis within 6 months after insertion	20%	20%	20%	50%	10%	0	10%	10%	20%
D5862	Precision Attachment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5863	Overdenture – Complete Maxillary	Not covered – Alternate benefit based on D5110	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5864	Overdenture – Partial Maxillary	Not covered – Alternate benefit based on D5211	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5865	Overdenture – Complete Mandibular	Not covered – Alternate benefit based on D5120	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5866	Overdenture – Partial Mandibular	Not covered – Alternate benefit based on D5212	40%	50%	50%	50%	40%	50%	40%	10%	20%
D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5875	Modification of Removable Prosthesis Following Implant Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5876	Add Metal Substructure to Acrylic Full Denture (per Arch)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D5899	Unspecified Removable Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5911 - D5993	Maxillofacial Prosthetics	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5994	Periodontal Medicament Carrier with Peripheral Seal – Laboratory Processed	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5999	Unspecified Maxillofacial Prosthesis, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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		Fixed Prosthetic Codes **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **<u>Effective 1/1/2024, the "initial placement rule" is removed.</u>** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **<u>Prior to 1/1/2024</u> - Eligible for Plan benefit if replacing teeth extracted while covered under the plan or is a replacement of an existing prosthesis that is over 5 years old (initial placement rule does <u>not</u> apply in California or Texas).** **Facings on molars are not covered.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)**									
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.									
D6010	Surgical Placement of Implant Body: Endosteal Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C 40%	N/C 50%	50%	N/C	N/C 40%	N/C	40%	N/C	N/C
D6011	Second Stage Implant Surgery	Not covered unless plan covers implants. For plans covering implants, this is inclusive to surgical placement of implant.	N/C $0	N/C $0	$0	N/C	N/C $0	N/C	$0	N/C	N/C
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6013	Surgical Placement of Mini Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C 40%	N/C 50%	50%	N/C	N/C 40%	N/C	40%	N/C	N/C
D6040	Surgical Placement: Eposteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6050	Surgical Placement: Transosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6051	Placement of Interim Implant Abutment	For plans covering implants, plan benefit and patient copay for permanent restoration includes all interim charges.	N/C $0	N/C $0	$0	N/C	N/C $0	N/C	$0	N/C	N/C
D6052	Semi-Precision Attachment Abutment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6055	Connecting Bar - Implant Supported or Abutment Supported	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6056	Prefabricated Abutment - Includes Modification and Placement	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C 40%	N/C 50%	50%	N/C	N/C 40%	N/C	40%	N/C	N/C
D6057	Custom Fabricated Abutment – Includes Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6058	Abutment Supported Porcelain/Ceramic Crown		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%

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D6062	Abutment Supported Cast Metal Crown (High Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6064	Abutment Supported Cast Metal Crown (Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6065	Implant Supported Porcelain/Ceramic Crown		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6075	Implant Supported Retainer for Ceramic FPD		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6080	Implant Maintenance Procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	Not covered unless plan covers implants.	N/C 40%	N/C 50%	50%	N/C	N/C 40%	N/C	40%	N/C	N/C
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths: includes cleaning of the implant surfaces, without flap entry and closure	Not covered unless plan covers implants.	N/C	N/C 50%	50%	N/C	N/C 40%	N/C	40%	N/C	N/C
D6082	Implant supported crown – porcelain fused to predominantly base alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6083	Implant supported crown – porcelain fused to noble alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%

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D6084	Implant supported crown – porcelain fused to titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6085	Provisional implant crown	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6086	Implant supported crown – predominantly base alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6087	Implant supported crown – noble alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6088	Implant supported crown – titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6089	Accessing and Retorquing Loose Implant Screw - per Screw		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6090	Repair of Implant/Abutment Supported Prosthesis		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6091	Replacement of Semi-Precision or Precision Attachment of Implant/Abutment Supported Prosthesis, per Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6092	Re-cement Or Re-bond Implant/Abutment Supported Crown		20%	20%	20%	50%	10%	0	10%	10%	20%
D6093	Re-cement Or Re-bond Implant/Abutment Supported Fixed Partial Denture		20%	20%	20%	50%	10%	0	10%	10%	20%
D6094	Abutment Supported Crown (Titanium)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6095	Repair Implant Abutment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6096	Remove Broken Implant Retaining Screw		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6098	Implant supported retainer – porcelain fused to predominantly base alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6100	Implant Removal, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6102	Debridement and osseous contouring of a periimplant defect: includes surface cleaning of exposed implant surfaces and flap entry and closure		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration		N/C	N/C	N/C	N/C	N/C	N/C	10%	N/C	N/C
D6104	Bone graft at time of implant placement		N/C	N/C	N/C	N/C	N/C	N/C	10%	N/C	N/C
D6105	Removal of Implant Body not Requiring Bone Removal or Flap Elevation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D6106	Guided Rissue Regeneration – Resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6107	Guided Rissue Regeneration – Non-resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6110	Implant /Abutment Supported Removable Denture for Edentulous Arch – Maxillary		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6111	Implant /Abutment Supported Removable Denture for Edentulous Arch – Mandibular		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6112	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Maxillary		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6113	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Mandibular		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6114	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Maxillary		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6115	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Mandibular		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6116	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Maxillary		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6117	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Mandibular		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6118	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Mandibular		40%	50%	50%	50%	40%	50%	40%	N/C	N/C
D6119	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Maxillary		40%	50%	50%	50%	40%	50%	40%	N/C	N/C
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6121	Implant supported retainer for metal FPD – predominantly base alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6122	Implant supported retainer for metal FPD – noble alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	This procedure includes active debriding of the implant(s) and prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s). Only covered if Plan has implant coverage.	N/C 40%	N/C 50%	50%	N/C	N/C 40%	N/C	40%	N/C	N/C
D6190	Radiographic / Surgical Implant Index, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6191	Semi-precision abutment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6192	Semi-precision attachment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6193	Replacement of an Implant Screw	If D6193 is eligible, D6096 on same day is inclusive (not separately eligible).	40%	50%	50%	50%	40%	50%	40%	10%	20%
D6194	Abutment Supported Retainer Crown for FPD (Titanium)		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%

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D6197	Replacement of Restorative Material Used to Close an Access Opening of a Screw-retained Implant Supported Prosthesis, per Implant	Not Covered for molars or stress-bearing surfaces of premolars – Alternate Benefit D2140 (See Elective Services/ Optional Treatment Plans)	20%	20%	20%	50%	10%	0	10%	10%	20%
D6198	Remove Interim Implant Component	Inclusive to permanent restoration	0	0	0	0	0	0	0	0	0
D6199	Unspecified Implant Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6205	Pontic – Indirect Resin Based Composite		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6210	Pontic – Cast High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6211	Pontic – Cast Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6212	Pontic – Cast Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6214	Pontic – Titanium		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6240	Pontic – Porcelain Fused to High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6241	Pontic – Porcelain Fused to Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6242	Pontic – Porcelain Fused to Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6243	Pontic – porcelain fused to titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6245	Pontic – Porcelain/Ceramic		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6250	Pontic – Resin with High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6251	Pontic – Resin with Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6252	Pontic – Resin with Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6253	Provisional Pontic– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan Benefit and patient copay for permanent to include all provisional charges	0	0	0	0	0	0	0	0	0
D6545	Retainer – Cast Metal for Resin-Bonded Fixed Prosthesis		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6548	Retainer – Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6549	Resin Retainer – for Resin Bonded Fixed Prosthesis		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6600	Retainer Inlay – Porcelain/Ceramic, 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6601	Retainer Inlay – Porcelain/Ceramic, 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6602	Retainer Inlay – Cast High Noble Metal, 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6603	Retainer Inlay – Cast High Noble Metal, 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6604	Retainer Inlay – Cast Predominantly Base Metal, 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6605	Retainer Inlay – Cast Predominantly Base Metal, 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6606	Retainer Inlay – Cast Noble Metal, 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6607	Retainer Inlay – Cast Noble Metal, 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6608	Retainer Onlay – Porcelain/Ceramic, 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%

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D6609	Retainer Onlay – Porcelain/Ceramic, 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6610	Retainer Onlay – Cast High Noble Metal, 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6611	Retainer Onlay – Cast High Noble Metal, 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6612	Retainer Onlay – Cast Predominantly Base Metal, 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6613	Retainer Onlay – Cast Predominantly Base Metal, 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6614	Retainer Onlay – Cast Noble Metal, 2 Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6615	Retainer Onlay – Cast Noble Metal, 3 or More Surfaces		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6624	Retainer Inlay – Titanium		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6634	Retainer Onlay – Titanium		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6710	Retainer Crown – Indirect Resin Based Composite		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6720	Retainer Crown – Resin with High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6721	Retainer Crown – Resin with Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6722	Retainer Crown – Resin with Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6740	Retainer Crown – Porcelain/Ceramic		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6750	Retainer Crown – Porcelain Fused to High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6751	Retainer Crown – Porcelain Fused to Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6752	Retainer Crown – Porcelain Fused to Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6753	Retainer crown – porcelain fused to titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6780	Retainer Crown – 3/4 Cast High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6781	Retainer Crown – 3/4 Cast Predominantly Based Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6782	Retainer Crown – 3/4 Cast Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6783	Retainer Crown – 3/4 Porcelain/Ceramic		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6784	Retainer crown 3/4 – titanium and titanium alloys		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6790	Retainer Crown – Full Cast High Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6791	Retainer Crown – Full Cast Predominantly Base Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6792	Retainer Crown – Full Cast Noble Metal		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6793	Provisional Retainer Crown– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan Benefit and patient copay for permanent to include all provisional charges	0	0	0	0	0	0	0	0	0
D6794	Retainer Crown – Titanium		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6920	Connector Bar	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6930	Re-cement or Re-bond Fixed Partial Denture		20%	20%	20%	50%	10%	0	10%	10%	20%
D6940	Stress Breaker		40%	50%	50%	50%	40%	50%	40%	10%	20%
D6950	Precision Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure		40%	50%	50%	50%	40%	50%	10%	10%	20%
D6985	Pediatric Partial Denture, Fixed	Eligible for anterior teeth. Not Covered for teeth other than anterior.	40%	50%	50%	50%	40%	50%	40%	10%	20%
D6999	Unspecified Fixed Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7111	Extraction, Coronal Remnants – Primary Tooth	Includes extractions for orthodontic purposes.	20%	20%	20%	50%	10%	0	10%	10%	20%
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	Includes extractions for orthodontic purposes.	20%	20%	20%	50%	10%	0	10%	10%	20%
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth and Including Elevation of Mucoperiosteal Flap if Indicated	Includes extractions for orthodontic purposes.	20%	20%	20%	50%	10%	0	10%	10%	20%
D7220	Removal of Impacted Tooth – Soft Tissue	Includes extractions for orthodontic purposes.	20%	20%	20%	50%	10%	0	10%	10%	20%
D7230	Removal of Impacted Tooth – Partially Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	40%	50%	50%	50%	40%	0	10%	10%	20%
D7240	Removal of Impacted Tooth – Completely Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	40%	50%	50%	50%	40%	0	10%	10%	20%
D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	40%	50%	50%	50%	40%	0	10%	10%	20%
D7250	Removal of Residual Tooth Roots (Cutting Procedure)		20%	20%	20%	50%	10%	0	10%	10%	20%
D7251	Coronectomy - Intentional Partial Tooth Removal	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	40%	50%	50%	50%	40%	0	10%	10%	20%
D7252	Partial Extraction for Immediate Implant Placement	Only covered if implants are covered.	20%	20%	20%	50%	10%	0	10%	10%	20%
D7259	Nerve Dissection		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7260	Oroantral Fistula Closure		20%	20%	20%	50%	40%	0	10%	10%	20%
D7261	Primary Closure of a Sinus Perforation		20%	20%	20%	50%	40%	0	10%	10%	20%
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7272	Tooth Transplantation (Includes Reimplantation from One Site to Another & Splinting and/or Stabilization)		20%	20%	20%	50%	10%	0	10%	10%	20%
D7280	Exposure of an Unerupted Tooth		20%	20%	20%	50%	10%	0	10%	10%	20%
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption		20%	20%	20%	50%	10%	0	10%	10%	20%
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth		20%	20%	20%	50%	10%	0	10%	10%	20%
D7284	Excisional Biopsy of Minor Salivary Glands		0	0	0	0	0	0	0	0	0
D7285	Incisional Biopsy of Oral Tissue – Hard (Bone, Tooth)		0	0	0	0	0	0	0	0	0
D7286	Incisional Biopsy of Oral Tissue – Soft		0	0	0	0	0	0	0	0	0

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D7287	Exfoliative Cytological Sample Collection		0	0	0	0	0	0	0	0	0
D7288	Brush Biopsy – Transepithelial Sample Collection	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7290	Surgical Repositioning of Teeth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7291	Transseptal Fiberotomy/ Supra Crestal Fiberotomy, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7292	Placement of Temporary Anchorage Device [Screw Retained Plate] Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7293	Placement of Temporary Anchorage Device Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7294	Placement of Temporary Anchorage Device Without Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7295	Harvest of Bone for Use in Autogenous Grafting Procedures		N/C	N/C	N/C	N/C	N/C	N/C	10%	N/C	N/C
D7296	Corticotomy - One to Three Teeth or Tooth Spaces, per Quadrant		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7297	Corticotomy – Four or More Teeth or Tooth Spaces, per Quadrant		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7298	Removal of Temporary Anchorage Device [Screw Retained Plate], Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	0	0	0	0	0	0	0	0	0
D7299	Removal of Temporary Anchorage Device, Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	0	0	0	0	0	0	0	0	0
D7300	Removal of Temporary Anchorage Device Without Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	0	0	0	0	0	0	0	0	0
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	20%	20%	20%	50%	10%	0	10%	10%	20%
D7311	Alveoloplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		20%	20%	20%	50%	10%	0	10%	10%	20%
D7320	Alveoloplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	20%	20%	20%	50%	10%	0	10%	10%	20%
D7321	Alveoloplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		20%	20%	20%	50%	10%	0	10%	10%	20%
D7340	Vestibuloplasty – Ridge Extension (Secondary Epithelialization)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7350	Vestibuloplasty – Ridge Extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7410	Excision of Benign Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7411	Excision of Benign Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7412	Excision of Benign Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7413	Excision of Malignant Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7414	Excision of Malignant Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7415	Excision of Malignant Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7440	Excision Malignant Tumor - Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7441	Excision Malignant Tumor Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7450	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm		20%	20%	20%	50%	10%	0	10%	10%	20%
D7451	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm		20%	20%	20%	50%	10%	0	10%	10%	20%
D7460	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7461	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7465	Destruction of Lesion(s) by Physical or Chemical Method, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)		20%	20%	20%	50%	10%	0	10%	10%	20%
D7472	Removal of Torus Palatinus		20%	20%	20%	50%	10%	0	10%	10%	20%
D7473	Removal of Torus Mandibularis		20%	20%	20%	50%	10%	0	10%	10%	20%
D7485	Reduction of Osseous Tuberosity		20%	20%	20%	50%	10%	0	10%	10%	20%
D7490	Radical Resection of Maxilla or Mandible	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7509	Marsupialization of Odontogenic Cyst		20%	20%	20%	50%	10%	0	10%	10%	20%
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue		20%	20%	20%	50%	10%	0	10%	10%	20%
D7511	Incision and Drainage of Abscess – Intraoral Soft Tissue - Complicated		20%	20%	20%	50%	10%	0	10%	10%	20%
D7520	Incision and Drainage of Abscess – Extraoral Soft Tissue		20%	20%	20%	50%	10%	0	10%	10%	20%
D7521	Incision and Drainage of Abscess – Extraoral Soft Tissue - Complicated		20%	20%	20%	50%	10%	0	10%	10%	20%
D7530	Removal of Foreign Body from Mucosa, Skin or Subcutaneous Alveolar Tissue		20%	20%	20%	50%	10%	0	10%	10%	20%
D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System		20%	20%	20%	50%	10%	0	10%	10%	20%
D7550	Partial Ostectomy/ Sequestrectomy for Removal of Non-Vital Bone		20%	20%	20%	50%	10%	0	10%	10%	20%

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* Pre November 1, 2000 Plan
# DMO Standard Plan

Dental Procedure Guidelines
for DMO Primary Care Dentists

ADA CODE[1]	NOMENCLATURE	GUIDELINES	1 1i	2 2i	2BA	3	8 8i	12	14i	21	22
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7610-D7820	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7830	Manipulation Under Anesthesia	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7840-D7870	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7871	Non-Arthroscopic Lysis and Lavage	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7872-D7877	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7880	Occlusal Orthotic Device, by Report		N/C	N/C	N/C	N/C	N/C	N/C	40%	N/C	N/C
D7881	Occlusal Orthotic Device Adjustment		N/C	N/C	N/C	N/C	N/C	N/C	40%	N/C	N/C
D7899	Unspecified TMD Therapy, by Report		N/C	N/C	N/C	N/C	N/C	N/C	40%	N/C	N/C
D7910	Suture of Recent Small Wound up to 5 cm		20%	20%	20%	50%	10%	0	10%	10%	20%
D7911	Complicated Suture - Up to 5 cm		20%	20%	20%	50%	10%	0	10%	10%	20%
D7912	Complicated Suture - greater than 5 cm		20%	20%	20%	50%	10%	0	10%	10%	20%
D7920-D7921	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Inclusive to the extraction Patient cannot be billed	0	0	0	0	0	0	0	0	0
D7939	Indexing for Osteotomy using Dynamic Robotic Assisted or Dynamic Navigation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7940-D7952	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7953	Bone Replacement Graft for Ridge Preservation – Per Site		N/C	N/C	N/C	N/C	N/C	N/C	10%	N/C	N/C
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7956	Guided Tissue Regeneration, Edentulous Area – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7957	Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7961	Buccal / labial frenectomy (frenulectomy)		20%	20%	20%	50%	10%	0	10%	10%	20%
D7962	Lingual frenectomy (frenulectomy)		20%	20%	20%	50%	10%	0	10%	10%	20%
D7963	Frenuloplasty		20%	20%	20%	50%	10%	0	10%	10%	20%
D7970	Excision of Hyperplastic Tissue – Per Arch		20%	20%	20%	50%	10%	0	10%	10%	20%
D7971	Excision of Pericoronal Gingiva		20%	20%	20%	50%	10%	0	10%	10%	20%
D7972	Surgical Reduction of Fibrous Tuberosity		20%	20%	20%	50%	10%	0	10%	10%	20%
D7979	Non-Surgical Sialolithotomy		20%	20%	20%	50%	10%	0	10%	10%	20%
D7980	Surgical Sialolithotomy		20%	20%	20%	50%	10%	0	10%	10%	20%
D7981	Excision Of Salivary Gland, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7982	Sialodochoplasty	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7983	Closure of Salivary Fistula		20%	20%	20%	50%	10%	0	10%	10%	20%
D7990-D7998	Other Surgical Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7999	Unspecified Oral Surgery Procedure, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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* Pre November 1, 2000 Plan
# DMO Standard Plan

Dental Procedure Guidelines
for DMO Primary Care Dentists

ADA CODE[1]	NOMENCLATURE	GUIDELINES	1 1i	2 2i	2BA	3	8 8i	12	14i	21	22
D8210	Removable Appliance Therapy	Includes appliances for thumb sucking and tongue thrusting. Pre Nov 2000 Plans (*) - Covered at percentage shown. DMO Standard Plans (#) – Covered at Ortho copayment level.	40%	50%	50%	50%	40%	50%	40%	10%	20%
D8220	Fixed Appliance Therapy	Includes appliances for thumb sucking and tongue thrusting. Pre Nov 2000 Plans (*) - Covered at percentage shown. DMO Standard Plans (#) – Covered at Ortho copayment level.	40%	50%	50%	50%	40%	50%	0	10%	20%
D8695	Removal of Fixed Orthodontic Appliances for Reasons other than Completion of Treatment		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	Inclusive when performed on the same date of service as definitive treatment; member cannot be billed. Definitive treatment is the treatment which resolves the pain permanently - this is the final measure taken to eliminate the pain.	0	0	0	0	0	0	0	0	0
D9120	Fixed Partial Denture Sectioning		40%	50%	50%	50%	40%	0	10%	10%	20%
D9130	Temporomandibular Joint Dysfunction – Non-invasive physical Therapies		N/C	N/C	N/C	N/C	N/C	N/C	40%	N/C	N/C
D9210	Local Anesthesia, Not in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	0	0	0	0	0	0	0	0	0
D9211	Regional Block Anesthesia	Included in cost of underlying procedure	0	0	0	0	0	0	0	0	0
D9212	Trigeminal Division Block Anesthesia	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	0	0	0	0	0	0	0	0	0
D9219[3]	Evaluation For Moderate Sedation, Deep Sedation or General Anesthesia	When rendered by anesthesiologist	40%	50%	50%	50%	40%	0	10%	10%	20%
D9222	Deep Sedation/General Anesthesia – First 15 Minutes	Covered for certain procedures and clinical conditions	40%	50%	50%	50%	40%	0	10%	10%	20%
D9223	Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	40%	50%	50%	50%	40%	0	10%	10%	20%
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia – First 15 Minutes	Covered for certain procedures and clinical conditions	40%	50%	50%	50%	40%	0	10%	10%	20%
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	40%	50%	50%	50%	40%	0	10%	10%	20%
D9248	Non-Intravenous Conscious Sedation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician	For Second Opinions only	0	0	0	0	0	0	0	0	0
D9311	Consultation with a medical health care professional		0	0	0	0	0	0	0	0	0
D9410	House/Extended Care Facility Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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# DMO Standard Plan

Dental Procedure Guidelines
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ADA CODE[1]	NOMENCLATURE	GUIDELINES	1 1i	2 2i	2BA	3	8 8i	12	14i	21	22
D9420	Hospital or Ambulatory Surgical Center Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	Included in cost of underlying procedure	0	0	0	0	0	0	0	0	0
D9440	Office Visit - After Regularly Scheduled Hours	Not Covered (Covered in Texas)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)	N/C (0)
D9450	Case Presentation, Detailed and Extensive Treatment Planning	Included in Cost of Underlying Procedure	0	0	0	0	0	0	0	0	0
D9610	Therapeutic Parenteral Drug, Single Administration	Injection of antibiotics Covered under Plan Code 10	N/C	N/C	N/C	N/C	N/C	N/C	10%	N/C	N/C
D9612	Therapeutic Parenteral Drugs, 2 or more Administrations, Different Medications	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9613	Infiltration of Sustained Release Therapeutic Drug	Eligible when performed in conjunction with procedure codes D7220, D7230, D7240, D7241, or D7251 on third molars (teeth #'s 01, 16, 17, or 32).	40%	50%	50%	50%	40%	50%	40%	10%	20%
D9630	Drugs or Medicaments dispensed in the office for home use	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9910	Application of Desensitizing Medicament	Inclusive with the restoration being performed on the same date of service; member cannot be billed.	0	0	0	0	0	0	0	0	0
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9912	Pre-visit Patient Screening	Inclusive with record keeping requirements	0	0	0	0	0	0	0	0	0
D9913	Administration of Neuromodulators		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9914	Administration of Dermal Fillers		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9920	Behavior Management, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9930	Treatment of Complications (Post-surgical) – Unusual Circumstances, by Report	Included in cost of underlying procedure	0	0	0	0	0	0	0	0	0
D9932	Cleaning and Inspection of Removable Complete Denture, Maxillary		40%	50%	50%	50%	40%	50%	40%	10%	20%
D9933	Cleaning and Inspection of Removable Complete Denture, Mandibular		40%	50%	50%	50%	40%	50%	40%	10%	20%
D9934	Cleaning and Inspection of Removable Partial Denture, Maxillary		40%	50%	50%	50%	40%	50%	40%	10%	20%
D9935	Cleaning and Inspection of Removable Partial Denture, Mandibular		40%	50%	50%	50%	40%	50%	40%	10%	20%
D9938	Fabrication of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9939	Placement of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9941	Fabrication of Athletic Mouthguard	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9942	Repair and/or Reline of Occlusal Guard		40%	50%	50%	50%	40%	50%	40%	10%	20%
D9943	Occlusal Guard Adjustment	Fee for occlusal guard includes adjustments performed within 6 months of placement	40%	50%	50%	50%	40%	50%	40%	10%	20%

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# DMO Standard Plan

Dental Procedure Guidelines
for DMO Primary Care Dentists

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D9944	Occlusal Guard – Hard Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	40%	50%	50%	50%	40%	50%	40%	10%	20%
D9945	Occlusal Guard – Soft Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	40%	50%	50%	50%	40%	50%	40%	10%	20%
D9946	Occlusal Guard – Hard Appliance, Partial Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	40%	50%	50%	50%	40%	50%	40%	10%	20%
D9947	Custom Sleep Apnea Appliance Fabrication and Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9948	Adjustment of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9949	Repair of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9950	Occlusion Analysis - Mounted Case	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9951	Occlusal Adjustment – Limited	Not separately eligible when performed in conjunction with a restoration, root canal therapy or appliance.	20%	20%	20%	50%	10%	0	10%	10%	20%
D9952	Occlusal Adjustment – Complete		20%	20%	20%	50%	10%	0	10%	10%	20%
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9954	Fabrication and Delivery of Oral Appliance Therapy (OAT) Morning Repositioning Device	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9955	Oral Appliance Therapy (OAT) Titration Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9956	Administration of Home Sleep Apnea Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9957	Screening for Sleep Related Breathing Disorders	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9959	Unspecified Sleep Apnea Services Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9961	Duplicate/Copy Patient's Records	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9970	Enamel Microabrasion	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9972	External Bleaching – per Arch - Performed in Office	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9973	External Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9974	Internal Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9975	External Bleaching for Home Application, per Arch	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9985[2]	Sales Tax	Inclusive to service being taxed	0	0	0	0	0	0	0	0	0
D9986	Missed Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9987	Cancelled Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9990	Certified Translation or Sign-language Services per Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9991	Dental case management - addressing appointment compliance barriers	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9992	Dental case management – care coordination	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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# DMO Standard Plan

Dental Procedure Guidelines
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D9993	Dental case management – motivational interviewing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9994	Dental case management – patient education to improve oral health literacy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9995	Teledentistry – Synchronous; Real-Time Encounter		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9996	Teledentistry – Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9997	Dental case management – patients with special health care needs	Inclusive to the primary service Patient cannot be billed	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9999	Unspecified Adjunctive Procedure, by Report	Used for procedure that is not adequately described by a code. Use of this code REQUIRES A WRITTEN NARRATIVE & supporting documentation	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

[1] Current Dental Terminology ©American Dental Association. All rights reserved.

[2] Not separately eligible/inclusive - the patient cannot be billed for these services.

[3] Covered only when performed by anesthesiologist.

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* Pre November 1, 2000 Plan
# DMO Standard Plan

Network Bulletin

Date: October 2024

From: Anna Huck, Director, Dental Network Operations

Subject: DMO® plans – New Jersey State Health Benefits Program

Applies to: DMO® plans 34, 34A, 34B and 34C

This bulletin is part of your *Dental Office Guide*.

Starting January 1, 2025*

We're making changes to the New Jersey State Health Benefit Program (Plan 34) and the nationwide DMO Copay plans (34A, 34B, 34C) for retirees of the New Jersey State Health Benefit Program. These changes will start on January 1, 2025.

New CDT® 2025[1] codes

The American Dental Association has issued new Current Dental Terminology (CDT) codes starting **January 1, 2025**. Attached are the new copay schedules**.

We're here to help

Coverage for any service not specifically listed on the applicable charts will be as determined by Aetna in its discretion. Furthermore, additional codes may be added and codes may be deleted at our discretion. Except as specified otherwise, "codes" refer to codes of the American Dental Association ("ADA"). The appropriate code must be designated when billing or when submitting claims or encounter information.

If you have questions, call our National Dentist Line at **1-800-451-7715**. Thanks for your continued participation and support of Aetna Dental® plans.

* Eligibility for most employees will begin January 1, 2025.
The schedules are subject to change, contingent upon regulatory approval.

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DMO plans are insured by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc. (Aetna). Each insurer has sole financial responsibility for its own products.

ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D0120	Periodic Oral Evaluation - Established Patient	$0	$0	$0	$0
D0140	Limited Oral Evaluation - Problem Focused	$0	$0	$0	$0
D0145	Oral Evaluation for a Patient Under 3 Years of Age and Counseling with Primary Caregiver	$0	$0	$0	$0
D0150	Comprehensive Oral Evaluation – New or Established Patient	$0	$0	$0	$0
D0160	Detailed and Extensive Oral Evaluation – Problem Focused, by Report	$0	$0	$0	$0
D0210	Intraoral – Comprehensive Series of Radiographic Images	$0	$0	$0	$0
D0220	Intraoral – Periapical First Radiographic Image	$0	$0	$0	$0
D0230	Intraoral - Periapical Each Additional Radiographic Image	$0	$0	$0	$0
D0240	Intraoral – Occlusal Radiographic Image	$0	$0	$0	$0
D0250	Extra-oral – 2D Projection Image Created Using a Stationary Radiation Source, and Detector	$0	$0	$0	$0
D0251	Extra-oral Posterior Dental Radiographic Image	$0	$0	$0	$0
D0270	Bitewing - Single Radiographic Image	$0	$0	$0	$0
D0272	Bitewings - Two Radiographic Images	$0	$0	$0	$0
D0273	Bitewings - Three Radiographic Images	$0	$0	$0	$0
D0274	Bitewings - Four Radiographic Images	$0	$0	$0	$0
D0277	Vertical Bitewings – 7 to 8 Radiographic Images	$0	$0	$0	$0
D0330	Panoramic Radiographic Image	$0	$0	$0	$0
D0340	2D Cephalometric Radiographic Image – Acquisition, Measurement and Analysis	$0	$0	$0	$0
D0372	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images	$0	$0	$0	$0
D0373	Intraoral Tomosynthesis – Bitewing Radiographic Image	$0	$0	$0	$0
D0374	Intraoral Tomosynthesis – Periapical Radiographic Image	$0	$0	$0	$0
D0387	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images – Image Capture only	$0	$0	$0	$0
D0388	Intraoral Tomosynthesis – Bitewing Radiographic Image – Image Capture Only	$0	$0	$0	$0
D0389	Intraoral Tomosynthesis – Periapical Radiographic Image – Image Capture only	$0	$0	$0	$0
D0391	Interpretation of Diagnostic Image by a Practitioner Not Associated with Capture of the Image, Including Report	$0	$0	$0	$0
D0412	Blood Glucose Level Test – In-office using a Glucose Meter	N/C	N/C	N/C	N/C
D0414	Laboratory Processing of Microbial Specimen to Include Culture and Sensitivity Studies, Preparation and Transmission of Written Report	$0	$0	$0	$0
D0415	Collection of Microorganisms for Culture and Sensitivity	$0	$0	$0	$0
D0416	Viral Culture	$0	$0	$0	$0
D0419	Assessment of salivary flow by measurement	N/C	N/C	N/C	N/C
D0425	Caries Susceptibility Tests	$0	$0	$0	$0
D0460	Pulp Vitality Tests	$0	$0	$0	$0
D0470	Diagnostic Casts	$0	$0	$0	$0
D0600	Non-Ionizing Diagnostic Procedure Capable of Quantifying, Monitoring, and Recording Changes in Structure of Enamel, Dentin and Cementum	$0	$0	$0	$0
D0604	Antigen testing for a public health related pathogen, including coronavirus	N/C	N/C	N/C	N/C
D0605	Antibody testing for a public health related pathogen, including coronavirus	N/C	N/C	N/C	N/C
D0701	Panoramic radiographic image – image capture only	$0	$0	$0	$0
D0705	Extra-oral posterior dental radiographic image – image capture only	$0	$0	$0	$0
D0706	Intraoral – occlusal radiographic image – image capture only	$0	$0	$0	$0
D0707	Intraoral – periapical radiographic image – image capture only	$0	$0	$0	$0
D0708	Intraoral – bitewing radiographic image – image capture only	$0	$0	$0	$0
D0709	Intraoral – complete series of radiographic images – image capture only	$0	$0	$0	$0
D1110	Prophylaxis - Adult	$0	$0	$0	$0
D1120	Prophylaxis - Child	$0	$0	$0	$0

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[2] Covered only when performed by an anesthesiologist

ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D1206	Topical Application of Fluoride Varnish	$0	$0	$0	$0
D1208	Topical Application of Fluoride – Excluding Varnish	$0	$0	$0	$0
D1301	Immunization Counseling	N/C	N/C	N/C	N/C
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	N/C	N/C	N/C	N/C
D1330	Oral Hygiene Instructions	$0	$0	$0	$0
D1351	Sealant - Per Tooth	$0	$0	$0	$0
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient – Permanent Tooth	$0	$0	$0	$0
D1353	Sealant repair – Per Tooth	$0	$0	$0	$0
D1354	Application of Caries Arresting Medicament – per Tooth	$0	$0	$0	$0
D1355	Caries preventive medicament application – per tooth	$0	$0	$0	$0
D1510	Space Maintainer - Fixed - Unilateral	$0	$0	$0	$0
D1516	Space Maintainer - Fixed – Bilateral, Maxillary	$0	$0	$0	$0
D1517	Space Maintainer - Fixed – Bilateral, Mandibular	$0	$0	$0	$0
D1520	Space Maintainer - Removable - Unilateral	$0	$0	$0	$0
D1526	Space Maintainer - Removable – Bilateral, Maxillary	$0	$0	$0	$0
D1527	Space Maintainer - Removable – Bilateral, Mandibular	$0	$0	$0	$0
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$0	$0	$0	$0
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$0	$0	$0	$0
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$0	$0	$0	$0
D1556	Removal of fixed unilateral space maintainer – per quadrant	$0	$0	$0	$0
D1557	Removal of fixed bilateral space maintainer – maxillary	$0	$0	$0	$0
D1558	Removal of fixed bilateral space maintainer – mandibular	$0	$0	$0	$0
D1575	Distal Shoe Space Maintainer – Fixed – Unilateral	$0	$0	$0	$0
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	N/C	N/C	N/C	N/C
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	N/C	N/C	N/C	N/C
D1710	Moderna Covid-19 vaccine administration – third dose	N/C	N/C	N/C	N/C
D1711	Moderna Covid-19 vaccine administration – booster dose	N/C	N/C	N/C	N/C
D1712	Janssen Covid-19 vaccine administration - booster dose	N/C	N/C	N/C	N/C
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	N/C	N/C	N/C	N/C
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	N/C	N/C	N/C	N/C
D1781	Vaccine Administration – Human Papillomavirus – Dose 1	N/C	N/C	N/C	N/C
D1782	Vaccine Administration – Human Papillomavirus – Dose 2	N/C	N/C	N/C	N/C
D1783	Vaccine Administration – Human Papillomavirus – Dose 3	N/C	N/C	N/C	N/C
D2140	Amalgam - One Surface, Primary or Permanent	$0	N/C	$15	$15
D2150	Amalgam - Two Surfaces, Primary or Permanent	$0	N/C	$20	$20
D2160	Amalgam - Three Surfaces, Primary or Permanent	$0	N/C	$25	$25
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	$0	N/C	$30	$30
D2330	Resin Based Composite – One Surface, Anterior	$0	N/C	$25	$25
D2331	Resin Based Composite – Two Surfaces, Anterior	$0	N/C	$30	$30
D2332	Resin Based Composite – Three Surfaces, Anterior	$0	N/C	$35	$35
D2335	Resin Based Composite – Four or More Surfaces (Anterior)	$0	N/C	$45	$45
D2390	Resin-Based Composite Crown, Anterior	$35	N/C	$55	$55
D2391	Resin-Based Composite - One Surface, Posterior	$15	N/C	$25	$25
D2392	Resin-Based Composite - Two Surfaces, Posterior	$25	N/C	$40	$40

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ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D2393	Resin-Based Composite - Three Surfaces, Posterior	$35	N/C	$55	$55
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	$45	N/C	$70	$70
D2510	Inlay - Metallic - One Surface	$100	N/C	$150	$150
D2520	Inlay - Metallic - Two Surfaces	$100	N/C	$150	$150
D2530	Inlay - Metallic - Three or More Surfaces	$100	N/C	$150	$150
D2542	Onlay - Metallic - Two Surfaces	$100	N/C	$150	$150
D2543	Onlay - Metallic - Three Surfaces	$100	N/C	$150	$150
D2544	Onlay - Metallic – Four Or More Surfaces	$100	N/C	$150	$150
D2610	Inlay - Porcelain/Ceramic – One Surface	$115	N/C	$175	$175
D2620	Inlay - Porcelain/Ceramic – Two Surfaces	$115	N/C	$175	$175
D2630	Inlay - Porcelain/Ceramic – Three Or More Surfaces	$115	N/C	$175	$175
D2642	Onlay - Porcelain/Ceramic – Two Surfaces	$115	N/C	$175	$175
D2643	Onlay - Porcelain/Ceramic – Three Surfaces	$115	N/C	$175	$175
D2644	Onlay - Porcelain/Ceramic – Four or More Surfaces	$115	N/C	$175	$175
D2650	Inlay – Resin-Based Composite – One Surface	$115	N/C	$160	$160
D2651	Inlay - Resin-Based Composite – Two Surfaces	$115	N/C	$160	$160
D2652	Inlay - Resin-Based Composite – Three Surfaces	$115	N/C	$160	$160
D2662	Onlay - Resin-Based Composite – Two Surfaces	$115	N/C	$160	$160
D2663	Onlay - Resin-Based Composite – Three Surfaces	$115	N/C	$160	$160
D2664	Onlay - Resin-Based Composite – Four or More Surfaces	$115	N/C	$160	$160
D2710	Crown - Resin-Based Composite (Indirect)	$115	N/C	$175	$175
Note: There is no copayment for procedure D2710 when performed in conjunction with a permanent crown on the same tooth.					
D2720	Crown - Resin with High Noble Metal	$150	N/C	$235	$235
D2721	Crown - Resin with Predominantly Base Metal	$150	N/C	$225	$225
D2722	Crown - Resin with Noble Metal	$150	N/C	$225	$225
D2740	Crown - Porcelain/Ceramic	$200	N/C	$295	$295
D2750	Crown - Porcelain Fused to High Noble Metal	$225	N/C	$340	$340
D2751	Crown -Porcelain Fused to Predominantly Base Metal	$200	N/C	$295	$295
D2752	Crown - Porcelain Fused to Noble Metal	$200	N/C	$295	$295
D2753	Crown - porcelain fused to titanium and titanium alloys	$200	N/C	$295	$295
D2780	Crown - ¾ Cast High Noble Metal	$225	N/C	$340	$340
D2781	Crown - ¾ Cast Predominantly Base Metal	$200	N/C	$295	$295
D2790	Crown - Full Cast High Noble Metal	$225	N/C	$340	$340
D2791	Crown - Full Cast Predominantly Metal	$200	N/C	$295	$295
D2792	Crown - Full Cast Noble Metal	$200	N/C	$295	$295
D2794	Crown - Titanium	$225	N/C	$340	$340
D2799	Interim Crown – Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	$0	N/C	$0	$0
D2910	Re-cement or Re-bond Inlay, Onlay, or Partial Coverage Restoration	$0	N/C	$15	$15
D2915	Re-cement or Re-bond Cast or Prefabricated Post and Core	$0	N/C	$15	$15
D2920	Re-cement or Re-bond Crown	$0	N/C	$15	$15
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp	$0	N/C	$0	$0
D2928	Prefabricated Porcelain/Ceramic Crown - Permanent Tooth	$49	N/C	$69	$69
D2929	Prefabricated Porcelain/Ceramic Crown - Primary Tooth	$49	N/C	$69	$69
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	$35	N/C	$55	$55
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	$35	N/C	$55	$55

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ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D2932	Prefabricated Resin Crown	$35	N/C	$55	$55
D2933	Prefabricated Stainless Steel Crown with Resin Window	$35	N/C	$55	$55
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	$35	N/C	$55	$55
D2940	Placement of Interim Direct Restoration	$0	N/C	$20	$20
D2950	Core Buildup, Including Any Pins When Required	$0	N/C	$45	$45
D2951	Pin Retention - Per Tooth, In Addition to Restoration	$0	N/C	$15	$15
D2952	Cast Post and Core in Addition to Crown, Indirectly Fabricated	$40	N/C	$60	$60
D2954	Prefabricated Post and Core, in Addition to Crown	$40	N/C	$60	$60
D2955	Post removal	$0	N/C	$45	$45
D2956	Removal of an Indirect Restoration on a Natural Tooth (Inclusive to any restorative service.)	$0	$0	$0	$0
D2971	Additional Procedures to Customize a Crown to Fit under an Existing Partial Denture Framework	$0	N/C	$20	$20
D2976	Band Stabilization – per tooth	N/C	N/C	N/C	N/C
D2980	Crown Repair Necessitated by Restorative Material Failure	$0	N/C	$15	$15
D2981	Inlay Repair Necessitated by Restorative Material Failure	$0	N/C	$15	$15
D2982	Onlay Repair Necessitated by Restorative Material Failure	$0	N/C	$15	$15
D2983	Veneer Repair Necessitated by Restorative Material Failure	$0	N/C	$15	$15
D2989	Excavation of a tooth resulting in the determination of non-restorability	$0	N/C	$8	$8
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	$0	N/C	$15	$15
D2991	Application of Hydroxyapatite Regeneration Medicament – per tooth	$0	$0	$0	$0
D3110	Pulp Cap – Direct (Excluding Final Restoration)	$0	N/C	N/C	$15
D3120	Pulp Cap – Indirect (Excluding Final Restoration)	$0	N/C	N/C	$15
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) – Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	$25	N/C	N/C	$35
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development	$25	N/C	N/C	$35
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)	$20	N/C	N/C	$35
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)	$20	N/C	N/C	$35
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	$100	N/C	N/C	$150
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	$125	N/C	N/C	$190
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	$150	N/C	N/C	$225
D3346	Retreatment of Previous Root Canal Therapy - Anterior	$125	N/C		$190
D3347	Retreatment of Previous Root Canal Therapy - Premolar	$150	N/C	N/C	$225
D3348	Retreatment of Previous Root Canal Therapy - Molar	$175	N/C	N/C	$265
D3351	Apexification/Recalcification - Initial Visit (apical closure / calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$35	N/C	N/C	$55
D3352	Apexification/Recalcification - Interim Medication Replacement	$35	N/C	N/C	$55
D3353	Apexification/Recalcification - Final Visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$35	N/C	N/C	$55
D3410	Apicoectomy – Anterior	$90	N/C	N/C	$135
D3421	Apicoectomy - Premolar (First Root)	$90	N/C	N/C	$135
D3425	Apicoectomy - Molar (First Root)	$90	N/C	N/C	$135
D3426	Apicoectomy (Each Additional Root)	$40	N/C	N/C	$60
D3430	Retrograde Filling – per Root	$20	N/C	N/C	$35
D3450	Root Amputation - per Root	$40	N/C	N/C	$60
D3471	Surgical repair of root resorption - anterior	$54	N/C	N/C	$81
D3472	Surgical repair of root resorption – premolar	$72	N/C	N/C	$108

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ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D3473	Surgical repair of root resorption – molar	$90	N/C	N/C	$135
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	$54	N/C	N/C	$78
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	$72	N/C	N/C	$104
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	$90	N/C	N/C	$130
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	$0	N/C	N/C	$15
D3911	Intraorifice Barrier	N/C	N/C	N/C	N/C
D3920	Hemisection (Including any Root Removal), Not Including Root Canal Therapy	$60	N/C	N/C	$80
D3921	Decoronation or Submergence of an Erupted Tooth	N/C	N/C	N/C	N/C
D4210	Gingivectomy/Gingivoplasty - Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$85	N/C	N/C	$135
D4211	Gingivectomy/Gingivoplasty, One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$30	N/C	N/C	$90
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	$12	N/C	N/C	$12
D4240	Gingival Flap Procedure Including Root Planing, Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$90	N/C	N/C	$160
D4241	Gingival Flap Procedure, Including Root Planing - One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$60	N/C	N/C	$90
D4245	Apically Positioned Flap	$90	N/C	N/C	$130
D4249	Clinical Crown Lengthening - Hard Tissue	$90	N/C	N/C	$160
D4260	Osseous Surgery (including flap entry and closure) – Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$175	N/C	N/C	$265
D4261	Osseous Surgery (including flap entry and closure) – One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	$100	N/C	N/C	$150
D4263	Bone Replacement Graft – Retained Natural Tooth – First Site in Quadrant Site	$100	N/C	N/C	$135
D4264	Bone Replacement Graft – Retained Natural Tooth – Each Additional Site in Quadrant	$50	N/C	N/C	$75
D4266	Guided Tissue Regeneration, Natural Teeth - Resorbable Barrier per Site	$90	N/C	N/C	$120
D4267	Guided Tissue Regeneration, Natural Teeth - Non-resorbable Barrier per Site (includes membrane removal)	$90	N/C	N/C	$135
D4270	Pedicle Soft Tissue Graft Procedure	$175	N/C	N/C	$235
D4273	Autogenous Connective Tissue Graft Procedures (Including Donor and Recipient Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft	$175	N/C	N/C	$250
D4274	Mesial/Distal Procedure, Single Tooth (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	$40	N/C	N/C	$100
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft	$175	N/C	N/C	$235
D4276	Combined Connective Tissue and Pedicle Graft, per Tooth	$175	N/C	N/C	$235
D4277	Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgical Site) First Tooth, Implant, or Edentulous Tooth Position in Graft	$70	N/C	N/C	$70
D4278	Free Soft Tissue Graft Procedure (Including Recipient and Donor Surgical Sites) Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site	$35	N/C	N/C	$35
D4283	Autogenous Connective Tissue Graft Procedure (Including Donor and Recipient Surgical Sites) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site	$96	N/C	N/C	$138
D4285	Non-Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site and Donor Material) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site	$96	N/C	N/C	$129
D4286	Removal of Non-resorbable Barrier	N/C	N/C	N/C	N/C
D4322	Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns	$0	N/C	N/C	$25
D4323	Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns	$0	N/C	N/C	$25
D4341	Periodontal Scaling and Root Planing, Four or More Teeth per Quadrant	$55	N/C	N/C	$70

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ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D4342	Periodontal Scaling and Root Planing, One to Three Teeth per Quadrant	$40	N/C	N/C	$40
D4346	Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation – Full Mouth, After Oral Evaluation	$28	N/C	N/C	$20
D4355	Full Mouth Debridement to Enable a Comprehensive Periodontal Evaluation and Diagnosis on a Subsequent Visit	$55	N/C	N/C	$40
D4910	Periodontal Maintenance	$30	N/C	N/C	$40
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist or Their Staff)	$0	N/C	N/C	$15
D5110	Complete Denture - Maxillary	$250	N/C	N/C	$340
D5120	Complete Denture - Mandibular	$250	N/C	N/C	$340
D5130	Immediate Denture - Maxillary	$275	N/C	N/C	$370
D5140	Immediate Denture - Mandibular	$275	N/C	N/C	$370
D5211	Maxillary Partial Denture - Resin Base (Including any Conventional Clasps, Rests and Teeth)	$250	N/C	N/C	$370
D5212	Mandibular Partial Denture - Resin Base (Including any Conventional Clasps, Rests and Teeth)	$250	N/C	N/C	$370
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)	$275	N/C	N/C	$405
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)	$275	N/C	N/C	$405
D5221	Immediate Maxillary Partial Denture – Resin Base (Including Any Conventional Clasps, Rests and Teeth)	$288	N/C	N/C	$426
D5222	Immediate Mandibular Partial Denture – Resin Base (Including Any Conventional Clasps, Rests and Teeth)	$288	N/C	N/C	$426
D5223	Immediate Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth) Includes Limited Follow-up Care Only; Does Not Include Future Rebasing	$316	N/C	N/C	$466
D5224	Immediate Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	$316	N/C	N/C	$466
D5225	Maxillary Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)	$300	N/C	N/C	$445
D5226	Mandibular Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)	$300	N/C	N/C	$445
D5227	Immediate Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)	$300	N/C	N/C	$445
D5228	Immediate Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)	$300	N/C	N/C	$445
D5282	Removable Unilateral Partial Denture One Piece Cast Metal (Including Clasps and Teeth), Maxillary	$125	N/C	N/C	$205
D5283	Removable Unilateral Partial Denture One Piece Cast Metal (Including Clasps and Teeth), Mandibular	$125	N/C	N/C	$205
D5284	removable unilateral partial denture – one-piece flexible base (including clasps and teeth) – per quadrant	$150	N/C	N/C	$223
D5286	removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	$125	N/C	N/C	$185
D5410	Adjust Complete Denture - Maxillary	$0	N/C	N/C	$15
D5411	Adjust Complete Denture - Mandibular	$0	N/C	N/C	$15
D5421	Adjust Partial Denture - Maxillary	$0	N/C	N/C	$15
D5422	Adjust Partial Denture - Mandibular	$0	N/C	N/C	$15
D5511	Repair Broken Complete Denture Base, Mandibular	$35	N/C	N/C	$55
D5512	Repair Broken Complete Denture Base, Maxillary	$35	N/C	N/C	$55
D5520	Replace Missing or Broken Teeth, Complete Denture – per Tooth	$35	N/C	N/C	$55
D5611	Repair Resin Partial Denture Base, Mandibular	$35	N/C	N/C	$55
D5612	Repair Resin Partial Denture Base, Maxillary	$35	N/C	N/C	$55
D5621	Repair Cast Partial Framework, Mandibular	$35	N/C	N/C	$55
D5622	Repair Cast Partial Framework, Maxillary	$35	N/C	N/C	$55
D5630	Repair Or Replace Broken Retentive/Clasping Materials – per Tooth	$35	N/C	N/C	$55

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ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D5640	Replace Missing or Broken Teeth – Partial Denture – per Tooth	$35	N/C	N/C	$55
D5650	Add Tooth to Existing Partial Denture – per Tooth	$35	N/C	N/C	$55
D5660	Add Clasp to Existing Partial Denture – per Tooth	$35	N/C	N/C	$55
D5710	Rebase Complete Maxillary Denture	$85	N/C	N/C	$130
D5711	Rebase Complete Mandibular Denture	$85	N/C	N/C	$130
D5720	Rebase Maxillary Partial Denture	$85	N/C	N/C	$130
D5721	Rebase Mandibular Partial Denture	$85	N/C	N/C	$130
D5725	Rebase Hybrid Prosthesis	$85	N/C	N/C	$130
D5730	Reline Complete Maxillary Denture (Chairside)	$40	N/C	N/C	$60
D5731	Reline Complete Mandibular Denture (Chairside)	$40	N/C	N/C	$60
D5740	Reline Maxillary Partial Denture (Chairside)	$40	N/C	N/C	$60
D5741	Reline Mandibular Partial Denture (Chairside)	$40	N/C	N/C	$60
D5750	Reline Complete Maxillary Denture (Laboratory)	$40	N/C	N/C	$60
D5751	Reline Complete Mandibular Denture (Laboratory)	$40	N/C	N/C	$60
D5760	Reline Maxillary Partial Denture (Laboratory)	$40	N/C	N/C	$60
D5761	Reline Mandibular Partial Denture (Laboratory)	$40	N/C	N/C	$60
D5765	Soft Liner for Complete or Partial Removable Denture – Indirect	$40	N/C	N/C	$60
D5810	Interim Complete Denture (Maxillary)	$40	N/C	N/C	$75
D5811	Interim Complete Denture (Mandibular)	$40	N/C	N/C	$75
D5820	Interim Partial Denture - (Maxillary)	$40	N/C	N/C	$60
D5821	Interim Partial Denture - (Mandibular)	$40	N/C	N/C	$60
D5850	Tissue Conditioning, Maxillary	$40	N/C	N/C	$55
D5851	Tissue Conditioning, Mandibular	$40	N/C	N/C	$55
D5876	Add Metal Substructure to Acrylic Full Denture (per Arch)	$35	N/C	N/C	$55
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	N/C	N/C	N/C	N/C
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	N/C	N/C	N/C	N/C
D6082	Implant supported crown – porcelain fused to predominantly base alloys	N/C	N/C	N/C	N/C
D6083	Implant supported crown – porcelain fused to noble alloys	N/C	N/C	N/C	N/C
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	N/C	N/C	N/C	N/C
D6086	Implant supported crown – predominantly base alloys	N/C	N/C	N/C	N/C
D6087	Implant supported crown – noble alloys	N/C	N/C	N/C	N/C
D6088	Implant supported crown – titanium and titanium alloys	N/C	N/C	N/C	N/C
D6089	Accessing and Retorquing Loose Implant Screw - per screw	N/C	N/C	N/C	N/C
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	$200	N/C	N/C	$295
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	N/C	N/C	N/C	N/C
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	N/C	N/C	N/C	N/C
D6106	Guided Tissue Regeneration – Resorbable Barrier, per Implant	N/C	N/C	N/C	N/C
D6107	Guided Tissue Regeneration – Non-resorbable Barrier, per Implant	N/C	N/C	N/C	N/C
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	N/C	N/C	N/C	N/C
D6121	Implant supported retainer for metal FPD – predominantly base alloys	N/C	N/C	N/C	N/C
D6122	Implant supported retainer for metal FPD – noble alloys	N/C	N/C	N/C	N/C
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	N/C	N/C	N/C	N/C
D6191	Semi-precision abutment – placement	N/C	N/C	N/C	N/C
D6192	Semi-precision attachment – placement	N/C	N/C	N/C	N/C
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys	N/C	N/C	N/C	N/C

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ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D6197	Replacement of Restorative Material Used to Close an Access Opening of a Screw-retained Implant Supported Prosthesis, per Implant	$15	N/C	$25	$25
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	N/C	N/C	N/C	N/C
D6193	Replacement of an Implant Screw	N/C	N/C	N/C	N/C
D6210	Pontic - Cast High Noble Metal	$225	N/C	N/C	$340
D6211	Pontic - Cast Predominantly Base Metal	$200	N/C	N/C	$295
D6212	Pontic - Cast Noble Metal	$200	N/C	N/C	$295
D6214	Pontic – Titanium	$225	N/C	N/C	$340
D6240	Pontic - Porcelain Fused to High Noble Metal	$225	N/C	N/C	$340
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	$200	N/C	N/C	$295
D6242	Pontic - Porcelain Fused to Noble Metal	$200	N/C	N/C	$295
D6243	Pontic – porcelain fused to titanium and titanium alloys	$200	N/C	N/C	$295
D6245	Pontic - Porcelain/Ceramic	$200	N/C	N/C	$295
D6250	Pontic - Resin with High Noble Metal	$150	N/C	N/C	$225
D6251	Pontic - Resin with Predominantly Base Metal	$150	N/C	N/C	$225
D6252	Pontic - Resin with Noble Metal	$150	N/C	N/C	$225
D6545	Retainer - Cast Metal for Resin Bonded Fixed Prosthesis	$100	N/C	N/C	$150
D6549	Resin retainer – for resin bonded fixed prosthesis	$75	N/C	N/C	$75
D6602	Inlay - Cast High Noble Metal, Two Surfaces	$175	N/C	N/C	$265
D6603	Inlay - Cast High Noble Metal, Three or More Surfaces	$175	N/C	N/C	$265
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	$100	N/C	N/C	$160
D6605	Inlay - Cast Predominantly Base Metal, Three or More Surfaces	$100	N/C	N/C	$160
D6606	Inlay - Cast Noble Metal, Two Surfaces	$155	N/C	N/C	$230
D6607	Retainer Inlay - Cast Noble Metal, Three or More Surfaces	$155	N/C	N/C	$230
D6610	Retainer Onlay - Cast High Noble Metal, Two Surfaces	$185	N/C	N/C	$275
D6611	Retainer Onlay - Cast High Noble Metal, Three or More Surfaces	$185	N/C	N/C	$275
D6612	Retainer Onlay - Cast Predominantly Base Metal, Two Surfaces	$100	N/C	N/C	$160
D6613	Retainer Onlay - Cast Predominantly Base Metal, Three or More Surfaces	$100	N/C	N/C	$160
D6614	Retainer Onlay - Cast Noble Metal, Two Surfaces	$175	N/C	N/C	$265
D6615	Retainer Onlay - Cast Noble Metal, Three or More Surfaces	$175	N/C	N/C	$265
D6624	Retainer Inlay – Titanium	$175	N/C	N/C	$265
D6634	Retainer Onlay – Titanium	$185	N/C	N/C	$275
D6720	Retainer Crown - Resin with High Noble Metal	$150	N/C	N/C	$225
D6721	Retainer Crown - Resin with Predominantly Base Metal	$150	N/C	N/C	$225
D6722	Retainer Crown - Resin with Noble Metal	$150	N/C	N/C	$225
D6740	Retainer Crown - Porcelain/Ceramic	$200	N/C	N/C	$295
D6750	Retainer Crown - Porcelain Fused to High Noble Metal	$225	N/C	N/C	$340
D6751	Retainer Crown - Porcelain Fused to Predominantly Base Metal	$200	N/C	N/C	$295
D6752	Retainer Crown - Porcelain Fused to Noble Metal	$200	N/C	N/C	$295
D6753	Retainer Crown – Porcelain Fused to Titanium and Titanium Alloys	$200	N/C	N/C	$295
D6780	Retainer Crown - ¾ Cast High Noble Metal	$225	N/C	N/C	$340
D6781	Retainer Crown - ¾ Cast Predominantly Base Metal	$200	N/C	N/C	$295
D6782	Retainer Crown - ¾ Cast Noble Metal	$200	N/C	N/C	$295
D6783	Retainer Crown - ¾ Porcelain/Ceramic	$200	N/C	N/C	$295
D6784	Retainer Crown ¾ – Titanium and Titanium Alloys	$200	N/C	N/C	$295
D6790	Retainer Crown - Full Cast High Noble Metal	$225	N/C	N/C	$340

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ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D6791	Retainer Crown - Full Cast Predominantly Base Metal	$200	N/C	N/C	$295
D6792	Retainer Crown - Full Cast Noble Metal	$200	N/C	N/C	$295
D6794	Retainer Crown – Titanium	$225	N/C	N/C	$340
D6930	Re-cement or Re-Bond Fixed Partial Denture	$15	N/C	N/C	$25
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure	$25	N/C	N/C	$45
D7111	Extraction - Coronal Remnants - Primary Tooth	$10	N/C	N/C	$20
D7140	Extraction - Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$20	N/C	N/C	$35
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth, and including Elevation of Mucoperiosteal Flap if Indicated	$30	N/C	N/C	$45
D7220	Removal of Impacted Tooth - Soft Tissue	$55	N/C	N/C	$80
D7230	Removal of Impacted Tooth - Partially Bony	$55	N/C	N/C	$80
D7240	Removal of Impacted Tooth - Completely Bony	$65	N/C	N/C	$100
D7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	$65	N/C	N/C	$100
D7250	Removal of Residual Tooth Roots (Cutting Procedure)	$30	N/C	N/C	$45
D7251	Coronectomy – Intentional Partial Tooth Removal, Impacted Teeth Only	$33	N/C	N/C	$48
D7259	Nerve Dissection	N/C	N/C	N/C	N/C
D7260	Oroantral Fistula Closure	$100	N/C	N/C	$150
D7261	Primary Closure of a Sinus Perforation	$100	N/C	N/C	$150
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	$60	N/C	N/C	$90
D7280	Exposure of an Unerupted Tooth	$60	N/C	N/C	$90
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$60	N/C	N/C	$70
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$0	N/C	N/C	$25
D7284	Excisional Biopsy of Minor Salivary Glands	$38	N/C	N/C	$60
D7285	Biopsy of Oral Tissue – Hard (Bone, Tooth)	$60	N/C	N/C	$95
D7286	Incisional Biopsy of Oral Tissue – Soft	$25	N/C	N/C	$40
D7287	Exfoliative Cytological Sample Collection	$13	N/C	N/C	$13
D7291	Transseptal Fiberotomy / Supra Crestal Fiberotomy, by Report	$20	N/C	N/C	$35
D7310	Alveoloplasty in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, per Quadrant	$30	N/C	N/C	$45
D7311	Alveoloplasty in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, per Quadrant	$15	N/C	N/C	$25
D7320	Alveoloplasty Not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, per Quadrant	$35	N/C	N/C	$55
D7321	Alveoloplasty Not in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, per Quadrant	$20	N/C	N/C	$35
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm	$60	N/C	N/C	$90
D7451	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Greater Than 1.25 cm	$60	N/C	N/C	$90
D7460	Removal of Benign Non-Odontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm	$60	N/C	N/C	$90
D7461	Removal of Benign Non-Odontogenic Cyst or Tumor - Lesion Diameter Greater Than 1.25 cm	$60	N/C	N/C	$90
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	$90	N/C	N/C	$135
D7472	Removal of Torus Palatinus	$90	N/C	N/C	$135
D7473	Removal of Torus Mandibularis	$90	N/C	N/C	$135
D7485	Reduction of Osseous Tuberosity	$90	N/C	N/C	$135
D7509	Marsupialization of Odontogenic Cyst	$60	N/C	N/C	$90
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$25	N/C	N/C	$40

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ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue, Complicated (Includes Drainage of Multiple Fascial Spaces)	$30	N/C	N/C	$45
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	$35	N/C	N/C	$55
D7521	Incision and Drainage of Abscess - Extraoral Soft Tissue - Complicated (Includes Drainage of Multiple Fascial Spaces)	$40	N/C	N/C	$60
D7922	Placement of Intra-socket Biological Dressing to Aid in Hemostasis or Clot Stabilization, per Site	$0	$0	$0	$0
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	N/C	N/C	N/C	N/C
D7953	Bone Replacement Graft for Ridge Preservation - Per Site	$75	N/C	N/C	$100
D7956	Guided Tissue Regeneration, Edentulous Area – Resorbable Barrier, per Site	N/C	N/C	N/C	N/C
D7957	Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	N/C	N/C	N/C	N/C
D7961	Buccal / labial frenectomy (frenulectomy)	$60	N/C	N/C	$90
D7962	Lingual frenectomy (frenulectomy)	$60	N/C	N/C	$90
D7963	Frenuloplasty	$65	N/C	N/C	$100
D7970	Excision of Hyperplastic Tissue - Per Arch	$60	N/C	N/C	$90
D7971	Excision of Pericoronal Gingiva	$30	N/C	N/C	$45
D7972	Surgical Reduction of Fibrous Tuberosity	$60	N/C	N/C	$90
D9110	Palliative Treatment of Dental Pain, Per Visit	$0	$15	$15	$15
D9130	Temporomandibular Joint Dysfunction – Non-invasive Physical Therapies	N/C	N/C	N/C	N/C
D9211	Regional Block Anesthesia	$0	N/C	N/C	$5
D9212	Trigeminal Division Block Anesthesia	$0	N/C	N/C	$5
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	$0	N/C	N/C	$5
D9219[2]	Evaluation for Moderate Sedation, Deep Sedation or General Anesthesia	$0	N/C	N/C	$0
D9222	Deep Sedation/General Anesthesia – First 15 Minutes	$25	N/C	N/C	$38
D9223	Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment	$20	N/C	N/C	$30
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	$0	N/C	N/C	$5
D9239	Intravenous Moderate (Conscious) Sedation/ Analgesia – First 15 Minutes	$25	N/C	N/C	$38
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each Subsequent 15 Minute Increment	$20	N/C	N/C	$30
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	$0	N/C	N/C	$5
D9311	Treating Dentist Consults with a Medical Health Care Professional Concerning Medical Issues that may Affect Patient's Planned Dental Treatment	$0	N/C	N/C	$5
D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	$0	N/C	N/C	$0
D9440	Office Visit – After Regularly Scheduled Hours	$0	N/C	N/C	$0
D9610	Therapeutic Parenteral Drug, Single Administration	$0	N/C	N/C	$5
D9612	Therapeutic Parenteral Drugs, Two or More Administrations, Different Medications	$0	N/C	N/C	$0
D9613	Infiltration of Sustained Release Therapeutic Drug, per Quadrant	$0	$0	$0	$0
D9630	Drugs or Medicaments Dispensed in the Office for Home Use	$0	N/C	N/C	$5
D9910	Application of Desensitizing Medicament	$0	N/C	N/C	$5
D9912	Pre-visit Patient Screening	N/C	N/C	N/C	N/C
D9914	Administration of Dermal Fillers	N/C	N/C	N/C	N/C
D9930	Treatment of Complications (Post-Surgical) – Unusual Circumstances, by Report	$0	N/C	N/C	$5
D9932	Cleaning and Inspection of a Removable Complete Denture, Maxillary	$0	N/C	N/C	$0
D9933	Cleaning and Inspection of a Removable Complete Denture, Mandibular	$0	N/C	N/C	$0
D9934	Cleaning and Inspection of a Removable Partial Denture, Maxillary	$0	N/C	N/C	$0
D9935	Cleaning and Inspection of a Removable Partial Denture, Mandibular	$0	N/C	N/C	$0
D9938	Fabrication of a custom removable clear plastic temporary aesthetic appliance	N/C	N/C	N/C	N/C

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ADA Code[1]	Description	Plan 34	Plan 34A	Plan 34B	Plan 34C
D9939	Placement of a custom removable clear plastic temporary aesthetic appliance	N/C	N/C	N/C	N/C
D9944	Occlusal Guard – Hard Appliance, Full Arch	$46	N/C	N/C	$69
D9945	Occlusal Guard – Soft Appliance, Full Arch	$40	N/C	N/C	$60
D9946	Occlusal Guard – Hard Appliance, Partial Arch	$24	N/C	N/C	$36
D9947	Custom Sleep Apnea Appliance Fabrication and Placement	N/C	N/C	N/C	N/C
D9948	Adjustment of Custom Sleep Apnea Appliance	N/C	N/C	N/C	N/C
D9949	Repair of Custom Sleep Apnea Appliance	N/C	N/C	N/C	N/C
D9942	Repair and/or Reline of Occlusal Guard	$20	N/C	N/C	$35
D9943	Occlusal Guard Adjustment	$5	N/C	N/C	$8
D9951	Occlusal Adjustment - Limited	$0	N/C	N/C	$5
D9952	Occlusal Adjustment - Complete	$60	N/C	N/C	$90
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	N/C	N/C	N/C	N/C
D9954	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	N/C	N/C	N/C	N/C
D9955	Oral appliance therapy (OAT) titration visit	N/C	N/C	N/C	N/C
D9956	Administration of home sleep apnea test	N/C	N/C	N/C	N/C
D9957	Screening for sleep related breathing disorders	N/C	N/C	N/C	N/C
D9959	Unspecified Sleep Apnea Services Procedure, by Report	N/C	N/C	N/C	N/C
D9961	Duplicate/Copy Patient's Records	N/C	N/C	N/C	N/C
D9990	Certified Translation or Sign-Language Services per Visit	N/C	N/C	N/C	N/C
D9997	Dental Case Management – Patients with Special Health Care Needs	$0	$0	$0	$0

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Dental Procedure Guidelines
for DMO Primary Care Dentists

ADA CODE[1]	NOMENCLATURE	GUIDELINES	41	41S	51	52	53 53i	54	55 55A	56	56H	56X	57 57i	58	59i
	Office Visit Copay	Check Roster When an Office Visit copay applies, the DMO Patient Roster will show the amount under column "Office Copay" (i.e. 000 = $0.00; 005 = $5.00). When submitted, use ADA code D0999.													
	Infection Control	May not bill patient for infection control procedures													
		Frequency limits on Preventive and Diagnostic services are waived in Arizona, California and Texas if medically necessary.													
D0120	Periodic Oral Evaluation - Established Patient	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0140	Limited Oral Evaluation - Problem Focused	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0145	Oral Evaluation for a Patient under Three Years of Age and Counseling with a Primary Caregiver	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0150	Comprehensive Oral Evaluation - New or Established Patient	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, by Report	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0170	Re-Evaluation - Limited, Problem Focused (Established Patient; not Post-Operative Visit)	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0171	Re-Evaluation - Post-Operative Office Visit	Inclusive to surgery. Patient cannot be billed.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0190-D0191[2]	Screening / Assessment of a Patient	Inclusive to oral evaluation Patient cannot be billed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0210	Intraoral - Complete Series of Radiographic Images	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — FMS or Panorex once every 3 years. (Frequency limit may be waived when done in conjunction with eligible specialty service)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0220-D0230	Intraoral - Periapical Image		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

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D0240	Intraoral - Occlusal Radiographic Image		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0250-D0251	Extra-Oral Image		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0270-D0274	Bitewing Radiographic Image	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0277	Vertical Bitewings - 7 to 8 Radiographic Images	1 series every 3 years	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0310	Sialography	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0320-D0321	Temporomandibular Joint Image	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0322	Tomographic Survey	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0330	Panoramic Radiographic Image	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — FMS or Panorex once every 3 years. (Frequency limit may be waived when done in conjunction with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0340	2D Cephalometric Radiographic Image – Acquisition, Measurement and Analysis	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0350	2D Oral/Facial Photographic Image Obtained Intra-orally or Extra-orally	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0364-D0368	Cone Beam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0369-D0371	Capture and Interpretation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0372	Intraoral - Complete Series of Radiographic Images	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0373	Intraoral Tomosynthesis – Bitewing Radiographic Image	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0374	Intraoral Tomosynthesis – Periapical Radiographic Image		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0380-D0384	Cone Beam CT Image Capture	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0385-D0386	Cone Beam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0387	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images – Image Capture Only	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

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D0388	Intraoral Tomosynthesis – Bitewing Radiographic Image – Image Capture Only	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0389	Intraoral Tomosynthesis – Periapical Radiographic Image – Image Capture Only		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0391	Interpretation of Diagnostic Image by Practitioner Not Associated with Capture of the Image, Including Report		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0393-D0395	3D Images	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0396	3D printing of a 3D dental surface scan	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0411	HbA1c In-office Point of Service Testing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0412	Blood Glucose Level Test – In-office Using a Glucose Meter	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0415	Collection of Microorganisms	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0416	Viral Culture	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0417	Collection & Preparation of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0418	Analysis of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0419	Assessment of Salivary Flow by Measurement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0422	Collection and Preparation of Genetic Sample Material for Laboratory Analysis and Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0423	Genetic Test for Susceptibility to Diseases – Specimen Analysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0425	Caries Susceptibility Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0431	Adjunctive Pre-Diagnostic Test	The use of any tools and/or devices that assist in a diagnosis to be an adjunctive technique that is part of the oral evaluation or primary service. Members cannot be billed for this service.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0460	Pulp Vitality Tests	Inclusive to oral evaluation Patient cannot be billed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0470	Diagnostic Casts		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0472-D0474	Accession of Tissue		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0475-D0502	Oral Pathology Laboratory Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0601-D0603[2]	Caries Risk Assessment	Inclusive to oral evaluation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0604	Antigen testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0605	Antibody testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0606	Molecular testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0701	panoramic radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0330. Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — FMS or Panorex once every 3 years. (Frequency limit may be waived when done in conjunction with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0702	2-D cephalometric radiographic image – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0705	extra-oral posterior dental radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0251.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0706	intraoral – occlusal radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0240.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0707	intraoral – periapical radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0220.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0708	intraoral – bitewing radiographic image – image capture only	Only eligible when submitted with D0391 Inclusive when submitted with D0270 Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

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D0709	intraoral – complete series of radiographic images – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0210. Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — FMS or Panorex once every 3 years. (Frequency limit may be waived when done in conjunction with eligible specialty service)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D0801	3D Intraoral Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0802	3D Dental Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0803	3D Facial Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0804	3D Facial Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0999	Unspecified Diagnostic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1110	Prophylaxis – Adult	Limited to 2 per year	$0	$0	$12	$12	$8	$0	$0	$0	$0	$0	$0	$0	$0
D1120	Prophylaxis – Child	Limited to 2 per year	$0	$0	$10	$10	$7	$0	$0	$0	$0	$0	$0	$0	$0
D1206	Topical Application of Fluoride Varnish	Pre Nov 2000 Plans (*) - No age or frequency limit DMO Standard Plans (#) – 1x per year for children under 16	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D1208	Topical Application of Fluoride – Excluding Varnish	Pre Nov 2000 Plans (*) - No age or frequency limit DMO Standard Plans (#) – 1x per year for children under 16	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D1301	Immunization Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1310-D1321	Nutritional or Tobacco Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1330	Oral Hygiene Instruction		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D1351	Sealant – per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to Molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$10	$10	$10	$10	$8	$0	$0	$0	$0	$0	$10	$5	$0

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D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to Molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$10	$10	$10	$10	$8	$0	$0	$0	$0	$0	$10	$5	$0
D1353	Sealant Repair - per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to permanent molars and to covered persons under age 16 (not limited to dependent children).	$5	$5	$5	$5	$4	$0	$0	$0	$0	$0	$5	$3	$0
D1354	Application of Caries Arresting Medicament – per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$10	$10	$10	$10	$8	$0	$0	$0	$0	$0	$10	$5	$0
D1355	Caries preventive medicament application – per tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$8	$8	$8	$8	$6	$0	$0	$0	$0	$0	$8	$4	$0
D1510	Space Maintainer - Fixed, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion	$100	$100	$100	$85	$65	$60	$0	$0	$0	$0	$65	$60	$0
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion	$100	$100	$100	$85	$65	$60	$0	$0	$0	$0	$65	$60	$0
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion	$100	$100	$100	$85	$65	$60	$0	$0	$0	$0	$65	$60	$0
D1520	Space Maintainer - Removable, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion	$100	$100	$100	$95	$80	$70	$0	$0	$0	$0	$80	$70	$0
D1526	Space Maintainer – Removable – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion	$100	$100	$100	$95	$80	$70	$0	$0	$0	$0	$80	$70	$0
D1527	Space Maintainer – Removable – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion	$100	$100	$100	$95	$80	$70	$0	$0	$0	$0	$80	$70	$0

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D1551	Re-cement or re-bond bilateral space maintainer – maxillary		$15	$15	$15	$15	$15	$12	$12	$12	$0	$0	$15	$12	$0
D1552	Re-cement or re-bond bilateral space maintainer – mandibular		$15	$15	$15	$15	$15	$12	$12	$12	$0	$0	$15	$12	$0
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant		$8	$8	$8	$8	$8	$6	$6	$6	$0	$0	$8	$6	$0
D1556	Removal of fixed unilateral space maintainer – per quadrant		$8	$8	$8	$8	$8	$6	$6	$6	$6	$6	$8	$6	$6
D1557	Removal of fixed bilateral space maintainer – maxillary		$15	$15	$15	$15	$15	$12	$12	$12	$12	$12	$15	$12	$12
D1558	Removal of fixed bilateral space maintainer – mandibular		$15	$15	$15	$15	$15	$12	$12	$12	$12	$12	$15	$12	$12
D1575	Distal shoe space maintainer – fixed, unilateral - per quadrant		$110	$110	$110	$94	$72	$66	$0	$0	$0	$0	$72	$66	$0
D1701 - D1714	Covid-19 vaccine administration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1781 - D1783	Vaccine Administration – Human Papillomavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		<u>Effective 11/1/2020</u> - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is considered part of the primary service done on the same day. Member cannot be charged. **<u>Prior to 11/1/2020</u> - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is not covered. The member will be responsible for the charge.**													
D1999	Unspecified Preventive Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2140	Amalgam – 1 Surface, Primary or Permanent		$22	$0	$22	$20	$16	$10	$0	$0	$0	$0	$0	$0	$0
D2150	Amalgam – 2 Surfaces, Primary or Permanent		$32	$0	$32	$30	$24	$12	$0	$0	$0	$0	$0	$0	$0
D2160	Amalgam – 3 Surfaces, Primary or Permanent		$43	$0	$43	$36	$32	$16	$0	$0	$0	$0	$0	$0	$0
D2161	Amalgam – 4+ Surfaces, Primary or Permanent		$53	$0	$53	$50	$40	$18	$0	$0	$0	$0	$0	$0	$0
D2330	Resin-Based Composite – 1 Surface, Anterior		$40	$0	$40	$40	$25	$15	$0	$0	$0	$0	$0	$0	$0
D2331	Resin-Based Composite – 2 Surfaces, Anterior		$55	$0	$55	$50	$35	$21	$0	$0	$0	$0	$0	$0	$0
D2332	Resin-Based Composite – 3 Surfaces, Anterior		$60	$0	$60	$55	$35	$25	$0	$0	$0	$0	$0	$0	$0
D2335	Resin-Based Composite – 4+ Surfaces or Involving Incisal Angle, Anterior		$70	$0	$70	$66	$46	$35	$0	$0	$0	$0	$0	$0	$0
D2390	Resin-Based Composite Crown, Anterior		$80	$80	$80	$70	$60	$50	$40	$0	$0	$0	$60	$50	$0
		<u>Effective 1/1/2024, posterior resin/composite restorations will no longer be subject to an upgrade.</u> DMO patients are only responsible for the applicable copayment based on the service performed. **<u>Prior to 1/1/2024</u> -** If you first offer an amalgam restoration and the patient elects to have a resin restoration on a molar or on the stress-bearing surfaces of a premolar, the patient is responsible for the copayment, if any, for an amalgam restoration plus the difference between your Usual and Customary fees for the resin restoration and the amalgam restoration. (Refer to Elective Services/Optional Treatment Plans.) If the office does not have an amalgam fee, use the corresponding resin fee reduced by 20%.													
D2391	Resin-Based Composite – 1 Surface, Posterior		$22	$22	$22	$20	$16	$10	$0	$0	$0	$0	$0	$0	$0
D2392	Resin-Based Composite – 2 Surfaces, Posterior		$32	$32	$32	$30	$24	$12	$0	$0	$0	$0	$0	$0	$0
D2393	Resin-Based Composite – 3 Surfaces, Posterior		$43	$43	$43	$36	$32	$16	$0	$0	$0	$0	$0	$0	$0

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D2394	Resin-Based Composite – 4+ Surfaces, Posterior		$53	$53	$53	$50	$40	$18	$0	$0	$0	$0	$0	$0	$0
D2410 - D2430	Gold Foil	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Crowns/Inlays Procedure Codes: **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Eligible for plan benefit when tooth cannot be restored with a filling. Plan benefit available for one crown once every 5 years per tooth.** **Facings on molar crowns and pontics will always be considered cosmetic.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)** **Additional $125.00 patient copayment per unit for treatment of 6 or more units of covered crown/bridge in the same treatment plan.**													
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.													
D2510	Inlay – Metallic - 1 Surface		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D2520	Inlay – Metallic - 2 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D2530	Inlay – Metallic - 3 or More Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D2542	Onlay – Metallic - 2 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$0	$0	$220	$180	$0
D2543	Onlay – Metallic - 3 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$0	$150	$220	$180	$150
D2544	Onlay - Metallic – 4 or More Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$0	$150	$220	$180	$150
D2610	Inlay, Porcelain/Ceramic – 1 Surface		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D2620	Inlay, Porcelain/Ceramic – 2 Surfaces	Member Copay Change Effective 01/01/2019	$463[7] $387[8]	$463[7] $387[8]	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D2630	Inlay, Porcelain/Ceramic – 3 or More Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D2642	Onlay, Porcelain/Ceramic – 2 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$0	$0	$220	$180	$0
D2643	Onlay, Porcelain/Ceramic – 3 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$0	$150	$220	$180	$150
D2644	Onlay, Porcelain/Ceramic – 4 or More Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$0	$150	$220	$180	$150
D2650	Inlay, Resin Based Composite – 1 Surface		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D2651	Inlay, Resin Based Composite – 2 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D2652	Inlay, Resin Based Composite – 3 or more Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D2662	Onlay, Resin Based Composite – 2 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$0	$0	$220	$180	$0
D2663	Onlay, Resin Based Composite – 3 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$0	$150	$220	$180	$150
D2664	Onlay, Resin Based Composite – 4 or More Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$0	$150	$220	$180	$150
D2710	Crown – Resin-Based Composite, Indirect	Member Copay Change Effective 04/01/2016	$488[4] $375[5]	$488[4] $375[5]	$325	$300	$260	$210	$185	$150	$50	$150	$260	$210	$150
D2712	Crown – 3/4 Resin-Based Composite, Indirect	Member Copay Change Effective 04/01/2016	$445[4] $395[5]	$445[4] $395[5]	$240	$224	$200	$176	$142	$120	$120	$120	$200	$176	$120
D2720	Crown – Resin with High Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$145	$150	$260	$210	$150

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D2721	Crown – Resin with Predominantly Base Metal		$488	$488	$325	$300	$260	$210	$185	$150	$145	$150	$260	$210	$150
D2722	Crown – Resin with Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$145	$145	$260	$210	$145
D2740	Crown – Porcelain/ Ceramic		$488	$488	$325	$300	$260	$210	$185	$150	$130	$130	$260	$210	$130
D2750	Crown – Porcelain Fused to High Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D2751	Crown – Porcelain Fused to Predominantly Base Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D2752	Crown – Porcelain Fused to Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D2753	Crown - porcelain fused to titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D2780	Crown – 3/4 Cast High Noble Metal		$475	$475	$300	$280	$250	$220	$178	$150	$140	$150	$250	$220	$150
D2781	Crown – 3/4 Cast Predominantly Base Metal		$475	$475	$300	$280	$250	$220	$178	$150	$140	$150	$250	$220	$150
D2782	Crown – 3/4 Cast Noble Metal		$475	$475	$300	$280	$250	$220	$178	$150	$140	$150	$250	$220	$150
D2783	Crown – 3/4 Cast Porcelain/Ceramic		$475	$475	$300	$280	$250	$220	$178	$150	$140	$150	$250	$220	$150
D2790	Crown – Full Cast High Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D2791	Crown – Full Cast Predominantly Base Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D2792	Crown – Full Cast Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D2794	Crown – Titanium and Titanium Alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D2799	Interim Crown – Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D2910	Re-cement Or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration		$18	$10	$18	$15	$15	$10	$5	$0	$0	$0	$15	$10	$0
D2915	Re-Cement or Re-Bond Indirectly Fabricated or Prefabricated Post and Core		$9	$9	$9	$8	$8	$5	$3	$0	$0	$0	$8	$5	$0
D2920	Re-Cement or Re-Bond Crown		$18	$10	$18	$15	$15	$10	$5	$0	$0	$0	$15	$10	$0
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp		$7	$7	$7	$7	$5	$4	$0	$0	$0	$0	$0	$0	$0
D2928	Prefabricated Porcelain/Ceramic Crown – Permanent Tooth	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	Alternate benefit based on D2930	$65	$65	$65	$55	$45	$35	$0	$0	$30	$30	$45	$35	$30
D2930	Prefabricated Stainless Steel Crown – Primary Tooth		$65	$65	$65	$55	$45	$35	$0	$0	$30	$30	$45	$35	$30

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D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	When used as permanent crown, subject to crown frequency limit. Eligible as temp only when used as temp restoration until adult dentition formed or when used due to accident away from home. Otherwise, temp is included in final restoration and not separately eligible.	$80	$80	$80	$70	$60	$50	$40	$0	$30	$30	$60	$50	$30
D2932	Prefabricated Resin Crown	Alternate benefit based on D2930 or D2931	$65 $80	$65 $80	$65 $80	$55 $70	$45 $60	$35 $50	$0 $40	$0	$30	$30	$45 $60	$35 $50	$30
D2933	Prefabricated Stainless Steel Crown with Resin Window	Alternate benefit based on D2930 or D2931	$65 $80	$65 $80	$65 $80	$55 $70	$45 $60	$35 $50	$0 $40	$0	$30	$30	$45 $60	$35 $50	$30
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	Alternate benefit based on D2930	$65	$65	$65	$55	$45	$35	$0	$0	$30	$30	$45	$35	$30
D2940	Placement of Interim Direct Restoration		$15	$0	$15	$15	$8	$3	$0	$0	$0	$0	$8	$3	$0
D2941	Interim Therapeutic Restoration – Primary Dentition		$7	$7	$7	$7	$4	$1	$0	$0	$0	$0	$4	$1	$0
D2949[2]	Restorative Foundation for an Indirect Restoration	Inclusive to permanent restoration	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D2950	Core Buildup, Including Any Pins When Required		$103	$103	$55	$50	$45	$40	$30	$35	$35	$35	$45	$40	$35
D2951	Pin Retention – Per Tooth, In Addition to Restoration		$15	$15	$15	$15	$6	$6	$6	$0	$0	$0	$6	$6	$0
D2952	Post & Core In Addition to Crown, Indirectly Fabricated		$160	$160	$95	$79	$80	$70	$50	$45	$45	$45	$80	$70	$45
D2953	Each Additional Indirectly Fabricated Post – Same Tooth	Member Copay Change Effective 04/01/2016	$160[4] $135[5]	$135	$95	$79	$80	$70	$50	$45	$45	$45	$80	$70	$45
D2954	Prefabricated Post & Core In Addition To Crown		$138	$138	$90	$90	$71	$63	$60	$40	$40	$40	$71	$63	$40
D2955	Post Removal	Included in cost of replacement post	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D2956	Removal of an Indirect Restoration on a Natural Tooth	Not to be used as a temporary or provisional restoration. Inclusive to any restorative service.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D2957	Each Additional Prefabricated Post - Same Tooth	Member Copay Change Effective 04/01/2016	$138[4] $115[5]	$138[4] $115[5]	$90	$90	$71	$63	$60	$40	$40	$40	$71	$63	$40
D2960	Labial Veneer (Resin Laminate) – Chairside	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2961	Labial Veneer (Resin Laminate) – Laboratory	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2962	Labial Veneer (Porcelain Laminate) – Laboratory	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2971	Additional Procedures to Customize a Crown to Fit under an Existing Partial Denture Framework		$49	$49	$49	$45	$39	$32	$28	$23	$23	$23	$39	$32	$23
D2975	Coping	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2976	Band Stabilization – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2980	Crown Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D2981	Inlay Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2982	Onlay Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2983	Veneer Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2989	Excavation of a Tooth Resulting in the Determination of Non-restorability	Restorations, endodontics, and/or D4249 on same day/same tooth will be denied.	$11	$0	$11	$10	$8	$5	$0	$0	$0	$0	$0	$0	$0
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to Molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years and to covered persons under age 16 (not limited to dependent children).	$10	$10	$10	$10	$8	$0	$0	$0	$0	$0	$10	$5	$0
D2991	Application of Hydroxyapatite Regeneration Medicament – per Tooth	One application per tooth, regardless of the number of appointments required to complete the full application. Once tooth application is completed, limited to once every 3 years for permanent teeth (1-32).	$15	$15	$15	$15	$12	$0	$0	$0	$0	$0	$15	$8	$0
D2999	Unspecified Restorative Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3110	Pulp Cap – Direct (Excluding Final Restoration)		$8	$8	$8	$8	$6	$4	$0	$0	$0	$0	$0	$0	$0
D3120	Pulp Cap – Indirect (Excluding Final Restoration)		$8	$8	$8	$8	$6	$4	$0	$0	$0	$0	$0	$0	$0
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	If done in conjunction with root canal therapy, included in cost of RCT	$50	$20	$50	$40	$35	$14	$0	$0	$0	$0	$35	$14	$0
D3221	Pulpal Debridement, Primary and Permanent Teeth	Considered inclusive with the Endodontic Treatment when completed on the same day	$10	$10	$10	$10	$10	$10	$10	$10	$0	$10	$10	$10	$10
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development		$45	$45	$45	$36	$32	$13	$0	$0	$50	$0	$32	$13	$0
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)		$50	$50	$50	$40	$35	$14	$0	$0	$100	$0	$35	$14	$0
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)		$50	$50	$50	$40	$35	$14	$0	$0	$100	$0	$35	$14	$0

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D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)		$150	$150	$150	$140	$120	$70	$50	$0	$0	$0	$120	$70	$0
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)		$195	$195	$195	$165	$140	$85	$70	$0	$0	$0	$140	$85	$0
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)		$435	$175	$295	$290	$260	$240	$150	$125	$0	$0	$280	$240	$0
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access		$150	$150	$150	$140	$120	$70	$50	$0	$0	$0	$120	$70	$0
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth		$98	$98	$98	$83	$70	$43	$35	$0	$0	$0	$70	$43	$0
D3333	Internal Root Repair of Perforation Defects		$130	$130	$130	$110	$90	$55	$40	$0	$0	$0	$90	$55	$0
D3346	Retreatment of Previous Root Canal Therapy – Anterior		$250	$250	$250	$240	$220	$170	$150	$100	$0	$100	$220	$170	$100
D3347	Retreatment of Previous Root Canal Therapy – Premolar		$295	$295	$295	$265	$240	$185	$170	$100	$0	$100	$240	$185	$100
D3348	Retreatment of Previous Root Canal Therapy – Molar		$485	$485	$395	$390	$360	$340	$250	$225	$0	$225	$380	$340	$225
D3351	Apexification/Recalcification – Initial Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3352	Apexification/Recalcification – Interim Medication Replacement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3353	Apexification/ Recalcification – Final Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3355	Pulpal Regeneration - Initial Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3356	Pulpal Regeneration – Interim Medication Replacement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3357	Pulpal Regeneration – Completion of Treatment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3410	Apicoectomy – Anterior		$156	$65	$156	$140	$130	$85	$60	$0	$0	$0	$130	$85	$0
D3421	Apicoectomy – Premolar (First Root)		$156	$156	$156	$140	$130	$85	$60	$0	$0	$0	$130	$85	$0
D3425	Apicoectomy – Molar (First Root)		$190	$190	$190	$170	$150	$90	$80	$0	$0	$0	$150	$90	$0
D3426	Apicoectomy – Each Additional Root		$130	$130	$130	$110	$90	$55	$40	$0	$0	$0	$90	$55	$0
D3428	Bone Graft In Conjunction With Periradicular Surgery - per Tooth, Single Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3429	Bone Graft in Conjunction with Periradicular Surgery - Each Additional Contiguous Tooth in the Same Surgical Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3430	Retrograde Filling – per Root		$75	$75	$75	$70	$65	$40	$20	$0	$0	$0	$65	$40	$0
D3431	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction With Periradicular Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D3432	Guided Tissue Regeneration, Resorbable Barrier, per Site, In Conjunction with Periradicular Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3450	Root Amputation – per Root		$100	$100	$100	$90	$80	$70	$60	$60	$0	$60	$80	$70	$60
D3460	Endodontic Endosseous Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3470	Intentional Re-Implantation (Including Necessary Splinting)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3471	Surgical repair of root resorption - anterior		$70	$70	$70	$63	$59	$38	$27	$0	$0	$0	$59	$38	$0
D3472	Surgical repair of root resorption – premolar		$94	$94	$94	$84	$78	$51	$36	$0	$0	$0	$78	$51	$0
D3473	Surgical repair of root resorption – molar		$117	$117	$117	$105	$98	$64	$45	$0	$0	$0	$98	$64	$0
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior		$120	$120	$120	$96	$84	$66	$54	$42	$0	$42	$84	$66	$42
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar		$160	$160	$160	$128	$112	$88	$72	$56	$0	$56	$112	$88	$56
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar		$200	$200	$200	$160	$140	$110	$90	$70	$0	$70	$140	$110	$70
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3911	Intraorifice Barrier	Inclusive to root canals	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3921	Decoronation or Submergence of an Erupted Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	If done in conjunction with root canal therapy, included in cost of RCT, unless performed by dentist other than who performed RCT or crown.	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3999	Unspecified Endodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4210	Gingivectomy or Gingivoplasty – 4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	$160	$105	$160	$140	$120	$100	$75	$65	$0	$0	$120	$100	$0
D4211	Gingivectomy or Gingivoplasty – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	$43	$43	$43	$43	$40	$38	$20	$20	$0	$0	$40	$38	$0
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	DMO Standard Plans (#) – 1 per quadrant every 3 years	$17	$17	$17	$17	$16	$15	$8	$8	$0	$0	$16	$15	$0
D4230	Anatomical Crown Exposure - 4 or More Contiguous Teeth per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D4231	Anatomical Crown Exposure - 1 to 3 Teeth or Bounded Tooth Spaces per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4240	Gingival Flap Procedure, Including Root Planing – 4 or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	$200	$200	$200	$160	$140	$110	$90	$70	$0	$0	$140	$110	$0
D4241	Gingival Flap Procedure, Including Root Planing – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	$120	$120	$120	$96	$84	$66	$54	$42	$0	$0	$84	$66	$0
D4245	Apically Positioned Flap		$200	$200	$200	$160	$140	$110	$90	$70	$0	$70	$140	$110	$70
D4249	Clinical Crown Lengthening – Hard Tissue		$204	$204	$204	$210	$195	$180	$150	$84	$0	$0	$195	$180	$0
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	$445	$445	$340	$350	$325	$300	$250	$140	$0	$0	$325	$300	$0
D4261	Osseous Surgery (Including Elevation of a Full Thickness Flap And Closure) – One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	DMO Standard Plans (#) – 1 per quadrant every 3 years	$427	$427	$204	$210	$195	$180	$150	$84	$0	$0	$195	$180	$0
D4263	Bone Replacement Graft – retained natural tooth - First Site in Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4264	Bone Replacement Graft – retained natural tooth - Each Additional Site in Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4265	Biologic Materials to Aid in Soft And Osseous Tissue Regeneration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4266	Guided Tissue Regeneration – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4267	Guided Tissue Regeneration – Non-Resorbable Barrier, per Site (Includes Membrane Removal)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4268	Surgical Revision Procedure, per Tooth		$136	$136	$136	$140	$130	$120	$100	$56	$56	$56	$130	$120	$56
D4270	Pedicle Soft Tissue Graft Procedure		$260	$260	$260	$270	$250	$230	$190	$110	$0	$0	$250	$230	$0
D4273	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) First Tooth, Implant or Edentulous Tooth Position		$155	$155	$155	$160	$150	$138	$115	$65	$0	$0	$150	$138	$0
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft		$480	$480	$310	$320	$300	$275	$230	$130	$0	$0	$300	$275	$0
D4276	Combined Connective Tissue and Pedicle Graft, per Tooth		$256	$256	$256	$264	$248	$227	$190	$107	$0	$0	$248	$227	$0
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft		$110	$110	$110	$114	$106	$98	$82	$46	$0	$0	$106	$98	$0
D4278	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) Each Additional Contiguous Tooth, Implant, or Edentulous Tooth Position in Same Graft Site		$55	$55	$55	$57	$53	$49	$41	$23	$0	$0	$53	$49	$0
D4283	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		$85	$85	$85	$88	$83	$76	$63	$36	$0	$0	$83	$76	$0
D4285	Non Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site And Donor Material) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		$264	$264	$171	$176	$165	$151	$127	$72	$0	$0	$165	$151	$0
D4286	Removal of Non-resorbable Barrier	Inclusive with D7957 - Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	0	0	0	0	0	0	0	0	0	0	0	0	0
D4322	Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4323	Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4341	Periodontal Scaling and Root Planing, 4 or More Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	$65	$65	$65	$50	$50	$45	$40	$25	$0	$0	$60	$55	$0
D4342	Periodontal Scaling and Root Planing – 1-3 Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	$39	$39	$39	$30	$30	$27	$24	$15	$0	$0	$36	$33	$0

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D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		$30	$30	$30	$30	$30	$30	$30	$30	$30	$30	$30	$30	$30
D4355	Full Mouth Debridement to Enable Comprehensive Oral Evaluation and Diagnosis on a Subsequent Visit	Once per lifetime when covered under Aetna dental plans •D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355. •D1110, D1120, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.	$60	$60	$60	$60	$60	$60	$60	$60	$0	$60	$60	$60	$60
D4381	Localized Delivery of Antimicrobial Agents via a Controlled Release Vehicle Into Diseased Crevicular Tissue, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Special Note for D4910: **Pre Nov 2000 Plans (*) - Covered once per year, no history of periodontal surgery required.** **DMO Standard Plans (#) - Periodontal Maintenance Procedures are covered twice per year only when there is a history of periodontal surgery. (Effective 04/01/2023, D4341 and D4342 have been added to the DMO list of procedure codes that will allow for future D4910.) If there is no history of periodontal surgery, an allowance for D1110 applies, provided prophy frequency of 2 per year has not been met. Dentist may charge the difference between their Usual and Customary fees for D1110 and D4910.** **If the prophy frequency has been met or there has been a combination of any two D1110 or D4910 done, then the procedure is not covered. The patient is responsible for the dentist's Usual and Customary fee for the service.**												
D4910	Periodontal Maintenance	(See Special Note above)	$60	$60	$60	$60	$40	$30	$20	$15	$0	$15	$40	$30	$15
D4920	Unscheduled Dressing Change (by Someone Other than Treating Dentist or Their Staff)		$10	$10	$10	$10	$10	$10	$10	$10	$10	$10	$10	$10	$10
D4921	Gingival Irrigation – per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Special Note for D4999: **Laser may not be submitted as D4999. The use of laser is not a procedure in and of itself; therefore, the patient may not be charged separately for this. Laser is considered inclusive with the service performed.**													
D4999	Unspecified Periodontal Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Removable Prosthetic Codes **Effective 1/1/2024, the "initial placement rule" is removed.** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **Prior to 1/1/2024** - Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does not apply in California or Texas) or is a replacement of an existing prosthesis that is over 5 years old. **Note – Benefit includes all adjustments, relines and rebases occurring within 6 months of insertion (exception D5130 & D5140).** **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.**												
D5110	Complete Denture – Maxillary		$500	$500	$350	$325	$300	$275	$250	$185	$160	$160	$320	$275	$160
D5120	Complete Denture – Mandibular		$500	$500	$350	$325	$300	$275	$250	$185	$170	$170	$320	$275	$170
D5130	Immediate Denture – Maxillary	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$588	$588	$400	$340	$330	$315	$300	$200	$160	$160	$330	$315	$160
D5140	Immediate Denture – Mandibular	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$588	$588	$400	$340	$330	$315	$300	$200	$170	$170	$330	$315	$170

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D5211	Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		$513	$513	$375	$320	$300	$275	$250	$185	$165	$165	$300	$275	$165
D5212	Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		$513	$513	$375	$320	$300	$275	$250	$185	$165	$165	$300	$275	$165
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		$625	$625	$475	$450	$400	$350	$300	$200	$165	$165	$400	$350	$165
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		$625	$625	$475	$450	$400	$350	$300	$200	$165	$165	$400	$350	$165
D5221	Immediate Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$590	$590	$431	$368	$345	$316	$288	$213	$165	$165	$345	$316	$165
D5222	Immediate Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$590	$590	$431	$368	$345	$316	$288	$213	$165	$165	$345	$316	$165
D5223	Immediate Maxillary Partial Denture – Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$719	$719	$546	$518	$460	$403	$345	$230	$165	$165	$460	$403	$165
D5224	Immediate Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$719	$719	$546	$518	$460	$403	$345	$230	$165	$165	$460	$403	$165
D5225	Maxillary Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		$613	$613	$450	$384	$360	$330	$300	$222	$165	$165	$360	$330	$165
D5226	Mandibular Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		$613	$613	$450	$384	$360	$330	$300	$222	$165	$165	$360	$330	$165
D5227	Immediate Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)		$613	$613	$450	$384	$360	$330	$300	$222	$165	$165	$360	$330	$165
D5228	Immediate Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)		$613	$613	$450	$384	$360	$330	$300	$222	$165	$165	$360	$330	$165

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D5282	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), maxillary		$513	$513	$375	$320	$300	$275	$250	$185	$165	$165	$300	$275	$165
D5283	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), mandibular		$513	$513	$375	$320	$300	$275	$250	$185	$165	$165	$300	$275	$165
D5284	Removable unilateral partial denture – one-piece flexible base (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		$307	$307	$225	$192	$180	$165	$150	$111	$83	$83	$180	$165	$83
D5286	Removable unilateral partial denture – one-piece resin (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		$257	$257	$188	$160	$150	$138	$125	$93	$83	$83	$150	$138	$83
D5410	Adjust Complete Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	$30	$30	$15	$15	$10	$10	$10	$10	$0	$0	$10	$10	$0
D5411	Adjust Complete Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	$30	$30	$15	$15	$10	$10	$10	$10	$0	$0	$10	$10	$0
D5421	Adjust Partial Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	$30	$30	$15	$15	$10	$10	$10	$10	$0	$0	$10	$10	$0
D5422	Adjust Partial Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	$30	$30	$15	$15	$10	$10	$10	$10	$0	$0	$10	$10	$0
D5511	Repair Broken Complete Denture Base, Mandibular		$45	$45	$35	$30	$30	$25	$25	$25	$0	$20	$30	$25	$20
D5512	Repair Broken Complete Denture Base, Maxillary		$45	$45	$35	$30	$30	$25	$25	$25	$0	$20	$30	$25	$20
D5520	Replace Missing or Broken Teeth – Complete Denture - per Tooth		$53	$53	$25	$20	$25	$20	$35	$25	$0	$25	$25	$20	$25
D5611	Repair Resin Partial Denture Base, Mandibular		$63	$63	$45	$30	$35	$35	$35	$30	$0	$20	$35	$35	$20
D5612	Repair Resin Partial Denture Base, Maxillary		$63	$63	$45	$30	$35	$35	$35	$30	$0	$20	$35	$35	$20
D5621	Repair Cast Partial Framework, Mandibular		$68	$68	$45	$30	$35	$35	$35	$30	$0	$30	$35	$35	$30
D5622	Repair Cast Partial Framework, Maxillary		$68	$68	$45	$30	$35	$35	$35	$30	$0	$30	$35	$35	$30
D5630	Repair or Replace Broken Retentive/Clasping Materials - per Tooth		$68	$68	$45	$30	$35	$35	$35	$30	$0	$30	$35	$35	$30
D5640	Replace Missing or Broken Teeth – Partial Denture - per Tooth		$63	$63	$45	$40	$35	$35	$35	$25	$30	$25	$35	$35	$25
D5650	Add Tooth to Existing Partial Denture - per Tooth		$63	$63	$45	$40	$35	$35	$35	$30	$30	$30	$35	$35	$30
D5660	Add Clasp to Existing Partial Denture - per Tooth		$68	$68	$50	$45	$45	$40	$40	$30	$30	$30	$45	$40	$30

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D5670 - D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary or Mandibular)		$173	$173	$95	$86	$86	$86	$86	$86	$86	$86	$86	$86	$86
D5710 - D5711	Rebase Complete Maxillary or Mandibular Denture	Includes all adjustments within 6 months after insertion	$173	$173	$95	$86	$86	$86	$86	$86	$45	$86	$86	$86	$86
D5720 - D5721	Rebase Maxillary or Mandibular Partial Denture	Includes all adjustments within 6 months after insertion	$173	$173	$95	$86	$86	$86	$86	$86	$45	$86	$86	$86	$86
D5725	Rebase Hybrid Prosthesis		$173	$173	$95	$86	$86	$86	$86	$86	$45	$86	$86	$86	$86
D5730	Reline Complete Maxillary Denture (Direct)	Includes all adjustments within 6 months after insertion	$100	$100	$65	$55	$50	$45	$40	$0	$35	$35	$50	$45	$35
D5731	Reline Complete Mandibular Denture (Direct)	Includes all adjustments within 6 months after insertion	$100	$100	$65	$55	$50	$45	$40	$0	$35	$35	$50	$45	$35
D5740	Reline Maxillary Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	$100	$100	$65	$55	$50	$45	$40	$0	$35	$35	$50	$45	$35
D5741	Reline Mandibular Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	$100	$100	$65	$55	$50	$45	$40	$0	$35	$35	$50	$45	$35
D5750	Reline Complete Maxillary Denture (Indirect)	Includes all adjustments within 6 months after insertion	$145	$145	$110	$100	$95	$85	$75	$40	$45	$45	$95	$85	$45
D5751	Reline Complete Mandibular Denture (Indirect)	Includes all adjustments within 6 months after insertion	$145	$145	$110	$100	$95	$85	$75	$40	$45	$45	$95	$85	$45
D5760	Reline Maxillary Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	$145	$145	$110	$100	$95	$85	$75	$40	$45	$45	$95	$85	$45
D5761	Reline Mandibular Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	$145	$145	$110	$100	$95	$85	$75	$40	$45	$45	$95	$85	$45
D5765	Soft Liner for Complete or Partial Removable Denture – Indirect		$145	$145	$110	$100	$95	$85	$75	$40	$45	$45	$95	$85	$45
D5810 - D5811	Interim Complete Denture (Maxillary or Mandibular)	Plan benefit and patient copay for permanent to include all interim provisional charges	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D5820	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Maxillary	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	$195	$195	$110	$100	$95	$60	$60	$60	$60	$60	$95	$60	$60
D5821	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Mandibular	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	$195	$195	$110	$100	$95	$60	$60	$60	$60	$60	$95	$60	$60
D5850 - D5851	Tissue Conditioning, Maxillary or Mandibular	Inclusive with prosthesis within 6 months after insertion	$63	$63	$35	$30	$25	$20	$20	$20	$0	$20	$25	$20	$20
D5862	Precision Attachment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5863	Overdenture – Complete Maxillary	Not covered – Alternate benefit based on D5110	$500	$500	$350	$325	$300	$275	$250	$185	$185	$185	$320	$275	$185
D5864	Overdenture – Partial Maxillary	Not covered – Alternate benefit based on D5211	$513	$513	$375	$320	$300	$275	$250	$185	$185	$185	$300	$275	$185

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D5865	Overdenture – Complete Mandibular	Not covered – Alternate benefit based on D5120	$500	$500	$350	$325	$300	$275	$250	$185	$185	$185	$320	$275	$185
D5866	Overdenture – Partial Mandibular	Not covered – Alternate benefit based on D5212	$513	$513	$375	$320	$300	$275	$250	$185	$185	$185	$300	$275	$185
D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5875	Modification of Removable Prosthesis Following Implant Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5876	Add Metal Substructure to Acrylic Full Denture (per Arch)		$45	$45	$35	$30	$30	$25	$25	$25	$25	$25	$30	$25	$25
D5899	Unspecified Removable Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5911 - D5993	Maxillofacial Prosthetics	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5994	Periodontal Medicament Carrier with Peripheral Seal – Laboratory Processed	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5999	Unspecified Maxillofacial Prosthesis, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Fixed Prosthetic Codes **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Effective 1/1/2024, the "initial placement rule" is removed.** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **Prior to 1/1/2024** - Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does not apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. **Facings on molars are not covered.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)** **Additional $125 patient copayment per unit for treatment of 6 or more units of covered crown/bridge in the same treatment plan.**													
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.													
D6010	Surgical Placement of Implant Body: Endosteal Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C	N/C	N/C	N/C	N/C $1,215	N/C	N/C	N/C	N/C	N/C	N/C $1,005	N/C	$1,005
D6011	Second Stage Implant Surgery	Not covered unless plan covers implants. For plans covering implants, this is inclusive to surgical placement of implant.	N/C	N/C	N/C	N/C	N/C $0	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D6013	Surgical Placement of Mini Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C	N/C	N/C	N/C	N/C $756	N/C	N/C	N/C	N/C	N/C	N/C $1,005	N/C	$1,005
D6040	Surgical Placement: Eposteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6050	Surgical Placement: Transosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6051	Placement of Interim Implant Abutment	Plan benefit and patient copay for permanent restoration includes all interim charges.	N/C	N/C	N/C	N/C	N/C $0	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6052	Semi-Precision Attachment Abutment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6055	Connecting Bar - Implant Supported or Abutment Supported	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6056	Prefabricated Abutment - Includes Modification and Placement	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C	N/C	N/C	N/C	N/C $440	N/C	N/C	N/C	N/C	N/C	N/C $245	N/C	$245
D6057	Custom Fabricated Abutment – Includes Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6058	Abutment Supported Porcelain/Ceramic Crown		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6064	Abutment Supported Cast Metal Crown (Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6065	Implant Supported Porcelain/Ceramic Crown		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150

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D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6075	Implant Supported Retainer for Ceramic FPD		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6080	Implant Maintenance Procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	Not covered unless plan covers implants.	N/C	N/C	N/C	N/C	N/C $88	N/C	N/C	N/C	N/C	N/C	N/C $55	N/C	$55
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths: includes cleaning of the implant surfaces, without flap entry and closure	Not covered unless plan covers implants.	N/C	N/C	N/C	N/C	N/C $15	N/C	N/C	N/C	N/C	N/C	N/C $12	N/C	$12
D6082	Implant supported crown – porcelain fused to predominantly base alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6083	Implant supported crown – porcelain fused to noble alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6086	Implant supported crown – predominantly base alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6087	Implant supported crown – noble alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6088	Implant supported crown – titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6085	Provisional implant crown		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D6089	Accessing and Retorquing Loose Implant Screw - per Screw	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6090	Repair of Implant/Abutment Supported Prosthesis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6091	Replacement of Semi-Precision or Precision Attachment of Implant/Abutment Supported Prosthesis, per Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6092	Re-cement Or Re-bond Implant/Abutment Supported Crown		$22	$22	$22	$22	$22	$22	$22	$22	$22	$22	$22	$22	$22
D6093	Re-cement Or Re-bond Implant/Abutment Supported Fixed Partial Denture		$24	$24	$24	$24	$24	$24	$24	$24	$24	$24	$24	$24	$24
D6094	Abutment Supported Crown (Titanium)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6095	Repair Implant Abutment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6096	Remove Broken Implant Retaining Screw	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6098	Implant supported retainer – porcelain fused to predominantly base alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6100	Implant Removal, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6102	Debridement and osseous contouring of a periimplant defect: includes surface cleaning of exposed implant surfaces and flap entry and closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6104	Bone graft at time of implant placement		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6105	Removal of Implant Body not Requiring Bone Removal or Flap Elevation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D6106	Guided Rissue Regeneration – Resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6107	Guided Rissue Regeneration – Non-resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6110	Implant /Abutment Supported Removable Denture for Edentulous Arch – Maxillary		$500	$500	$350	$325	$300	$275	$250	$185	$185	$185	$320	$275	$185
D6111	Implant /Abutment Supported Removable Denture for Edentulous Arch – Mandibular		$500	$500	$350	$325	$300	$275	$250	$185	$185	$185	$320	$275	$185
D6112	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Maxillary		$513	$513	$375	$320	$300	$275	$250	$185	$185	$185	$300	$275	$185
D6113	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Mandibular		$513	$513	$375	$320	$300	$275	$250	$185	$185	$185	$300	$275	$185
D6114	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Maxillary		$500	$500	$350	$325	$300	$275	$250	$185	$185	$185	$300	$275	$185
D6115	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Mandibular		$500	$500	$350	$325	$300	$275	$250	$185	$185	$185	$300	$275	$185
D6116	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Maxillary		$475	$475	$475	$345	$400	$275	$250	$200	$200	$200	$400	$275	$200
D6117	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Mandibular		$475	$475	$475	$345	$400	$275	$250	$200	$200	$200	$400	$275	$200
D6118	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Mandibular	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6119	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Maxillary	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6121	Implant supported retainer for metal FPD – predominantly base alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6122	Implant supported retainer for metal FPD – noble alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150

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D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	This procedure includes active debriding of the implant(s) and prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s). Only covered if Plan has implant coverage.	N/C	N/C	N/C	N/C	N/C $22	N/C	N/C	N/C	N/C	N/C	N/C $14	N/C	$14
D6190	Radiographic / Surgical Implant Index, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6191	Semi-precision abutment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6192	Semi-precision attachment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6193	Replacement of an Implant Screw		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6194	Abutment Supported Retainer Crown for FPD (Titanium)		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6197	Replacement of Restorative Material Used to Close an Access Opening of a Screw-retained Implant Supported Prosthesis, per Implant	Not covered for molars or stress-bearing surfaces of premolars – Alternate Benefit D2140 (See Elective Services/ Optional Treatment Plans)	$22	$22	$22	$20	$16	$10	$0	$0	$0	$0	$0	$0	$0
D6198	Remove Interim Implant Component	Inclusive to permanent restoration	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D6199	Unspecified Implant Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6205	Pontic – Indirect Resin Based Composite	Member Copay Change Effective 04/01/2016	$488 [4] $420 [5]	$488 [4] $420 [5]	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6210	Pontic – Cast High Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6211	Pontic – Cast Predominantly Base Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6212	Pontic – Cast Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6214	Pontic – Titanium		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6240	Pontic – Porcelain Fused to High Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6241	Pontic – Porcelain Fused to Predominantly Base Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6242	Pontic – Porcelain Fused to Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6243	Pontic – porcelain fused to titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6245	Pontic – Porcelain/Ceramic		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6250	Pontic – Resin with High Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6251	Pontic – Resin with Predominantly Base Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6252	Pontic – Resin with Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150

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D6253	Provisional Pontic– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan Benefit and patient copay for permanent to include all provisional charges	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D6545	Retainer – Cast Metal for Resin-Bonded Fixed Prosthesis		$378	$378	$275	$255	$220	$180	$160	$150	$210	$150	$220	$180	$150
D6548	Retainer – Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis		$463	$463	$275	$255	$220	$180	$160	$150	$210	$150	$220	$180	$150
D6549	Resin Retainer – for Resin Bonded Fixed Prosthesis	Member Copay Change Effective 01/01/2019	$244[7] $217[8]	$244[7] $217[8]	$163	$150	$130	$105	$93	$75	$75	$75	$130	$105	$75
D6600	Retainer Inlay – Porcelain/Ceramic, 2 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D6601	Retainer Inlay – Porcelain/Ceramic, 3 or More Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$150	$150	$220	$180	$150
D6602	Retainer Inlay – Cast High Noble Metal, 2 Surfaces		$478	$478	$295	$275	$240	$200	$180	$170	$210	$170	$240	$200	$170
D6603	Retainer Inlay – Cast High Noble Metal, 3 or More Surfaces		$478	$478	$295	$275	$240	$200	$180	$170	$210	$170	$240	$200	$170
D6604	Retainer Inlay – Cast Predominantly Base Metal, 2 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$210	$150	$220	$180	$150
D6605	Retainer Inlay – Cast Predominantly Base Metal, 3 or More Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$210	$150	$220	$180	$150
D6606	Retainer Inlay – Cast Noble Metal, 2 Surfaces		$473	$473	$295	$275	$240	$200	$180	$170	$210	$170	$240	$200	$170
D6607	Retainer Inlay – Cast Noble Metal, 3 or More Surfaces		$473	$473	$295	$275	$240	$200	$180	$170	$210	$170	$240	$200	$170
D6608	Retainer Onlay – Porcelain/Ceramic, 2 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$210	$150	$220	$180	$150
D6609	Retainer Onlay – Porcelain/Ceramic, 3 or More Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$210	$150	$220	$180	$150
D6610	Retainer Onlay – Cast High Noble Metal, 2 Surfaces		$478	$478	$295	$275	$240	$200	$180	$170	$210	$170	$240	$200	$170
D6611	Retainer Onlay – Cast High Noble Metal, 3 or More Surfaces		$478	$478	$295	$275	$240	$200	$180	$170	$210	$170	$240	$200	$170
D6612	Retainer Onlay – Cast Predominantly Base Metal, 2 Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$210	$150	$220	$180	$150
D6613	Retainer Onlay – Cast Predominantly Base Metal, 3 or More Surfaces		$463	$463	$275	$255	$220	$180	$160	$150	$210	$150	$220	$180	$150
D6614	Retainer Onlay – Cast Noble Metal, 2 Surfaces		$473	$473	$295	$275	$240	$200	$180	$170	$210	$170	$240	$200	$170
D6615	Retainer Onlay – Cast Noble Metal, 3 or More Surfaces		$473	$473	$295	$275	$240	$200	$180	$170	$210	$170	$240	$200	$170
D6624	Retainer Inlay – Titanium		$478	$478	$295	$275	$240	$200	$180	$170	$210	$170	$240	$200	$170
D6634	Retainer Onlay – Titanium		$478	$478	$295	$275	$240	$200	$180	$170	$170	$170	$240	$200	$170

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D6710	Retainer Crown – Indirect Resin Based Composite	Member Copay Change Effective 04/01/2016	$488 [4] $420 [5]	$488 [4] $420 [5]	$325	$300	$260	$210	$185	$150	$150	$150	$260	$210	$150
D6720	Retainer Crown – Resin with High Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6721	Retainer Crown – Resin with Predominantly Base Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6722	Retainer Crown – Resin with Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6740	Retainer Crown – Porcelain/Ceramic		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6750	Retainer Crown – Porcelain Fused to High Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6751	Retainer Crown – Porcelain Fused to Predominantly Base Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6752	Retainer Crown – Porcelain Fused to Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6753	Retainer crown – porcelain fused to titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6780	Retainer Crown – 3/4 Cast High Noble Metal		$475	$475	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6781	Retainer Crown – 3/4 Cast Predominantly Based Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6782	Retainer Crown – 3/4 Cast Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6783	Retainer Crown – 3/4 Porcelain/Ceramic		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6784	Retainer crown 3/4 – titanium and titanium alloys		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6790	Retainer Crown – Full Cast High Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$210	$150	$260	$210	$150
D6791	Retainer Crown – Full Cast Predominantly Base Metal		$488	$488	$325	$300	$260	$210	$185	$150	$250	$150	$260	$210	$150
D6792	Retainer Crown – Full Cast Noble Metal		$488	$488	$325	$300	$260	$210	$185	$150	$250	$150	$260	$210	$150
D6793	Provisional Retainer Crown– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan Benefit and patient copay for permanent to include all provisional charges	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D6794	Retainer Crown – Titanium		$488	$488	$325	$300	$260	$210	$185	$150	$250	$150	$260	$210	$150
D6920	Connector Bar	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6930	Re-cement or Re-bond Fixed Partial Denture		$20	$10	$20	$20	$20	$15	$15	$15	$90	$0	$20	$15	$0
D6940	Stress Breaker	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6950	Precision Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6985	Pediatric Partial Denture, Fixed	Eligible for anterior teeth. Not Covered for teeth other than anterior.	$110	$110	$110	$100	$95	$60	$60	$60	$60	$60	$95	$60	$60
D6999	Unspecified Fixed Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7111	Extraction, Coronal Remnants – Primary Tooth	Includes extractions for orthodontic purposes.	$12	$5	$12	$10	$6	$4	$0	$0	$0	$0	$0	$0	$0
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	Includes extractions for orthodontic purposes.	$30	$30	$30	$25	$15	$11	$0	$0	$0	$0	$0	$0	$0
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth and Including Elevation of Mucoperiosteal Flap if Indicated	Includes extractions for orthodontic purposes.	$60	$60	$60	$48	$36	$28	$0	$0	$0	$0	$36	$28	$0
D7220	Removal of Impacted Tooth – Soft Tissue	Includes extractions for orthodontic purposes.	$80	$25	$80	$70	$60	$46	$0	$0	$0	$0	$60	$46	$0
D7230	Removal of Impacted Tooth – Partially Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$175	$50	$100	$85	$72	$58	$45	$45	$80	$0	$72	$58	$0
D7240	Removal of Impacted Tooth – Completely Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$225	$75	$150	$135	$110	$100	$60	$60	$92	$0	$110	$100	$0
D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$238	$238	$150	$135	$110	$100	$60	$60	$92	$60	$110	$100	$60
D7250	Removal of Residual Tooth Roots (Cutting Procedure)		$55	$55	$55	$45	$35	$25	$15	$15	$0	$0	$35	$25	$0
D7251	Coronectomy - Intentional Partial Tooth Removal	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$113	$113	$75	$68	$55	$50	$30	$30	$0	$30	$55	$50	$30
D7252	Partial Extraction for Immediate Implant Placement	Only covered if implants are covered.	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7259	Nerve Dissection		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7260	Oroantral Fistula Closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7261	Primary Closure of a Sinus Perforation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7272	Tooth Transplantation (Includes Reimplantation from One Site to Another & Splinting and/or Stabilization)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7280	Exposure of an Unerupted Tooth		$77	$77	$77	$68	$60	$26	$26	$26	$0	$26	$60	$26	$26
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption		$90	$90	$90	$80	$70	$30	$30	$30	$30	$30	$70	$30	$30
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth		$18	$18	$18	$16	$14	$6	$6	$6	$6	$6	$14	$6	$6
D7284	Excisional Biopsy of Minor Salivary Glands		$150	$150	$150	$135	$120	$45	$30	$30	$30	$30	$120	$45	$30
D7285	Incisional Biopsy of Oral Tissue – Hard (Bone, Tooth)		$100	$100	$100	$90	$80	$30	$20	$20	$20	$20	$80	$30	$20
D7286	Incisional Biopsy of Oral Tissue – Soft		$100	$100	$100	$90	$80	$30	$20	$20	$20	$20	$80	$30	$20

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D7287	Exfoliative Cytological Sample Collection		$50	$50	$50	$45	$40	$15	$10	$10	$10	$10	$40	$15	$10
D7288	Brush Biopsy – Transepithelial Sample Collection	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7290	Surgical Repositioning of Teeth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7291	Transseptal Fiberotomy/ Supra Crestal Fiberotomy, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7292	Placement of Temporary Anchorage Device [Screw Retained Plate] Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7293	Placement of Temporary Anchorage Device Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7294	Placement of Temporary Anchorage Device Without Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7295	Harvest of Bone for Use in Autogenous Grafting Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7296	Corticotomy - One to Three Teeth or Tooth Spaces, per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7297	Corticotomy – Four or More Teeth or Tooth Spaces, per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7298	Removal of Temporary Anchorage Device [Screw Retained Plate], Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7299	Removal of Temporary Anchorage Device, Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7300	Removal of Temporary Anchorage Device Without Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in same quadrant	$55	$37	$55	$45	$35	$25	$18	$18	$0	$0	$35	$25	$0
D7311	Alveoloplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		$28	$28	$28	$23	$18	$13	$9	$9	$0	$0	$18	$13	$0
D7320	Alveoloplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in same quadrant	$75	$37	$75	$70	$60	$40	$25	$25	$0	$0	$60	$40	$0
D7321	Alveoloplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		$38	$38	$38	$35	$30	$20	$13	$13	$0	$0	$30	$20	$0
D7340	Vestibuloplasty – Ridge Extension (Secondary Epithelialization)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7350	Vestibuloplasty – Ridge Extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7410	Excision of Benign Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7411	Excision of Benign Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7412	Excision of Benign Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7413	Excision of Malignant Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7414	Excision of Malignant Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7415	Excision of Malignant Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7440	Excision Malignant Tumor - Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7441	Excision Malignant Tumor Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7450	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7451	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7460	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7461	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7465	Destruction of Lesion(s) by Physical or Chemical Method, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7472	Removal of Torus Palatinus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7473	Removal of Torus Mandibularis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7485	Reduction of Osseous Tuberosity	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7490	Radical Resection of Maxilla or Mandible	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7509	Marsupialization of Odontogenic Cyst	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue		$50	$50	$50	$40	$30	$20	$10	$10	$0	$10	$30	$20	$10
D7511	Incision and Drainage of Abscess – Intraoral Soft Tissue - Complicated		$55	$55	$55	$44	$33	$22	$11	$11	$0	$11	$33	$22	$11
D7520	Incision and Drainage of Abscess – Extraoral Soft Tissue	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7521	Incision and Drainage of Abscess – Extraoral Soft Tissue - Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7530	Removal of Foreign Body from Mucosa, Skin or Subcutaneous Alveolar Tissue	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7550	Partial Ostectomy/ Sequestrectomy for Removal of Non-Vital Bone	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7610-D7820	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7830	Manipulation Under Anesthesia	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7840-D7870	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7871	Non-Arthroscopic Lysis and Lavage	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7872-D7877	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7880	Occlusal Orthotic Device, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7881	Occlusal Orthotic Device Adjustment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7899	Unspecified TMD Therapy, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7910	Suture of Recent Small Wound up to 5 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7911	Complicated Suture - Up to 5 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7912	Complicated Suture - greater than 5 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7920-D7921	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Inclusive to the extraction Patient cannot be billed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D7939	Indexing for Osteotomy using Dynamic Robotic Assisted or Dynamic Navigation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7940-D7952	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7953	Bone Replacement Graft for Ridge Preservation – Per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7956	Guided Tissue Regeneration, Edentulous Area – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7957	Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7961	Buccal / labial frenectomy (frenulectomy)		$128	$128	$128	$110	$90	$34	$24	$24	$0	$0	$90	$34	$0
D7962	Lingual frenectomy (frenulectomy)		$128	$128	$128	$110	$90	$34	$24	$24	$0	$0	$90	$34	$0
D7963	Frenuloplasty		$134	$134	$134	$116	$95	$36	$25	$25	$0	$25	$95	$36	$25
D7970	Excision of Hyperplastic Tissue – Per Arch	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7971	Excision of Pericoronal Gingiva	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7972	Surgical Reduction of Fibrous Tuberosity	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7979	Non-Surgical Sialolithotomy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7980	Surgical Sialolithotomy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7981	Excision Of Salivary Gland, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7982	Sialodochoplasty	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7983	Closure of Salivary Fistula	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7990-D7998	Other Surgical Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7999	Unspecified Oral Surgery Procedure, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D8210	Removable Appliance Therapy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D8220	Fixed Appliance Therapy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D8695	Removal of Fixed Orthodontic Appliances for Reasons other than Completion of Treatment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	Inclusive when performed on the same date of service as definitive treatment; member cannot be billed. Definitive treatment is the treatment which resolves the pain permanently - this is the final measure taken to eliminate the pain.	$10	$10	$10	$10	$10	$10	$10	$10	$40	$0	$10	$10	$0
D9120	Fixed Partial Denture Sectioning	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9130	Temporomandibular Joint Dysfunction – Non-invasive physical Therapies	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9210	Local Anesthesia, Not in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9211	Regional Block Anesthesia	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9212	Trigeminal Division Block Anesthesia	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9219[3]	Evaluation For Moderate Sedation, Deep Sedation or General Anesthesia	When rendered by anesthesiologist	$0	$0	$0	$0	$0	$0	$0	$0	$40	$0	$0	$0	$0
D9222	Deep Sedation/General Anesthesia – First 15 Minutes	Covered for certain procedures and clinical conditions	$104	$104	$104	$104	$104	$104	$104	$104	$40	$0	$104	$104	$0

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D9223	Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	$83	$83	$83	$83	$83	$83	$83	$83	$40	$0	$83	$83	$0
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia – First 15 Minutes	Covered for certain procedures and clinical conditions	$104	$104	$104	$104	$104	$104	$104	$104	$40	$0	$104	$104	$0
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	$83	$83	$83	$83	$83	$83	$83	$83	$40	$0	$83	$83	$0
D9248	Non-Intravenous Conscious Sedation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician	For Second Opinions only	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9311	Consultation with a medical health care professional		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9410	House/Extended Care Facility Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9420	Hospital or Ambulatory Surgical Center Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9440	Office Visit - After Regularly Scheduled Hours	Not Covered (Covered in Texas)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)
D9450	Case Presentation, Detailed and Extensive Treatment Planning	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9610	Therapeutic Parenteral Drug, Single Administration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9612	Therapeutic Parenteral Drugs, 2 or more Administrations, Different Medications	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9613	Infiltration of Sustained Release Therapeutic Drug	Eligible when performed in conjunction with procedure codes D7220, D7230, D7240, D7241, or D7251 on third molars (teeth #'s 01, 16, 17, or 32).	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9630	Drugs or Medicaments dispensed in the office for home use	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9910	Application of Desensitizing Medicament	Inclusive with the restoration being performed on the same date of service; member cannot be billed.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9912	Pre-visit Patient Screening	Inclusive with record keeping requirements	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9913	Administration of Neuromodulators		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D9914	Administration of Dermal Fillers		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9920	Behavior Management, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9930	Treatment of Complications (Post-surgical) – Unusual Circumstances, by Report	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9932	Cleaning and Inspection of Removable Complete Denture, Maxillary		$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9933	Cleaning and Inspection of Removable Complete Denture, Mandibular		$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9934	Cleaning and Inspection of Removable Partial Denture, Maxillary		$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9935	Cleaning and Inspection of Removable Partial Denture, Mandibular		$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25
D9938	Fabrication of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9939	Placement of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9941	Fabrication of Athletic Mouthguard	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9942	Repair and/or Reline of Occlusal Guard		$23	$23	$23	$15	$18	$18	$18	$15	$15	$15	$18	$18	$15
D9943	Occlusal Guard Adjustment	Fee for occlusal guard includes adjustments performed within 6 months of placement	$23	$23	$11	$9	$9	$9	$9	$9	$9	$9	$9	$9	$9
D9944	Occlusal Guard – Hard Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$210	$210	$104	$81	$81	$81	$81	$81	$81	$0	$81	$81	$0
D9945	Occlusal Guard – Soft Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$183	$183	$90	$70	$70	$70	$70	$70	$70	$0	$70	$70	$0
D9946	Occlusal Guard – Hard Appliance, Partial Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$110	$110	$54	$42	$42	$42	$42	$42	$42	$0	$42	$42	$0
D9947	Custom Sleep Apnea Appliance Fabrication and Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9948	Adjustment of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9949	Repair of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9950	Occlusion Analysis - Mounted Case	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9951	Occlusal Adjustment – Limited	Not separately eligible when performed in conjunction with a restoration, root canal therapy or appliance.	$25	$25	$25	$10	$10	$10	$10	$10	$0	$0	$10	$10	$0

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D9952	Occlusal Adjustment – Complete		$90	$90	$90	$60	$60	$60	$60	$60	$0	$0	$60	$60	$0
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9954	Fabrication and Delivery of Oral Appliance Therapy (OAT) Morning Repositioning Device	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9955	Oral Appliance Therapy (OAT) Titration Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9956	Administration of Home Sleep Apnea Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9957	Screening for Sleep Related Breathing Disorders	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9959	Unspecified Sleep Apnea Services Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9961	Duplicate/Copy Patient's Records	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9970	Enamel Microabrasion	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9972	External Bleaching – per Arch - Performed in Office	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9973	External Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9974	Internal Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9975	External Bleaching for Home Application, per Arch	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9985[2]	Sales Tax	Inclusive to service being taxed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D9986	Missed Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9987	Cancelled Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9990	Certified Translation or Sign-language Services per Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9991	Dental case management - addressing appointment compliance barriers	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9992	Dental case management – care coordination	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9993	Dental case management – motivational interviewing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9994	Dental case management – patient education to improve oral health literacy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9995	Teledentistry – Synchronous; Real-Time Encounter	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9996	Teledentistry – Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9997	Dental case management – patients with special health care needs	Inclusive to the primary service Patient cannot be billed	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

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D9999	Unspecified Adjunctive Procedure, by Report	Used for procedure that is not adequately described by a code. Use of this code REQUIRES A WRITTEN NARRATIVE & supporting documentation	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

[1] Current Dental Terminology ©American Dental Association. All rights reserved.
[2] Not separately eligible/inclusive - the patient cannot be billed for these services.
[3] Covered only when performed by anesthesiologist.
[4] Amount thru 03/31/2016
[5] Amount effective 04/01/2016
[6] Copay noted applies only when performed by the PCD. This procedure is not covered when performed by a Specialist;
[7] Amount thru 12/31/2018
[8] Amount effective 01/01/2019

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	Office Visit Copay	Check Roster When an Office Visit copay applies, the DMO Patient Roster will show the amount under column "Office Copay" (i.e. 000 = $0.00; 005 = $5.00). When submitted, use ADA code D0999.						
	Infection Control	May not bill patient for infection control procedures						
		Frequency limits on Preventive and Diagnostic services are waived in Arizona, California and Texas if medically necessary.						
D0120	Periodic Oral Evaluation - Established Patient	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0
D0140	Limited Oral Evaluation - Problem Focused	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0
D0145	Oral Evaluation for a Patient under Three Years of Age and Counseling with a Primary Caregiver	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0
D0150	Comprehensive Oral Evaluation - New or Established Patient	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, by Report	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0
D0170	Re-Evaluation - Limited, Problem Focused (Established Patient; not Post-Operative Visit)	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0
D0171	Re-Evaluation - Post-Operative Office Visit	Inclusive to surgery. Patient cannot be billed.	$0	$0	$0	$0	$0	$0
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Limited to 4X per year. (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0
D0190-D0191[2]	Screening / Assessment of a Patient	Inclusive to oral evaluation Patient cannot be billed	$0	$0	$0	$0	$0	$0
D0210	Intraoral - Complete Series of Radiographic Images	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — FMS or Panorex once every 3 years. (Frequency limit may be waived when done in conjunction with eligible specialty service)	$0	$0	$0	$0	$0	$0
D0220-D0230	Intraoral - Periapical Image		$0	$0	$0	$0	$0	$0
D0240	Intraoral - Occlusal Radiographic Image		$0	$0	$0	$0	$0	$0
D0250-D0251	Extra-Oral Image		$0	$0	$0	$0	$0	$0
D0270-D0274	Bitewing Radiographic Image	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	$0	$0	$0	$0	$0	$0
D0277	Vertical Bitewings - 7 to 8 Radiographic Images	1 series every 3 years	$0	$0	$0	$0	$0	$0

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D0310	Sialography	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0320-D0321	Temporomandibular Joint Image	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0322	Tomographic Survey	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0330	Panoramic Radiographic Image	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — FMS or Panorex once every 3 years. (Frequency limit may be waived when done in conjunction with eligible Specialty Service)	$0	$0	$0	$0	$0	$0
D0340	2D Cephalometric Radiographic Image – Acquisition, Measurement and Analysis	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C
D0350	2D Oral/Facial Photographic Image Obtained Intra-orally or Extra-orally	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C
D0364-D0368	Cone Beam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0369-D0371	Capture and Interpretation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0372	Intraoral - Complete Series of Radiographic Images	Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0
D0373	Intraoral Tomosynthesis – Bitewing Radiographic Image	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	$0	$0	$0	$0	$0	$0
D0374	Intraoral Tomosynthesis – Periapical Radiographic Image		$0	$0	$0	$0	$0	$0
D0380-D0384	Cone Beam CT Image Capture	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0385-D0386	Cone Beam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0387	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images – Image Capture Only	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0
D0388	Intraoral Tomosynthesis – Bitewing Radiographic Image – Image Capture Only	Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	$0	$0	$0	$0	$0	$0
D0389	Intraoral Tomosynthesis – Periapical Radiographic Image – Image Capture Only		$0	$0	$0	$0	$0	$0
D0391	Interpretation of Diagnostic Image by Practitioner Not Associated with Capture of the Image, Including Report		$0	$0	$0	$0	$0	$0
D0393-D0395	3D Images	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0396	3D printing of a 3D dental surface scan	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C
D0411	HbA1c In-office Point of Service Testing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0412	Blood Glucose Level Test – In-office Using a Glucose Meter	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C

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D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0415	Collection of Microorganisms	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0416	Viral Culture	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0417	Collection & Preparation of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0418	Analysis of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0419	Assessment of Salivary Flow by Measurement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0422	Collection and Preparation of Genetic Sample Material for Laboratory Analysis and Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0423	Genetic Test for Susceptibility to Diseases – Specimen Analysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0425	Caries Susceptibility Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0431	Adjunctive Pre-Diagnostic Test	The use of any tools and/or devices that assist in a diagnosis to be an adjunctive technique that is part of the oral evaluation or primary service. Members cannot be billed for this service.	$0	$0	$0	$0	$0	$0
D0460	Pulp Vitality Tests	Inclusive to oral evaluation Patient cannot be billed	$0	$0	$0	$0	$0	$0
D0470	Diagnostic Casts		$0	$0	$0	$0	$0	$0
D0472-D0474	Accession of Tissue		$0	$0	$0	$0	$0	$0
D0475-D0502	Oral Pathology Laboratory Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D0601-D0603[2]	Caries Risk Assessment	Inclusive to oral evaluation	$0	$0	$0	$0	$0	$0
D0604	Antigen testing for a public health related pathogen including coronavirus		N/C	N/C	N/C	N/C	N/C	N/C
D0605	Antibody testing for a public health related pathogen including coronavirus		N/C	N/C	N/C	N/C	N/C	N/C
D0606	Molecular testing for a public health related pathogen including coronavirus		N/C	N/C	N/C	N/C	N/C	N/C
D0701	panoramic radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0330. Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — FMS or Panorex once every 3 years. (Frequency limit may be waived when done in conjunction with eligible Specialty Service)	$0	$0	$0	$0	$0	$0
D0702	2-D cephalometric radiographic image – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C

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D0705	extra-oral posterior dental radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0251.	$0	$0	$0	$0	$0	$0
D0706	intraoral – occlusal radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0240.	$0	$0	$0	$0	$0	$0
D0707	intraoral – periapical radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0220.	$0	$0	$0	$0	$0	$0
D0708	intraoral – bitewing radiographic image – image capture only	Only eligible when submitted with D0391 Inclusive when submitted with D0270 Pre Nov 2000 Plans (*) — 1 series 2x per year DMO Standard Plans (#) — 1 series per year	$0	$0	$0	$0	$0	$0
D0709	intraoral – complete series of radiographic images – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0210. Pre Nov 2000 Plans (*) — No limits DMO Standard Plans (#) — FMS or Panorex once every 3 years. (Frequency limit may be waived when done in conjunction with eligible specialty service)	$0	$0	$0	$0	$0	$0
D0801	3D Intraoral Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C
D0802	3D Dental Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C
D0803	3D Facial Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C
D0804	3D Facial Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C
D0999	Unspecified Diagnostic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D1110	Prophylaxis – Adult	Limited to 2 per year	$8	$0	$0	$0	$0	$0
D1120	Prophylaxis – Child	Limited to 2 per year	$7	$0	$0	$0	$0	$0
D1206	Topical Application of Fluoride Varnish	Pre Nov 2000 Plans (*) - No age or frequency limit DMO Standard Plans (#) – 1x per year for children under 16	$0	$0	$0	$0	$0	$0
D1208	Topical Application of Fluoride – Excluding Varnish	Pre Nov 2000 Plans (*) - No age or frequency limit DMO Standard Plans (#) – 1x per year for children under 16	$0	$0	$0	$0	$0	$0
D1301	Immunization Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D1310-D1321	Nutritional or Tobacco Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D1330	Oral Hygiene Instruction		$0	$0	$0	$0	$0	$0
D1351	Sealant – per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$8	$0	$0	$0	$10	$5

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D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to permanent molars and to covered persons under age 16 (not limited to dependent children).	$8	$0	$0	$0	$10	$5
D1353	Sealant Repair - per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to permanent molars and to covered persons under age 16 (not limited to dependent children).	$4	$0	$0	$0	$5	$3
D1354	Application of Caries Arresting Medicament – per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$8	$0	$0	$0	$10	$5
D1355	Caries preventive medicament application – per tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$6	$0	$0	$0	$8	$4
D1510	Space Maintainer - Fixed, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion	$80	$75	$0	$0	$80	$75
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion	$80	$75	$0	$0	$80	$75
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion	$80	$75	$0	$0	$80	$75
D1520	Space Maintainer - Removable, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion	$80	$70	$0	$0	$80	$70
D1526	Space Maintainer – Removable – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion	$80	$70	$0	$0	$80	$70
D1527	Space Maintainer – Removable – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion	$80	$70	$0	$0	$80	$70
D1551	Re-cement or re-bond bilateral space maintainer – maxillary		$15	$12	$12	$12	$15	$12
D1552	Re-cement or re-bond bilateral space maintainer – mandibular		$15	$12	$12	$12	$15	$12
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant		$8	$6	$6	$6	$8	$6
D1556	Removal of fixed unilateral space maintainer – per quadrant		$8	$6	$6	$6	$8	$6
D1557	Removal of fixed bilateral space maintainer – maxillary		$15	$12	$12	$12	$15	$12
D1558	Removal of fixed bilateral space maintainer – mandibular		$15	$12	$12	$12	$15	$12

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D1575	Distal shoe space maintainer – fixed, unilateral - per quadrant		$88	$83	$0	$0	$88	$83
D1701 - D1714	Covid-19 vaccine administration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D1781 - D1783	Vaccine Administration – Human Papillomavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
		Effective 11/1/2020 - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is considered part of the primary service done on the same day. Member cannot be charged. **Prior to 11/1/2020 - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is not covered. The member will be responsible for the charge.**						
D1999	Unspecified Preventive Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2140	Amalgam – 1 Surface, Primary or Permanent		$16	$10	$0	$0	$0	$0
D2150	Amalgam – 2 Surfaces, Primary or Permanent		$24	$12	$0	$0	$0	$0
D2160	Amalgam – 3 Surfaces, Primary or Permanent		$32	$16	$0	$0	$0	$0
D2161	Amalgam – 4+ Surfaces, Primary or Permanent		$40	$18	$0	$0	$0	$0
D2330	Resin-Based Composite – 1 Surface, Anterior		$25	$15	$0	$0	$0	$0
D2331	Resin-Based Composite – 2 Surfaces, Anterior		$35	$21	$0	$0	$0	$0
D2332	Resin-Based Composite – 3 Surfaces, Anterior		$35	$25	$0	$0	$0	$0
D2335	Resin-Based Composite – 4+ Surfaces or Involving Incisal Angle, Anterior		$60	$45	$40	$35	$60	$45
D2390	Resin-Based Composite Crown, Anterior		$60	$50	$40	$0	$60	$50
D2391	Resin-Based Composite – 1 Surface, Posterior		$45	$35	$35	$35	$35	$35
D2392	Resin-Based Composite – 2 Surfaces, Posterior		$60	$50	$45	$45	$45	$45
D2393	Resin-Based Composite – 3 Surfaces, Posterior		$85	$60	$55	$55	$55	$55
D2394	Resin-Based Composite – 4+ Surfaces, Posterior		$90	$90	$75	$75	$75	$75
D2410 - D2430	Gold Foil	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
		Crowns/Inlays Procedure Codes: **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Eligible for plan benefit when tooth cannot be restored with a filling. Plan benefit available for one crown once every 5 years per tooth.** **Facings on molar crowns and pontics will always be considered cosmetic.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)** **Additional $125.00 patient copayment per unit for treatment of 6 or more units of covered crown/bridge in the same treatment plan.**						
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.						
D2510	Inlay – Metallic - 1 Surface		$225	$195	$190	$180	$225	$195
D2520	Inlay – Metallic - 2 Surfaces		$225	$195	$190	$180	$225	$195

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D2530	Inlay – Metallic - 3 or More Surfaces		$225	$195	$190	$180	$225	$195
D2542	Onlay – Metallic - 2 Surfaces		$240	$210	$200	$190	$240	$210
D2543	Onlay – Metallic - 3 Surfaces		$240	$210	$200	$190	$240	$210
D2544	Onlay - Metallic – 4 or More Surfaces		$240	$210	$200	$190	$240	$210
D2610	Inlay, Porcelain/Ceramic – 1 Surface		$225	$195	$190	$180	$225	$195
D2620	Inlay, Porcelain/Ceramic – 2 Surfaces		$225	$195	$190	$180	$225	$195
D2630	Inlay, Porcelain/Ceramic – 3 or More Surfaces		$225	$195	$190	$180	$225	$195
D2642	Onlay, Porcelain/Ceramic – 2 Surfaces		$240	$210	$200	$190	$240	$210
D2643	Onlay, Porcelain/Ceramic – 3 Surfaces		$240	$210	$200	$190	$240	$210
D2644	Onlay, Porcelain/Ceramic – 4 or More Surfaces		$240	$210	$200	$190	$240	$210
D2650	Inlay, Resin Based Composite – 1 Surface		$225	$195	$190	$180	$225	$195
D2651	Inlay, Resin Based Composite – 2 Surfaces		$225	$195	$190	$180	$225	$195
D2652	Inlay, Resin Based Composite – 3 or more Surfaces		$225	$195	$190	$180	$225	$195
D2662	Onlay, Resin Based Composite – 2 Surfaces		$240	$210	$200	$190	$240	$210
D2663	Onlay, Resin Based Composite – 3 Surfaces		$240	$210	$200	$190	$240	$210
D2664	Onlay, Resin Based Composite – 4 or More Surfaces		$240	$210	$200	$190	$240	$210
D2710	Crown – Resin-Based Composite, Indirect		$315	$255	$225	$180	$315	$255
D2712	Crown – 3/4 Resin-Based Composite, Indirect		$252	$204	$180	$144	$252	$204
D2720	Crown – Resin with High Noble Metal		$315	$255	$225	$180	$315	$255
D2721	Crown – Resin with Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D2722	Crown – Resin with Noble Metal		$315	$255	$225	$180	$315	$255
D2740	Crown – Porcelain/ Ceramic		$315	$255	$225	$180	$315	$255
D2750	Crown – Porcelain Fused to High Noble Metal		$315	$255	$225	$180	$315	$255
D2751	Crown – Porcelain Fused to Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D2752	Crown – Porcelain Fused to Noble Metal		$315	$255	$225	$180	$315	$255
D2753	Crown - porcelain fused to titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D2780	Crown – 3/4 Cast High Noble Metal		$315	$255	$225	$180	$315	$255
D2781	Crown – 3/4 Cast Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D2782	Crown – 3/4 Cast Noble Metal		$315	$255	$225	$180	$315	$255
D2783	Crown – 3/4 Cast Porcelain/Ceramic		$315	$255	$225	$180	$315	$255
D2790	Crown – Full Cast High Noble Metal		$315	$255	$225	$180	$315	$255
D2791	Crown – Full Cast Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D2792	Crown – Full Cast Noble Metal		$315	$255	$225	$180	$315	$255
D2794	Crown – Titanium and Titanium Alloys		$315	$255	$225	$180	$315	$255

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D2799	Interim Crown – Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	$0	$0	$0	$0	$0	$0
D2910	Re-cement Or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration		$15	$10	$5	$0	$15	$10
D2915	Re-Cement or Re-Bond Indirectly Fabricated or Prefabricated Post and Core		$8	$5	$3	$0	$8	$5
D2920	Re-Cement or Re-Bond Crown		$15	$10	$5	$0	$15	$10
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp		$6	$5	$4	$4	$6	$5
D2928	Prefabricated Porcelain/Ceramic Crown – Permanent Tooth	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	$0	$0	$0	$0	$0	$0
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	Alternate benefit based on D2930	$50	$40	$0	$0	$50	$40
D2930	Prefabricated Stainless Steel Crown – Primary Tooth		$50	$40	$0	$0	$50	$40
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	When used as permanent crown, subject to crown frequency limit. Eligible as temp only when used as temp restoration until adult dentition is formed or when used due to accident away from home. Otherwise, temp is included in final restoration and not separately eligible.	$60	$50	$40	$0	$60	$50
D2932	Prefabricated Resin Crown	Alternate benefit based on D2930 or D2931	$50/$60	$40/$50	$0/$40	$0 / $0	$50/$60	$40/$50
D2933	Prefabricated Stainless Steel Crown with Resin Window	Alternate benefit based on D2930 or D2931	$50/$60	$40/$50	$0/$40	$0 / $0	$50/$60	$40/$50
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	Alternate benefit based on D2930	$50	$40	$0	$0	$50	$40
D2940	Placement of Interim Direct Restoration		$8	$3	$0	$0	$8	$3
D2941	Interim Therapeutic Restoration – Primary Dentition		$4	$1	$0	$0	$4	$1
D2949[2]	Restorative Foundation for an Indirect Restoration	Inclusive to permanent restoration	$0	$0	$0	$0	$0	$0
D2950	Core Buildup, Including Any Pins When Required		$90	$80	$60	$70	$80	$80
D2951	Pin Retention – Per Tooth, In Addition to Restoration		$10	$10	$10	$0	$10	$10
D2952	Post & Core In Addition to Crown, Indirectly Fabricated		$128	$112	$80	$72	$100	$112
D2953	Each Additional Indirectly Fabricated Post – Same Tooth		$128	$112	$80	$72	$100	$112
D2954	Prefabricated Post & Core In Addition To Crown		$83	$74	$70	$63	$90	$74
D2955	Post Removal	Included in cost of replacement post	$0	$0	$0	$0	$0	$0
D2956	Removal of an Indirect Restoration on a Natural Tooth	Not to be used as a temporary or provisional restoration. Inclusive to any restorative service.	$0	$0	$0	$0	$0	$0
D2957	Each Additional Prefabricated Post - Same Tooth		$83	$74	$70	$63	$90	$74

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D2960	Labial Veneer (Resin Laminate) – Chairside	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2961	Labial Veneer (Resin Laminate) – Laboratory	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2962	Labial Veneer (Porcelain Laminate) – Laboratory	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2971	Additional Procedures to Customize a Crown to Fit under an Existing Partial Denture Framework		$47	$38	$34	$27	$47	$38
D2975	Coping	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2976	Band Stabilization – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2980	Crown Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2981	Inlay Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2982	Onlay Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2983	Veneer Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D2989	Excavation of a Tooth Resulting in the Determination of Non-restorability	Restorations, endodontics, and/or D4249 on same day/same tooth will be denied.	$8	$5	$0	$0	$0	$0
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to Molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years and to covered persons under age 16 (not limited to dependent children).	$8	$0	$0	$0	$10	$5
D2991	Application of Hydroxyapatite Regeneration Medicament – per Tooth	One application per tooth, regardless of the number of appointments required to complete the full application. Once tooth application is completed, limited to once every 3 years for permanent teeth (1-32).	$12	$0	$0	$0	$15	$8
D2999	Unspecified Restorative Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3110	Pulp Cap – Direct (Excluding Final Restoration)		$6	$4	$0	$0	$0	$0
D3120	Pulp Cap – Indirect (Excluding Final Restoration)		$6	$4	$0	$0	$0	$0
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	If done in conjunction with root canal therapy, included in cost of RCT	$55	$22	$0	$0	$55	$22
D3221	Pulpal Debridement, Primary And Permanent Teeth	Considered inclusive with the Endodontic treatment when completed on the same day.	$10	$10	$10	$10	$10	$10
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development		$50	$20	$0	$0	$50	$20
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)		$55	$22	$0	$0	$55	$22
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)		$55	$22	$0	$0	$55	$22
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)		$120	$70	$50	$0	$120	$70

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D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)		$180	$109	$70	$0	$180	$109
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)		$303	$280	$175	$146	$300	$280
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access		$120	$70	$50	$0	$120	$70
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth		$90	$55	$35	$0	$90	$55
D3333	Internal Root Repair of Perforation Defects		$90	$55	$40	$0	$100	$55
D3346	Retreatment of Previous Root Canal Therapy – Anterior		$220	$170	$150	$100	$220	$170
D3347	Retreatment of Previous Root Canal Therapy – Premolar		$280	$209	$170	$100	$280	$209
D3348	Retreatment of Previous Root Canal Therapy – Molar		$403	$380	$275	$246	$400	$380
D3351	Apexification/Recalcification – Initial Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3352	Apexification/Recalcification – Interim Medication Replacement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3353	Apexification/ Recalcification – Final Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3355	Pulpal Regeneration - Initial Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3356	Pulpal Regeneration – Interim Medication Replacement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3357	Pulpal Regeneration – Completion of Treatment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3410	Apicoectomy – Anterior		$141	$92	$65	$0	$170	$92
D3421	Apicoectomy – Premolar (First Root)		$141	$92	$65	$0	$170	$92
D3425	Apicoectomy – Molar (First Root)		$150	$90	$80	$0	$170	$90
D3426	Apicoectomy – Each Additional Root		$90	$55	$40	$0	$100	$55
D3428	Bone Graft In Conjunction With Periradicular Surgery - per Tooth, Single Site		N/C	N/C	N/C	N/C	N/C	N/C
D3429	Bone Graft in Conjunction with Periradicular Surgery - Each Additional Contiguous Tooth in the Same Surgical Site		N/C	N/C	N/C	N/C	N/C	N/C
D3430	Retrograde Filling – per Root		$65	$40	$20	$0	$65	$40
D3431	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction With Periradicular Surgery		N/C	N/C	N/C	N/C	N/C	N/C
D3432	Guided Tissue Regeneration, Resorbable Barrier, per Site, In Conjunction with Periradicular Surgery		N/C	N/C	N/C	N/C	N/C	N/C
D3450	Root Amputation – per Root		$80	$70	$60	$60	$80	$70
D3460	Endodontic Endosseous Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3470	Intentional Re-Implantation (Including Necessary Splinting)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3471	Surgical repair of root resorption - anterior		$64	$41	$29	$0	$77	$41

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D3472	Surgical repair of root resorption – premolar		$85	$55	$39	$0	$102	$55
D3473	Surgical repair of root resorption – molar		$106	$69	$49	$0	$128	$69
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior		$84	$66	$54	$42	$84	$66
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar		$112	$88	$72	$56	$112	$88
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar		$140	$110	$90	$70	$140	$110
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3911	Intraorifice Barrier	Inclusive to root canals	$0	$0	$0	$0	$0	$0
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3921	Decoronation or Submergence of an Erupted Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	If done in conjunction with root canal therapy, included in cost of RCT, unless performed by dentist other than who performed RCT or crown.	N/C	N/C	N/C	N/C	N/C	N/C
D3999	Unspecified Endodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4210	Gingivectomy or Gingivoplasty – 4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	1 per quadrant every 3 years	$160	$133	$100	$87	$125	$133
D4211	Gingivectomy or Gingivoplasty – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$60	$57	$30	$30	$55	$57
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	1 per quadrant every 3 years	$24	$23	$12	$12	$22	$23
D4230	Anatomical Crown Exposure - 4 or More Contiguous Teeth per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4231	Anatomical Crown Exposure - 1 to 3 Teeth or Bounded Tooth Spaces per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4240	Gingival Flap Procedure, Including Root Planing – 4 or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$171	$134	$110	$86	$155	$134
D4241	Gingival Flap Procedure, Including Root Planing – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$103	$80	$66	$52	$93	$80
D4245	Apically Positioned Flap		$140	$110	$90	$70	$140	$110
D4249	Clinical Crown Lengthening – Hard Tissue		$195	$180	$150	$84	$225	$180

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D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	1 per quadrant every 3 years	$325	$300	$250	$140	$375	$300
D4261	Osseous Surgery (Including Elevation of a Full Thickness Flap And Closure) – One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$195	$180	$150	$84	$225	$180
D4263	Bone Replacement Graft – retained natural tooth - First Site in Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4264	Bone Replacement Graft – retained natural tooth - Each Additional Site in Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4265	Biologic Materials to Aid in Soft And Osseous Tissue Regeneration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4266	Guided Tissue Regeneration – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4267	Guided Tissue Regeneration – Non-Resorbable Barrier, per Site (Includes Membrane Removal)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4268	Surgical Revision Procedure, per Tooth		$130	$120	$100	$56	$150	$120
D4270	Pedicle Soft Tissue Graft Procedure		$250	$230	$190	$110	$285	$230
D4273	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) First Tooth, Implant or Edentulous Tooth Position		$150	$138	$115	$65	$173	$138
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft		$300	$275	$230	$130	$345	$275
D4276	Combined Connective Tissue and Pedicle Graft, per Tooth		$248	$227	$190	$107	$285	$227
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft		$106	$98	$82	$46	$122	$98
D4278	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) Each Additional Contiguous Tooth, Implant, or Edentulous Tooth Position in Same Graft Site		$53	$49	$41	$23	$61	$49

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D4283	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		$83	$76	$63	$36	$95	$76
D4285	Non Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site And Donor Material) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		$165	$151	$127	$72	$190	$151
D4286	Removal of Non-resorbable Barrier	Inclusive with D7957 - Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	$0	$0	$0	$0	$0	$0
D4322	Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4323	Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D4341	Periodontal Scaling and Root Planing, 4 or More Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	$56	$51	$50	$35	$60	$62
D4342	Periodontal Scaling and Root Planing – 1-3 Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	$34	$31	$30	$21	$36	$37
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		$30	$30	$30	$30	$30	$30
D4355	Full Mouth Debridement to Enable Comprehensive Oral Evaluation and Diagnosis on a Subsequent Visit	Once per lifetime when covered under Aetna dental plans •D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355. •D1110, D1120, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.	$60	$60	$60	$60	$60	$60
D4381	Localized Delivery of Antimicrobial Agents via a Controlled Release Vehicle Into Diseased Crevicular Tissue, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
		Special Note for D4910: **<u>Pre Nov 2000 Plans (*)</u> - Covered once per year, no history of periodontal surgery required.** **<u>DMO Standard Plans (#)</u> - Periodontal Maintenance Procedures are covered twice per year only when there is a history of periodontal surgery. (Effective 04/01/2023, D4341 and D4342 have been added to the DMO list of procedure codes that will allow for future D4910.) If there is no history of periodontal surgery, an allowance for D1110 applies, provided prophy frequency of 2 per year has not been met. Dentist may charge the difference between their Usual and Customary fees for D1110 and D4910.** **If the prophy frequency has been met or there has been a combination of any two D1110 or D4910 done, then the procedure is not covered. The patient is responsible for the dentist's Usual and Customary fee for the service.**						
D4910	Periodontal Maintenance	(See Special Note above)	$60	$45	$30	$23	$40	$45
D4920	Unscheduled Dressing Change (by Someone Other than Treating Dentist or Their Staff)		$10	$10	$10	$10	$10	$10
D4921	Gingival Irrigation – per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C

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		Special Note for D4999: **Laser may not be submitted as D4999. The use of laser is not a procedure in and of itself; therefore, the patient may not be charged separately for this. Laser is considered inclusive with the service performed.**						
D4999	Unspecified Periodontal Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
		Removable Prosthetic Codes **Effective 1/1/2024, the "initial placement rule" is removed.** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **Prior to 1/1/2024** - Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does not apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. **Note – Benefit includes all adjustments, relines and rebases occurring within 6 months of insertion (exception D5130 & D5140).** **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.**						
D5110	Complete Denture – Maxillary		$300	$275	$275	$200	$320	$275
D5120	Complete Denture – Mandibular		$300	$275	$275	$200	$320	$275
D5130	Immediate Denture – Maxillary	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$330	$315	$325	$225	$330	$315
D5140	Immediate Denture – Mandibular	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$330	$315	$325	$225	$330	$315
D5211	Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		$300	$275	$275	$200	$320	$275
D5212	Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		$300	$275	$275	$200	$320	$275
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		$400	$350	$325	$225	$400	$350
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		$400	$350	$325	$225	$400	$350
D5221	Immediate Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$345	$316	$316	$230	$368	$316
D5222	Immediate Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$345	$316	$316	$230	$368	$316
D5223	Immediate Maxillary Partial Denture – Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$460	$403	$374	$259	$460	$403
D5224	Immediate Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$460	$403	$374	$259	$460	$403
D5225	Maxillary Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		$360	$330	$330	$240	$384	$330

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D5226	Mandibular Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		$360	$330	$330	$240	$384	$330
D5227	Immediate Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)		$360	$330	$330	$240	$384	$330
D5228	Immediate Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)		$360	$330	$330	$240	$384	$330
D5282	Removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), maxillary		$300	$275	$275	$200	$320	$275
D5283	Removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), mandibular		$300	$275	$275	$200	$320	$275
D5284	Removable unilateral partial denture – one-piece flexible base (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		$180	$165	$165	$120	$192	$165
D5286	Removable unilateral partial denture – one-piece resin (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		$150	$138	$138	$100	$160	$138
D5410	Adjust Complete Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	$10	$10	$10	$10	$10	$10
D5411	Adjust Complete Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	$10	$10	$10	$10	$10	$10
D5421	Adjust Partial Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	$10	$10	$10	$10	$10	$10
D5422	Adjust Partial Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	$10	$10	$10	$10	$10	$10
D5511	Repair Broken Complete Denture Base, Mandibular		$36	$30	$30	$30	$40	$30
D5512	Repair Broken Complete Denture Base, Maxillary		$36	$30	$30	$30	$40	$30
D5520	Replace Missing or Broken Teeth – Complete Denture - per Tooth		$25	$20	$35	$25	$40	$20
D5611	Repair Resin Partial Denture Base, Mandibular		$35	$35	$35	$30	$40	$35
D5612	Repair Resin Partial Denture Base, Maxillary		$35	$35	$35	$30	$40	$35
D5621	Repair Cast Partial Framework, Mandibular		$35	$35	$35	$30	$40	$35
D5622	Repair Cast Partial Framework, Maxillary		$35	$35	$35	$30	$40	$35
D5630	Repair or Replace Broken Retentive/Clasping Materials - per Tooth		$35	$35	$35	$30	$40	$35
D5640	Replace Missing or Broken Teeth – Partial Denture - per Tooth		$35	$35	$35	$25	$45	$35
D5650	Add Tooth to Existing Partial Denture - per Tooth		$35	$35	$35	$30	$40	$35

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D5660	Add Clasp to Existing Partial Denture - per Tooth		$45	$40	$40	$30	$45	$40
D5670 - D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary or Mandibular)		$100	$100	$100	$100	$100	$100
D5710 - D5711	Rebase Complete Maxillary or Mandibular Denture	Includes all adjustments within 6 months after insertion	$100	$100	$100	$100	$100	$100
D5725	Rebase Hybrid Prosthesis		$100	$100	$100	$100	$100	$100
D5720 - D5721	Rebase Maxillary or Mandibular Partial Denture	Includes all adjustments within 6 months after insertion	$100	$100	$100	$100	$100	$100
D5730	Reline Complete Maxillary Denture (Direct)	Includes all adjustments within 6 months after insertion	$50	$45	$40	$0	$60	$45
D5731	Reline Complete Mandibular Denture (Direct)	Includes all adjustments within 6 months after insertion	$50	$45	$40	$0	$60	$45
D5740	Reline Maxillary Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	$50	$45	$40	$0	$60	$45
D5741	Reline Mandibular Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	$50	$45	$40	$0	$60	$45
D5750	Reline Complete Maxillary Denture (Indirect)	Includes all adjustments within 6 months after insertion	$114	$102	$90	$48	$100	$102
D5751	Reline Complete Mandibular Denture (Indirect)	Includes all adjustments within 6 months after insertion	$114	$102	$90	$48	$100	$102
D5760	Reline Maxillary Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	$114	$102	$90	$48	$100	$102
D5761	Reline Mandibular Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	$114	$102	$90	$48	$100	$102
D5765	Soft Liner for Complete or Partial Removable Denture – Indirect		$114	$102	$90	$48	$100	$102
D5810 - D5811	Interim Complete Denture (Maxillary or Mandibular)	Plan benefit and patient copay for permanent to include all interim Provisional charges	$0	$0	$0	$0	$0	$0
D5820	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Maxillary	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	$143	$90	$90	$90	$120	$90
D5821	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Mandibular	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	$143	$90	$90	$90	$120	$90
D5850 - D5851	Tissue Conditioning, Maxillary or Mandibular	Inclusive with prosthesis within 6 months after insertion	$50	$40	$40	$40	$55	$40
D5862	Precision Attachment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D5863	Overdenture – Complete Maxillary	Not covered – Alternate benefit based on D5110	$300	$275	$275	$200	$320	$275
D5864	Overdenture – Partial Maxillary	Not covered – Alternate benefit based on D5211	$300	$275	$275	$200	$320	$275
D5865	Overdenture – Complete Mandibular	Not covered – Alternate benefit based on D5120	$300	$275	$275	$200	$320	$275
D5866	Overdenture – Partial Mandibular	Not covered – Alternate benefit based on D5212	$300	$275	$275	$200	$320	$275
D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D5875	Modification of Removable Prosthesis Following Implant Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D5876	Add Metal Substructure to Acrylic Full Denture (per Arch)		$36	$30	$30	$30	$40	$30

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D5899	Unspecified Removable Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D5911 - D5993	Maxillofacial Prosthetics	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D5994	Periodontal Medicament Carrier with Peripheral Seal – Laboratory Processed	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D5999	Unspecified Maxillofacial Prosthesis, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
		Fixed Prosthetic Codes **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Effective 1/1/2024, the "initial placement rule" is removed**. Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **Prior to 1/1/2024 -** Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does not apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. **Facings on molars are not covered.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)** **Additional $125 patient copayment per unit for treatment of 6 or more units of covered crown/bridge in the same treatment plan.**						
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.						
D6010	Surgical Placement of Implant Body: Endosteal Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth). Member Copay Change for i Plans Effective 04/01/2016	N/C $1,375[4] $1,215[5]	N/C $1,375[4] $1,215[5]	N/C $1,375[4] $1,215[5]	N/C $1,375[4] $1,215[5]	N/C $1,375[4] $1,215[5]	N/C $1,375[4] $1,215[5]
D6011	Second Stage Implant Surgery	Not covered unless plan covers implants. For plans covering implants, this is inclusive to surgical placement of implant.	N/C $0	N/C $0	N/C $0	N/C $0	N/C $0	N/C $0
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6013	Surgical Placement of Mini Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	N/C $756	N/C $756	N/C $756	N/C $756	N/C $756	N/C $756
D6040	Surgical Placement: Eposteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6050	Surgical Placement: Transosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6051	Placement of Interim Implant Abutment	For plans covering implants, plan benefit and patient copay for permanent restoration includes all interim charges.	N/C $0	N/C $0	N/C $0	N/C $0	N/C $0	N/C $0

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D6052	Semi-Precision Attachment Abutment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6055	Connecting Bar - Implant Supported or Abutment Supported	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6056	Prefabricated Abutment - Includes Modification and Placement	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth). Member Copay Change for i Plans Effective 04/01/2016	N/C $785[4] $440[5]	N/C $785[4] $440[5]	N/C $785[4] $440[5]	N/C $785[4] $440[5]	N/C $785[4] $440[5]	N/C $785[4] $440[5]
D6057	Custom Fabricated Abutment – Includes Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6058	Abutment Supported Porcelain/Ceramic Crown		$315	$255	$225	$180	$315	$255
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)		$315	$255	$225	$180	$315	$255
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)		$315	$255	$225	$180	$315	$255
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)		$315	$255	$225	$180	$315	$255
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)		$315	$255	$225	$180	$315	$255
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)		$315	$255	$225	$180	$315	$255
D6064	Abutment Supported Cast Metal Crown (Noble Metal)		$315	$255	$225	$180	$315	$255
D6065	Implant Supported Porcelain/Ceramic Crown		$315	$255	$225	$180	$315	$255
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		$315	$255	$225	$180	$315	$255
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		$315	$255	$225	$180	$315	$255
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD		$315	$255	$225	$180	$315	$255
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)		$315	$255	$225	$180	$315	$255
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)		$315	$255	$225	$180	$315	$255
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)		$315	$255	$225	$180	$315	$255
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)		$315	$255	$225	$180	$315	$255
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)		$315	$255	$225	$180	$315	$255
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)		$315	$255	$225	$180	$315	$255
D6075	Implant Supported Retainer for Ceramic FPD		$315	$255	$225	$180	$315	$255

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D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		$315	$255	$225	$180	$315	$255
D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		$315	$255	$225	$180	$315	$255
D6080	Implant Maintenance Procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	Not covered unless plan covers implants.	N/C $88	N/C $88	N/C $88	N/C $88	N/C $88	N/C $88
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths: includes cleaning of the implant surfaces, without flap entry and closure	Not covered unless plan covers implants.	N/C $17	N/C $16	N/C $15	N/C $11	N/C $18	N/C $19
D6082	Implant supported crown – porcelain fused to predominantly base alloys		$315	$255	$225	$180	$315	$255
D6083	Implant supported crown – porcelain fused to noble alloys		$315	$255	$225	$180	$315	$255
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D6085	Provisional implant crown		N/C	N/C	N/C	N/C	N/C	N/C
D6086	Implant supported crown – predominantly base alloys		$315	$255	$225	$180	$315	$255
D6087	Implant supported crown – noble alloys		$315	$255	$225	$180	$315	$255
D6088	Implant supported crown – titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D6089	Accessing and Retorquing Loose Implant Screw - per Screw	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6090	Repair of Implant/Abutment Supported Prosthesis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6091	Replacement of Semi-Precision or Precision Attachment of Implant/Abutment Supported Prosthesis, per Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6092	Re-cement Or Re-bond Implant/Abutment Supported Crown		$22	$22	$22	$22	$22	$22
D6093	Re-cement Or Re-bond Implant/Abutment Supported Fixed Partial Denture		$24	$24	$24	$24	$24	$24
D6094	Abutment Supported Crown (Titanium)		$315	$255	$225	$180	$315	$255
D6095	Repair Implant Abutment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6096	Remove Broken Implant Retaining Screw	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D6098	Implant supported retainer – porcelain fused to predominantly base alloys		$315	$255	$225	$180	$315	$255
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys		$315	$255	$225	$180	$315	$255

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D6100	Implant Removal, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6102	Debridement and osseous contouring of a periimplant defect: includes surface cleaning of exposed implant surfaces and flap entry and closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6104	Bone graft at time of implant placement		N/C	N/C	N/C	N/C	N/C	N/C
D6105	Removal of Implant Body not Requiring Bone Removal or Flap Elevation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6106	Guided Rissue Regeneration – Resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6107	Guided Rissue Regeneration – Non-resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6110	Implant /Abutment Supported Removable Denture for Edentulous Arch – Maxillary		$300	$275	$275	$200	$320	$275
D6111	Implant /Abutment Supported Removable Denture for Edentulous Arch – Mandibular		$300	$275	$275	$200	$320	$275
D6112	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Maxillary		$300	$275	$275	$200	$320	$275
D6113	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Mandibular		$300	$275	$275	$200	$320	$275
D6114	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Maxillary		$300	$275	$275	$200	$320	$275
D6115	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Mandibular		$300	$275	$275	$200	$320	$275
D6116	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Maxillary		$300	$275	$275	$200	$320	$275
D6117	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Mandibular		$300	$275	$275	$200	$320	$275
D6118	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Mandibular	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6119	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Maxillary	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C

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D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D6121	Implant supported retainer for metal FPD – predominantly base alloys		$315	$255	$225	$180	$315	$255
D6122	Implant supported retainer for metal FPD – noble alloys		$315	$255	$225	$180	$315	$255
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	This procedure includes active debriding of the implant(s) and prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s). Only covered if Plan has implant coverage.	N/C $22	N/C $22	N/C $22	N/C $22	N/C $22	N/C $22
D6190	Radiographic / Surgical Implant Index, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6191	Semi-precision abutment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6192	Semi-precision attachment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6193	Replacement of an Implant Screw	If D6193 is eligible, D6096 on same day is inclusive (not separately eligible).	N/C	N/C	N/C	N/C	N/C	N/C
D6194	Abutment Supported Retainer Crown for FPD (Titanium)		$315	$255	$225	$180	$315	$255
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D6197	Replacement of Restorative Material Used to Close an Access Opening of a Screw-retained Implant Supported Prosthesis, per Implant		$45	$35	$35	$35	$35	$35
D6198	Remove Interim Implant Component	Inclusive to permanent restoration	$0	$0	$0	$0	$0	$0
D6199	Unspecified Implant Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6205	Pontic – Indirect Resin Based Composite		$315	$255	$225	$180	$315	$255
D6210	Pontic – Cast High Noble Metal		$315	$255	$225	$180	$315	$255
D6211	Pontic – Cast Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D6212	Pontic – Cast Noble Metal		$315	$255	$225	$180	$315	$255
D6214	Pontic – Titanium		$315	$255	$225	$180	$315	$255
D6240	Pontic – Porcelain Fused to High Noble Metal		$315	$255	$225	$180	$315	$255
D6241	Pontic – Porcelain Fused to Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D6242	Pontic – Porcelain Fused to Noble Metal		$315	$255	$225	$180	$315	$255
D6243	Pontic – porcelain fused to titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D6245	Pontic – Porcelain/Ceramic		$315	$255	$225	$180	$315	$255
D6250	Pontic – Resin with High Noble Metal		$315	$255	$225	$180	$315	$255
D6251	Pontic – Resin with Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D6252	Pontic – Resin with Noble Metal		$315	$255	$225	$180	$315	$255

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D6253	Provisional Pontic– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan benefit and patient copay for permanent to include all provisional charges	$0	$0	$0	$0	$0	$0
D6545	Retainer – Cast Metal for Resin-Bonded Fixed Prosthesis		$225	$195	$190	$180	$225	$195
D6548	Retainer – Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis		$225	$195	$190	$180	$225	$195
D6549	Resin Retainer – for Resin Bonded Fixed Prosthesis		$158	$128	$113	$90	$158	$128
D6600	Retainer Inlay – Porcelain/Ceramic, 2 Surfaces		$225	$195	$190	$180	$225	$195
D6601	Retainer Inlay – Porcelain/Ceramic, 3 or More Surfaces		$225	$195	$190	$180	$225	$195
D6602	Retainer Inlay – Cast High Noble Metal, 2 Surfaces		$245	$215	$210	$200	$245	$215
D6603	Retainer Inlay – Cast High Noble Metal, 3 or More Surfaces		$245	$215	$210	$200	$245	$215
D6604	Retainer Inlay – Cast Predominantly Base Metal, 2 Surfaces		$225	$195	$190	$180	$225	$195
D6605	Retainer Inlay – Cast Predominantly Base Metal, 3 or More Surfaces		$225	$195	$190	$180	$225	$195
D6606	Retainer Inlay – Cast Noble Metal, 2 Surfaces		$245	$215	$210	$200	$245	$215
D6607	Retainer Inlay – Cast Noble Metal, 3 or More Surfaces		$245	$215	$210	$200	$245	$215
D6608	Retainer Onlay – Porcelain/Ceramic, 2 Surfaces		$240	$210	$200	$190	$240	$210
D6609	Retainer Onlay – Porcelain/Ceramic, 3 or More Surfaces		$240	$210	$200	$190	$240	$210
D6610	Retainer Onlay – Cast High Noble Metal, 2 Surfaces		$260	$230	$220	$210	$260	$230
D6611	Retainer Onlay – Cast High Noble Metal, 3 or More Surfaces		$260	$230	$220	$210	$260	$230
D6612	Retainer Onlay – Cast Predominantly Base Metal, 2 Surfaces		$240	$210	$200	$190	$240	$210
D6613	Retainer Onlay – Cast Predominantly Base Metal, 3 or More Surfaces		$240	$210	$200	$190	$240	$210
D6614	Retainer Onlay – Cast Noble Metal, 2 Surfaces		$260	$230	$220	$210	$260	$230
D6615	Retainer Onlay – Cast Noble Metal, 3 or More Surfaces		$260	$230	$220	$210	$260	$230
D6624	Retainer Inlay – Titanium		$245	$215	$210	$200	$245	$215
D6634	Retainer Onlay – Titanium		$260	$230	$220	$210	$260	$230
D6710	Retainer Crown – Indirect Resin Based Composite		$315	$255	$225	$180	$315	$255
D6720	Retainer Crown – Resin with High Noble Metal		$315	$255	$225	$180	$315	$255
D6721	Retainer Crown – Resin with Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D6722	Retainer Crown – Resin with Noble Metal		$315	$255	$225	$180	$315	$255

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D6740	Retainer Crown – Porcelain/Ceramic		$315	$255	$225	$180	$315	$255
D6750	Retainer Crown – Porcelain Fused to High Noble Metal		$315	$255	$225	$180	$315	$255
D6751	Retainer Crown – Porcelain Fused to Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D6752	Retainer Crown – Porcelain Fused to Noble Metal		$315	$255	$225	$180	$315	$255
D6753	Retainer crown – porcelain fused to titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D6780	Retainer Crown – 3/4 Cast High Noble Metal		$315	$255	$225	$180	$315	$255
D6781	Retainer Crown – 3/4 Cast Predominantly Based Metal		$315	$255	$225	$180	$315	$255
D6782	Retainer Crown – 3/4 Cast Noble Metal		$315	$255	$225	$180	$315	$255
D6783	Retainer Crown – 3/4 Porcelain/Ceramic		$315	$255	$225	$180	$315	$255
D6784	Retainer crown 3/4 – titanium and titanium alloys		$315	$255	$225	$180	$315	$255
D6790	Retainer Crown – Full Cast High Noble Metal		$315	$255	$225	$180	$315	$255
D6791	Retainer Crown – Full Cast Predominantly Base Metal		$315	$255	$225	$180	$315	$255
D6792	Retainer Crown – Full Cast Noble Metal		$315	$255	$225	$180	$315	$255
D6793	Provisional Retainer Crown– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan benefits and patient copay for permanent to include all provisional charges.	$0	$0	$0	$0	$0	$0
D6794	Retainer Crown – Titanium		$315	$255	$225	$180	$315	$255
D6920	Connector Bar	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6930	Re-cement or Re-bond Fixed Partial Denture		$20	$15	$15	$15	$20	$15
D6940	Stress Breaker	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6950	Precision Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D6985	Pediatric Partial Denture, Fixed	Eligible for anterior teeth. Not Covered for teeth other than anterior.	$143	$90	$90	$90	$120	$90
D6999	Unspecified Fixed Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7111	Extraction, Coronal Remnants – Primary Tooth	Includes extractions for orthodontic purposes.	$6	$4	$0	$0	$0	$0
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	Includes extractions for orthodontic purposes.	$15	$11	$0	$0	$0	$0
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth and Including Elevation of Mucoperiosteal Flap if Indicated	Includes extractions for orthodontic purposes.	$36	$28	$0	$0	$50	$28
D7220	Removal of Impacted Tooth – Soft Tissue	Includes extractions for orthodontic purposes.	$60	$46	$0	$0	$60	$46

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D7230	Removal of Impacted Tooth – Partially Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$72	$58	$45	$45	$80	$58
D7240	Removal of Impacted Tooth – Completely Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$128	$117	$70	$70	$120	$117
D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$128	$117	$70	$70	$120	$117
D7250	Removal of Residual Tooth Roots (Cutting Procedure)		$35	$25	$15	$15	$55	$25
D7251	Coronectomy - Intentional Partial Tooth Removal	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$64	$59	$35	$35	$60	$59
D7252	Partial Extraction for Immediate Implant Placement	Only covered if implants are covered.	N/C	N/C	N/C	N/C	N/C	N/C
D7259	Nerve Dissection		N/C	N/C	N/C	N/C	N/C	N/C
D7260	Oroantral Fistula Closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7261	Primary Closure of a Sinus Perforation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7272	Tooth Transplantation (Includes Reimplantation from One Site to Another & Splinting and/or Stabilization)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7280	Exposure of an Unerupted Tooth		$60	$26	$26	$26	$60	$26
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption		$70	$30	$30	$30	$70	$30
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth		$14	$6	$6	$6	$14	$6
D7284	Excisional Biopsy of Minor Salivary Glands		$300	$113	$75	$75	$120	$113
D7285	Incisional Biopsy of Oral Tissue – Hard (Bone, Tooth)		$100	$75	$50	$50	$80	$75
D7286	Incisional Biopsy of Oral Tissue – Soft		$100	$75	$50	$50	$80	$75
D7287	Exfoliative Cytological Sample Collection		$100	$38	$25	$25	$40	$38
D7288	Brush Biopsy – Transepithelial Sample Collection	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7290	Surgical Repositioning of Teeth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7291	Transseptal Fiberotomy/ Supra Crestal Fiberotomy, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7292	Placement of Temporary Anchorage Device [Screw Retained Plate] Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7293	Placement of Temporary Anchorage Device Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7294	Placement of Temporary Anchorage Device Without Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7295	Harvest of Bone for Use in Autogenous Grafting Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C

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D7296	Corticotomy - One to Three Teeth or Tooth Spaces, per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7297	Corticotomy – Four or More Teeth or Tooth Spaces, per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7298	Removal of Temporary Anchorage Device [Screw Retained Plate], Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0	$0	$0	$0
D7299	Removal of Temporary Anchorage Device, Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0	$0	$0	$0
D7300	Removal of Temporary Anchorage Device Without Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0	$0	$0	$0
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	$35	$25	$18	$18	$60	$25
D7311	Alveoloplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		$18	$13	$9	$9	$30	$13
D7320	Alveoloplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	$60	$40	$25	$25	$75	$40
D7321	Alveoloplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		$30	$20	$13	$13	$38	$20
D7340	Vestibuloplasty – Ridge Extension (Secondary Epithelialization)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7350	Vestibuloplasty – Ridge Extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7410	Excision of Benign Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7411	Excision of Benign Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7412	Excision of Benign Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7413	Excision of Malignant Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7414	Excision of Malignant Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7415	Excision of Malignant Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7440	Excision Malignant Tumor - Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7441	Excision Malignant Tumor Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7450	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7451	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C

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D7460	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7461	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7465	Destruction of Lesion(s) by Physical or Chemical Method, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7472	Removal of Torus Palatinus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7473	Removal of Torus Mandibularis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7485	Reduction of Osseous Tuberosity	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7509	Marsupialization of Odontogenic Cyst	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7450	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue		$30	$20	$10	$20	$30	$20
D7511	Incision and Drainage of Abscess – Intraoral Soft Tissue - Complicated		$33	$22	$11	$22	$33	$22
D7520	Incision and Drainage of Abscess – Extraoral Soft Tissue	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7521	Incision and Drainage of Abscess – Extraoral Soft Tissue - Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7530	Removal of Foreign Body from Mucosa, Skin or Subcutaneous Alveolar Tissue	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7550	Partial Ostectomy/ Sequestrectomy for Removal of Non-Vital Bone	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7610-D7820	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7830	Manipulation Under Anesthesia	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7840-D7870	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7871	Non-Arthroscopic Lysis and Lavage	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7872-D7877	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7880	Occlusal Orthotic Device, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7881	Occlusal Orthotic Device Adjustment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7899	Unspecified TMD Therapy, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7910	Suture of Recent Small Wound up to 5 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C

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D7911	Complicated Suture - Up to 5 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7912	Complicated Suture - greater than 5 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7920-D7921	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Inclusive to the extraction Patient cannot be billed	$0	$0	$0	$0	$0	$0
D7939	Indexing for Osteotomy using Dynamic Robotic Assisted or Dynamic Navigation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7940-D7952	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7953	Bone Replacement Graft for Ridge Preservation – Per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7956	Guided Tissue Regeneration, Edentulous Area – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7957	Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7961	Buccal / labial frenectomy (frenulectomy)		$90	$34	$24	$24	$90	$34
D7962	Lingual frenectomy (frenulectomy)		$90	$34	$24	$24	$90	$34
D7963	Frenuloplasty		$95	$36	$25	$25	$95	$36
D7970	Excision of Hyperplastic Tissue – Per Arch	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7971	Excision of Pericoronal Gingiva	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7972	Surgical Reduction of Fibrous Tuberosity	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7979	Non-Surgical Sialolithotomy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7980	Surgical Sialolithotomy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7981	Excision Of Salivary Gland, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7982	Sialodochoplasty	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7983	Closure of Salivary Fistula	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7990-D7998	Other Surgical Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D7999	Unspecified Oral Surgery Procedure, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D8210	Removable Appliance Therapy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D8220	Fixed Appliance Therapy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D8695	Removal of Fixed Orthodontic Appliances for Reasons other than Completion of Treatment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	Inclusive when performed on the same date of service as definitive treatment; member cannot be billed. Definitive treatment is the treatment which resolves the pain permanently - this is the final measure taken to eliminate the pain.	$10	$10	$10	$10	$10	$10
D9120	Fixed Partial Denture Sectioning	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9130	Temporomandibular Joint Dysfunction – Non-invasive physical Therapies	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9210	Local Anesthesia, Not in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	$0	$0	$0	$0	$0	$0

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D9211	Regional Block Anesthesia	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0
D9212	Trigeminal Division Block Anesthesia	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	$0	$0	$0	$0	$0	$0
D9219[3]	Evaluation For Moderate Sedation, Deep Sedation or General Anesthesia	When rendered by anesthesiologist	$0	$0	$0	$0	$0	$0
D9222	Deep Sedation/General Anesthesia – First 15 Minutes		$104	$104	$104	$104	$104	$104
D9223	Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	$83	$83	$83	$83	$83	$83
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia – First 15 Minutes		$104	$104	$104	$104	$104	$104
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	$83	$83	$83	$83	$83	$83
D9248	Non-Intravenous Conscious Sedation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician	For Second Opinions only	$0	$0	$0	$0	$0	$0
D9311	Consultation with a medical health care professional		$0	$0	$0	$0	$0	$0
D9410	House/Extended Care Facility Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9420	Hospital or Ambulatory Surgical Center Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0
D9440	Office Visit - After Regularly Scheduled Hours	Not Covered (Covered in Texas)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)
D9450	Case Presentation, Detailed and Extensive Treatment Planning	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0
D9610	Therapeutic Parenteral Drug, Single Administration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9612	Therapeutic Parenteral Drugs, 2 or more Administrations, Different Medications	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9613	Infiltration of Sustained Release Therapeutic Drug	Eligible when performed in conjunction with procedure codes D7220, D7230, D7240, D7241, or D7251 on third molars (teeth #'s 01, 16, 17, or 32).	$0	$0	$0	$0	$0	$0
D9630	Drugs or Medicaments dispensed in the office for home use	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9910	Application of Desensitizing Medicament	Inclusive with the restoration being performed on the same date of service; member cannot be billed.	$0	$0	$0	$0	$0	$0
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9912	Pre-visit Patient Screening	Inclusive with record keeping requirements	$0	$0	$0	$0	$0	$0
D9913	Administration of Neuromodulators		N/C	N/C	N/C	N/C	N/C	N/C

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D9914	Administration of Dermal Fillers		N/C	N/C	N/C	N/C	N/C	N/C
D9920	Behavior Management, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9930	Treatment of Complications (Post-surgical) – Unusual Circumstances, by Report	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0
D9932	Cleaning and Inspection of Removable Complete Denture, Maxillary		$25	$25	$25	$25	$25	$25
D9933	Cleaning and Inspection of Removable Complete Denture, Mandibular		$25	$25	$25	$25	$25	$25
D9934	Cleaning and Inspection of Removable Partial Denture, Maxillary		$25	$25	$25	$25	$25	$25
D9935	Cleaning and Inspection of Removable Partial Denture, Mandibular		$25	$25	$25	$25	$25	$25
D9938	Fabrication of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9939	Placement of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9941	Fabrication of Athletic Mouthguard	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9942	Repair and/or Reline of Occlusal Guard		$18	$18	$18	$15	$20	$18
D9943	Occlusal Guard Adjustment	Fee for occlusal guard includes adjustments performed within 6 months of placement	$16	$13	$13	$13	$16	$13
D9944	Occlusal Guard – Hard Appliance, Full Arch	Covered for bruxism only; If for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$150	$115	$115	$115	$150	$115
D9945	Occlusal Guard – Soft Appliance, Full Arch	Covered for bruxism only; If for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$130	$100	$100	$100	$130	$100
D9946	Occlusal Guard – Hard Appliance, Partial Arch	Covered for bruxism only; If for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$78	$60	$60	$60	$78	$60
D9947	Custom Sleep Apnea Appliance Fabrication and Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9948	Adjustment of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9949	Repair of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9950	Occlusion Analysis - Mounted Case	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9951	Occlusal Adjustment – Limited	Not separately eligible when performed in conjunction with a restoration, root canal therapy or appliance.	$30	$20	$20	$20	$30	$20
D9952	Occlusal Adjustment – Complete		$100	$80	$80	$80	$100	$80
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9954	Fabrication and Delivery of Oral Appliance Therapy (OAT) Morning Repositioning Device	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9955	Oral Appliance Therapy (OAT) Titration Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C

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D9956	Administration of Home Sleep Apnea Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9957	Screening for Sleep Related Breathing Disorders	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9959	Unspecified Sleep Apnea Services Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9961	Duplicate/Copy Patient's Records	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9970	Enamel Microabrasion	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9972	External Bleaching – per Arch - Performed in Office	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9973	External Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9974	Internal Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9975	External Bleaching for Home Application, per Arch	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9985[2]	Sales Tax	Inclusive to service being taxed	$0	$0	$0	$0	$0	$0
D9986	Missed Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9987	Cancelled Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9990	Certified Translation or Sign-language Services per Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9991	Dental case management - addressing appointment compliance barriers	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9992	Dental case management – care coordination	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9993	Dental case management – motivational interviewing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9994	Dental case management – patient education to improve oral health literacy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9995	Teledentistry – Synchronous; Real-Time Encounter	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9996	Teledentistry – Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C
D9997	Dental case management – patients with special health care needs	Inclusive to the primary service Patient cannot be billed	$0	$0	$0	$0	$0	$0
D9999	Unspecified Adjunctive Procedure, by Report	Used for procedure that is not adequately described by a code. Use of this code REQUIRES A WRITTEN NARRATIVE & supporting documentation	N/C	N/C	N/C	N/C	N/C	N/C

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[2] Not separately eligible/inclusive - the patient cannot be billed for these services.

[3] Covered only when performed by anesthesiologist.

[4] Amount through 03/31/2016

[5] Amount effective 04/01/2016

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	Office Visit Copay	Check Roster When an Office Visit copay applies, the DMO Patient Roster will show the amount under column "Office Copay" (i.e. 000 = $0.00; 005 = $5.00). When submitted, use ADA code D0999.								
	Infection Control	May not bill patient for infection control procedures								
		Frequency limits on Preventive and Diagnostic services are waived in Arizona, California and Texas if medically necessary.								
D0120	Periodic Oral Evaluation - Established Patient	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0
D0140	Limited Oral Evaluation - Problem Focused	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0
D0145	Oral Evaluation for a Patient under Three Years of Age and Counseling with a Primary Caregiver	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0
D0150	Comprehensive Oral Evaluation - New or Established Patient	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, by Report	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0
D0170	Re-Evaluation - Limited, Problem Focused (Established Patient; not Post-Operative Visit)	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0
D0171	Re-Evaluation - Post-Operative Office Visit	Inclusive to surgery. Patient cannot be billed.	$0	$0	$0	$0	$0	$0	$0	$0
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0	$0	$0	$0	$0	$0
D0190-D0191[2]	Screening / Assessment of a Patient	Inclusive to oral evaluation Patient cannot be billed	$0	$0	$0	$0	$0	$0	$0	$0
D0210	Intraoral - Complete Series of Radiographic Images	FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0
D0220-D0230	Intraoral - Periapical Image		$0	$0	$0	$0	$0	$0	$0	$0
D0240	Intraoral - Occlusal Radiographic Image		$0	$0	$0	$0	$0	$0	$0	$0
D0250-D0251	Extra-Oral Image		$0	$0	$0	$0	$0	$0	$0	$0
D0270-D0274	Bitewing Radiographic Image	1 series per year	$0	$0	$0	$0	$0	$0	$0	$0
D0277	Vertical Bitewings - 7 to 8 Radiographic Images	1 series every 3 years	$0	$0	$0	$0	$0	$0	$0	$0
D0310	Sialography	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0320-D0321	Temporomandibular Joint Image	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0322	Tomographic Survey	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0330	Panoramic Radiographic Image	FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0
D0340	2D Cephalometric Radiographic Image – Acquisition, Measurement and Analysis	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	73 73i	73S	74 74i	75F	75 75i	76 76i	77 77i	78 78i
D0350	2D Oral/Facial Photographic Image Obtained Intra-orally or Extra-orally	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0364-D0368	Cone Beam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0369-D0371	Capture and Interpretation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0372	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0
D0373	Intraoral Tomosynthesis – Bitewing Radiographic Image	1 series per year	$0	$0	$0	$0	$0	$0	$0	$0
D0374	Intraoral Tomosynthesis – Periapical Radiographic Image		$0	$0	$0	$0	$0	$0	$0	$0
D0380-D0384	Cone Beam CT Image Capture	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0385-D0386	Cone Beam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0387	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images – Image Capture Only	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0
D0388	Intraoral Tomosynthesis – Bitewing Radiographic Image – Image Capture Only	1 series per year	$0	$0	$0	$0	$0	$0	$0	$0
D0389	Intraoral Tomosynthesis – Periapical Radiographic Image – Image Capture Only		$0	$0	$0	$0	$0	$0	$0	$0
D0391	Interpretation of Diagnostic Image by Practitioner Not Associated with Capture of the Image, Including Report		$0	$0	$0	$0	$0	$0	$0	$0
D0393-D0395	3D Images	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0396	3D printing of a 3D dental surface scan	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0411	HbA1c In-office Point of Service Testing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0412	Blood Glucose Level Test – In-office Using a Glucose Meter	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0415	Collection of Microorganisms	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0416	Viral Culture	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0417	Collection & Preparation of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0418	Analysis of Saliva Sample	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0419	Assessment of Salivary Flow by Measurement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0422	Collection and Preparation of Genetic Sample Material for Laboratory Analysis and Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0423	Genetic Test for Susceptibility to Diseases – Specimen Analysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D0425	Caries Susceptibility Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0431	Adjunctive Pre-Diagnostic Test	The use of any tools and/or devices that assist in a diagnosis to be an adjunctive technique that is part of the oral evaluation or primary service. Members cannot be billed for this service.	$0	$0	$0	$0	$0	$0	$0	$0
D0460	Pulp Vitality Tests	Inclusive to oral evaluation Patient cannot be billed	$0	$0	$0	$0	$0	$0	$0	$0
D0470	Diagnostic Casts		$0	$0	$0	$0	$0	$0	$0	$0
D0472-D0474	Accession of Tissue		$0	$0	$0	$0	$0	$0	$0	$0
D0475-D0502	Oral Pathology Laboratory Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0601-D0603[2]	Caries Risk Assessment	Inclusive to oral evaluation	$0	$0	$0	$0	$0	$0	$0	$0
D0604	Antigen testing for a public health related pathogen including coronavirus		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0605	Antibody testing for a public health related pathogen including coronavirus		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0606	Molecular testing for a public health related pathogen including coronavirus		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0701	panoramic radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0330. FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0
D0702	2-D cephalometric radiographic image – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0705	extra-oral posterior dental radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0251.	$0	$0	$0	$0	$0	$0	$0	$0
D0706	intraoral – occlusal radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0240.	$0	$0	$0	$0	$0	$0	$0	$0
D0707	intraoral – periapical radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0220.	$0	$0	$0	$0	$0	$0	$0	$0
D0708	intraoral – bitewing radiographic image – image capture only	Only eligible when submitted with D0391 Inclusive when submitted with D0270 1 series per year	$0	$0	$0	$0	$0	$0	$0	$0

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D0709	intraoral – complete series of radiographic images – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0210. FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0	$0	$0	$0	$0	$0
D0801	3D Intraoral Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0802	3D Dental Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0803	3D Facial Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0804	3D Facial Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D0999	Unspecified Diagnostic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1110	Prophylaxis – Adult	Limited to 2 per year	$0	$0	$0	$0	$0	$0	$0	$0
D1120	Prophylaxis – Child	Limited to 2 per year	$0	$0	$0	$0	$0	$0	$0	$0
D1206	Topical Application of Fluoride Varnish	Pre Nov 2000 Plans (*) - No age or frequency limit DMO Standard Plans (#) – 1x per year for children under 16	$0	$0	$0	$0	$0	$0	$0	$0
D1208	Topical Application of Fluoride – Excluding Varnish	Pre Nov 2000 Plans (*) - No age or frequency limit DMO Standard Plans (#) – 1x per year for children under 16	$0	$0	$0	$0	$0	$0	$0	$0
D1301	Immunization Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1310-D1321	Nutritional or Tobacco Counseling	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1330	Oral Hygiene Instruction		$0	$0	$0	$0	$0	$0	$0	$0
D1351	Sealant – per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$0	$0	$0	$0	$0	$0	$0	$0
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$0	$0	$0	$0	$0	$0	$0	$0

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D1353	Sealant Repair - per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to permanent molars and to covered persons under age 16 (not limited to dependent children).	$0	$0	$0	$0	$0	$0	$0	$0
D1354	Application of Caries Arresting Medicament – per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$0	$0	$0	$0	$0	$0	$0	$0
D1355	Caries preventive medicament application – per tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$0	$0	$0	$0	$0	$0	$0	$0
D1510	Space Maintainer - Fixed, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion	$92	$92	$86	$0	$0	$0	$92	$86
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion	$92	$92	$86	$0	$0	$0	$92	$86
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion	$92	$92	$86	$0	$0	$0	$92	$86
D1520	Space Maintainer - Removable, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion	$92	$92	$86	$0	$0	$0	$92	$80
D1526	Space Maintainer – Removable – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion	$92	$92	$86	$0	$0	$0	$92	$80
D1527	Space Maintainer – Removable – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion	$92	$92	$86	$0	$0	$0	$92	$80
D1551	Re-cement or re-bond bilateral space maintainer – maxillary		$15	$15	$12	$10	$12	$12	$15	$12
D1552	Re-cement or re-bond bilateral space maintainer – mandibular		$15	$15	$12	$10	$12	$12	$15	$12
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant		$8	$8	$6	$5	$6	$6	$8	$6
D1556	Removal of fixed unilateral space maintainer – per quadrant		$8	$8	$6	$6	$6	$6	$8	$6
D1557	Removal of fixed bilateral space maintainer – maxillary		$15	$15	$12	$12	$12	$12	$15	$12
D1558	Removal of fixed bilateral space maintainer – mandibular		$15	$15	$12	$12	$12	$12	$15	$12
D1575	Distal shoe space maintainer – fixed, unilateral - per quadrant		$101	$101	$95	$0	$0	$0	$101	$95
D1701 - D1714	Covid-19 vaccine administration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D1781 - D1783	Vaccine Administration – Human Papillomavirus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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		<u>Effective 11/1/2020</u> - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is considered part of the primary service done on the same day. Member cannot be charged. **<u>Prior to 11/1/2020</u> - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is not covered. The member will be responsible for the charge.**								
D1999	Unspecified Preventive Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2140	Amalgam – 1 Surface, Primary or Permanent		$19	$0	$12	$0	$0	$0	$0	$0
D2150	Amalgam – 2 Surfaces, Primary or Permanent		$30	$0	$16	$0	$0	$0	$0	$0
D2160	Amalgam – 3 Surfaces, Primary or Permanent		$41	$0	$20	$0	$0	$0	$0	$0
D2161	Amalgam – 4+ Surfaces, Primary or Permanent		$50	$0	$23	$0	$0	$0	$0	$0
D2330	Resin-Based Composite – 1 Surface, Anterior		$26	$12	$16	$0	$0	$0	$0	$0
D2331	Resin-Based Composite – 2 Surfaces, Anterior		$37	$20	$22	$0	$0	$0	$0	$0
D2332	Resin-Based Composite – 3 Surfaces, Anterior		$37	$25	$26	$0	$0	$0	$0	$0
D2335	Resin-Based Composite – 4+ Surfaces or Involving Incisal Angle, Anterior		$72	$72	$54	$48	$48	$42	$72	$54
D2390	Resin-Based Composite Crown, Anterior		$72	$72	$60	$48	$48	$0	$72	$60
D2391	Resin-Based Composite – 1 Surface, Posterior		$63	$63	$49	$46	$49	$49	$49	$49
D2392	Resin-Based Composite – 2 Surfaces, Posterior		$84	$84	$70	$50	$63	$63	$63	$63
D2393	Resin-Based Composite – 3 Surfaces, Posterior		$119	$119	$84	$71	$77	$77	$77	$77
D2394	Resin-Based Composite – 4+ Surfaces, Posterior		$126	$126	$126	$106	$106	$106	$106	$106
D2410 - D2430	Gold Foil	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Crowns/Inlays Procedure Codes: **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Eligible for plan benefit when tooth cannot be restored with a filling. Plan benefit available for one crown once every 5 years per tooth.** **Facings on molar crowns and pontics will always be considered cosmetic.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)** **Additional $125.00 patient copayment per unit for treatment of 6 or more units of covered crown/bridge in the same treatment plan.**								
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.								
D2510	Inlay – Metallic - 1 Surface		$236	$236	$205	$95	$200	$189	$236	$205
D2520	Inlay – Metallic - 2 Surfaces		$236	$236	$205	$105	$200	$189	$236	$205
D2530	Inlay – Metallic - 3 or More Surfaces		$236	$236	$205	$130	$200	$189	$236	$205
D2542	Onlay – Metallic - 2 Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D2543	Onlay – Metallic - 3 Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D2544	Onlay - Metallic – 4 or More Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D2610	Inlay, Porcelain/Ceramic – 1 Surface		$236	$236	$205	$200	$200	$189	$236	$205
D2620	Inlay, Porcelain/Ceramic – 2 Surfaces		$236	$236	$205	$200	$200	$189	$236	$205
D2630	Inlay, Porcelain/Ceramic – 3 or More Surfaces		$236	$236	$205	$200	$200	$189	$236	$205

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D2642	Onlay, Porcelain/Ceramic – 2 Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D2643	Onlay, Porcelain/Ceramic – 3 Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D2644	Onlay, Porcelain/Ceramic – 4 or More Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D2650	Inlay, Resin Based Composite – 1 Surface		$236	$236	$205	$200	$200	$189	$236	$205
D2651	Inlay, Resin Based Composite – 2 Surfaces		$236	$236	$205	$200	$200	$189	$236	$205
D2652	Inlay, Resin Based Composite – 3 or more Surfaces		$236	$236	$205	$200	$200	$189	$236	$205
D2662	Onlay, Resin Based Composite – 2 Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D2663	Onlay, Resin Based Composite – 3 Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D2664	Onlay, Resin Based Composite – 4 or More Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D2710	Crown – Resin-Based Composite, Indirect		$362	$362	$293	$259	$259	$207	$362	$293
D2712	Crown – 3/4 Resin-Based Composite, Indirect		$265	$265	$214	$189	$189	$151	$265	$214
D2720	Crown – Resin with High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2721	Crown – Resin with Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2722	Crown – Resin with Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2740	Crown – Porcelain/ Ceramic		$362	$362	$293	$259	$259	$207	$362	$293
D2750	Crown – Porcelain Fused to High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2751	Crown – Porcelain Fused to Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2752	Crown – Porcelain Fused to Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2753	Crown - porcelain fused to titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D2780	Crown – 3/4 Cast High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2781	Crown – 3/4 Cast Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2782	Crown – 3/4 Cast Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2783	Crown – 3/4 Cast Porcelain/Ceramic		$362	$362	$293	$259	$259	$207	$362	$293
D2790	Crown – Full Cast High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2791	Crown – Full Cast Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2792	Crown – Full Cast Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D2794	Crown – Titanium and Titanium Alloys		$362	$362	$293	$259	$259	$207	$362	$293
D2799	Interim Crown – Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	$0	$0	$0	$0	$0	$0	$0	$0
D2910	Re-cement Or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration		$15	$10	$10	$5	$5	$0	$15	$10
D2915	Re-Cement or Re-Bond Indirectly Fabricated or Prefabricated Post and Core		$8	$8	$5	$3	$3	$0	$8	$5
D2920	Re-Cement or Re-Bond Crown		$15	$10	$10	$5	$5	$0	$15	$10
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp		$7	$7	$5	$5	$5	$4	$7	$5

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D2928	Prefabricated Porcelain/Ceramic Crown – Permanent Tooth	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	$0	$0	$0	$0	$0	$0	$0	$0
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	Alternate benefit based on D2930	$54	$54	$43	$0	$0	$0	$54	$43
D2930	Prefabricated Stainless Steel Crown – Primary Tooth		$54	$54	$43	$0	$0	$0	$54	$43
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	When used as permanent crown, subject to crown frequency limit. Eligible as temp only when used as temp restoration until adult dentition is formed or when used due to accident away from home. Otherwise, temp is included in final restoration and not separately eligible.	$65	$65	$54	$43	$43	$0	$65	$54
D2932	Prefabricated Resin Crown	Alternate benefit based on D2930 or D2931	$54/$65	$54/$65	$43/$54	$0/$43	$0/$43	$0 / $0	$54/$65	$43/$54
D2933	Prefabricated Stainless Steel Crown with Resin Window	Alternate benefit based on D2930 or D2931	$54/$65	$54/$65	$43/$54	$0/$43	$0/$43	$0 / $0	$54/$65	$43/$54
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	Alternate benefit based on D2930	$54	$54	$43	$0	$0	$0	$54	$43
D2940	Placement of Interim Direct Restoration		$8	$0	$3	$0	$0	$0	$8	$3
D2941	Interim Therapeutic Restoration – Primary Dentition		$4	$4	$1	$0	$0	$0	$4	$1
D2949[2]	Restorative Foundation for an Indirect Restoration	Inclusive to permanent restoration	$0	$0	$0	$0	$0	$0	$0	$0
D2950	Core Buildup, Including Any Pins When Required		$158	$158	$140	$45	$105	$123	$141	$141
D2951	Pin Retention – Per Tooth, In Addition to Restoration		$14	$14	$14	$14	$14	$0	$14	$14
D2952	Post & Core In Addition to Crown, Indirectly Fabricated		$179	$179	$157	$90	$112	$101	$140	$157
D2953	Each Additional Indirectly Fabricated Post – Same Tooth	Member Copay Change Effective 04/01/2016	$179[4] $140[5]	$140	$157[4] $140[5]	$90	$112	$101	$140	$157[4] $140[5]
D2954	Prefabricated Post & Core In Addition To Crown		$95	$95	$85	$90	$80	$72	$103	$85
D2955	Post Removal	Included in cost of replacement post	$0	$0	$0	$0	$0	$0	$0	$0
D2956	Removal of an Indirect Restoration on a Natural Tooth	Not to be used as a temporary or provisional restoration. Inclusive to any restorative service.	$0	$0	$0	$0	$0	$0	$0	$0
D2957	Each Additional Prefabricated Post - Same Tooth		$95	$95	$85	$80	$80	$72	$103	$85
D2960	Labial Veneer (Resin Laminate) – Chairside	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2961	Labial Veneer (Resin Laminate) – Laboratory	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2962	Labial Veneer (Porcelain Laminate) – Laboratory	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2971	Additional Procedures to Customize a Crown to Fit under an Existing Partial Denture Framework		$49	$49	$40	$36	$36	$28	$49	$40
D2975	Coping	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2976	Band Stabilization – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2980	Crown Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D2981	Inlay Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2982	Onlay Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2983	Veneer Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D2989	Excavation of a Tooth Resulting in the Determination of Non-restorability	Restorations, endodontics, and/or D4249 on same day/same tooth will be denied.	$10	$0	$6	$0	$0	$0	$0	$0
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to Molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years and to covered persons under age 16 (not limited to dependent children).	$8	$8	$0	$0	$0	$0	$10	$5
D2991	Application of Hydroxyapatite Regeneration Medicament – per Tooth	One application per tooth, regardless of the number of appointments required to complete the full application. Once tooth application is completed, limited to once every 3 years for permanent teeth (1-32).	$0	$0	$0	$0	$0	$0	$0	$0
D2999	Unspecified Restorative Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3110	Pulp Cap – Direct (Excluding Final Restoration)		$6	$6	$4	$0	$0	$0	$0	$0
D3120	Pulp Cap – Indirect (Excluding Final Restoration)		$6	$6	$4	$0	$0	$0	$0	$0
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	If done in conjunction with root canal therapy, included in cost of RCT	$77	$20	$31	$0	$0	$0	$77	$31
D3221	Pulpal Debridement, Primary And Permanent Teeth	Considered inclusive with the Endodontic treatment when completed on the same day.	$14	$14	$14	$14	$14	$14	$14	$14
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development		$70	$70	$28	$0	$0	$0	$70	$28
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)		$77	$77	$31	$0	$0	$0	$77	$31
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)		$77	$77	$31	$0	$0	$0	$77	$31
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)		$135	$135	$79	$56	$56	$0	$135	$79
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)		$216	$216	$131	$84	$84	$0	$216	$131
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)		$333	$175	$308	$180	$193	$161	$331	$309
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access		$135	$135	$79	$56	$56	$0	$135	$79

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D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth		$99	$99	$61	$39	$39	$0	$99	$61
D3333	Internal Root Repair of Perforation Defects		$99	$99	$61	$45	$45	$0	$110	$61
D3346	Retreatment of Previous Root Canal Therapy – Anterior		$242	$242	$187	$165	$165	$110	$242	$187
D3347	Retreatment of Previous Root Canal Therapy – Premolar		$308	$308	$230	$187	$187	$110	$308	$230
D3348	Retreatment of Previous Root Canal Therapy – Molar		$435	$435	$410	$297	$297	$266	$433	$411
D3351	Apexification/Recalcification – Initial Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3352	Apexification/Recalcification – Interim Medication Replacement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3353	Apexification/ Recalcification – Final Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3355	Pulpal Regeneration - Initial Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3356	Pulpal Regeneration – Interim Medication Replacement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3357	Pulpal Regeneration – Completion of Treatment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3410	Apicoectomy – Anterior		$148	$65	$97	$68	$68	$0	$179	$97
D3421	Apicoectomy – Premolar (First Root)		$148	$148	$97	$68	$68	$0	$179	$97
D3425	Apicoectomy – Molar (First Root)		$158	$158	$95	$84	$84	$0	$179	$95
D3426	Apicoectomy – Each Additional Root		$99	$99	$61	$44	$44	$0	$110	$61
D3428	Bone Graft In Conjunction With Periradicular Surgery - per Tooth, Single Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3429	Bone Graft in Conjunction with Periradicular Surgery - Each Additional Contiguous Tooth in the Same Surgical Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3430	Retrograde Filling – per Root		$80	$80	$49	$25	$25	$0	$80	$49
D3431	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction With Periradicular Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3432	Guided Tissue Regeneration, Resorbable Barrier, per Site, In Conjunction with Periradicular Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3450	Root Amputation – per Root		$88	$88	$77	$66	$66	$66	$88	$77
D3460	~~Endodontic Endosseous Implant~~	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3470	Intentional Re-Implantation (Including Necessary Splinting)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3471	Surgical repair of root resorption - anterior		$67	$67	$44	$31	$31	$0	$80	$44
D3472	Surgical repair of root resorption – premolar		$89	$89	$58	$41	$41	$0	$107	$58
D3473	Surgical repair of root resorption – molar		$111	$111	$73	$51	$51	$0	$134	$73
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior		$88	$88	$70	$57	$57	$44	$88	$70
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar		$118	$118	$93	$76	$76	$59	$118	$93

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D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar		$147	$147	$116	$95	$95	$74	$147	$116
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3911	Intraorifice Barrier	Inclusive to root canals	$0	$0	$0	$0	$0	$0	$0	$0
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3921	Decoronation or Submergence of an Erupted Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	If done in conjunction with root canal therapy, included in cost of RCT, unless performed by dentist other than who performed RCT or crown.	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D3999	Unspecified Endodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4210	Gingivectomy or Gingivoplasty – 4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	1 per quadrant every 3 years	$168	$90	$140	$105	$105	$91	$131	$140
D4211	Gingivectomy or Gingivoplasty – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$78	$78	$74	$39	$39	$39	$72	$75
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	1 per quadrant every 3 years	$26	$26	$25	$13	$13	$13	$24	$25
D4230	Anatomical Crown Exposure - 4 or More Contiguous Teeth per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4231	Anatomical Crown Exposure - 1 to 3 Teeth or Bounded Tooth Spaces per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4240	Gingival Flap Procedure, Including Root Planing – 4 or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$180	$180	$141	$116	$116	$90	$163	$141
D4241	Gingival Flap Procedure, Including Root Planing – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$108	$108	$84	$69	$69	$55	$98	$84
D4245	Apically Positioned Flap		$147	$147	$116	$95	$95	$74	$147	$116
D4249	Clinical Crown Lengthening – Hard Tissue		$205	$205	$189	$158	$158	$88	$236	$189
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	1 per quadrant every 3 years	$341	$341	$315	$263	$263	$147	$394	$315
D4261	Osseous Surgery (Including Elevation of a Full Thickness Flap And Closure) – One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$205	$205	$189	$158	$158	$88	$236	$189
D4263	Bone Replacement Graft – retained natural tooth - First Site in Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4264	Bone Replacement Graft – retained natural tooth - Each Additional Site in Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D4265	Biologic Materials to Aid in Soft And Osseous Tissue Regeneration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4266	Guided Tissue Regeneration – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4267	Guided Tissue Regeneration – Non-Resorbable Barrier, per Site (Includes Membrane Removal)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4268	Surgical Revision Procedure, per Tooth		$137	$137	$126	$105	$105	$59	$158	$126
D4270	Pedicle Soft Tissue Graft Procedure		$263	$263	$242	$200	$200	$116	$299	$242
D4273	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) First Tooth, Implant or Edentulous Tooth Position		$158	$158	$145	$121	$121	$68	$181	$144
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft		$347	$347	$331	$342	$342	$237	$348	$332
D4276	Combined Connective Tissue and Pedicle Graft, per Tooth		$260	$260	$238	$200	$200	$112	$299	$238
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft		$111	$111	$103	$86	$86	$48	$128	$103
D4278	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) Each Additional Contiguous Tooth, Implant, or Edentulous Tooth Position in Same Graft Site		$56	$56	$51	$43	$43	$24	$64	$51
D4283	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		$87	$87	$80	$67	$67	$37	$100	$79
D4285	Non Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site And Donor Material) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		$191	$191	$182	$188	$188	$130	$191	$183
D4286	Removal of Non-resorbable Barrier	Inclusive with D7957 - Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	$0	$0	$0	$0	$0	$0	$0	$0
D4322	Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D4323	Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D4341	Periodontal Scaling and Root Planing, 4 or More Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	$59	$59	$54	$50	$53	$37	$63	$65
D4342	Periodontal Scaling and Root Planing – 1-3 Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	$36	$36	$33	$32	$32	$22	$38	$39
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		$35	$35	$35	$35	$35	$35	$35	$35
D4355	Full Mouth Debridement to Enable Comprehensive Oral Evaluation and Diagnosis on a Subsequent Visit	Once per lifetime when covered under Aetna dental plans •D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355. •D1110, D1120, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.	$70	$70	$70	$45	$70	$70	$70	$70
D4381	Localized Delivery of Antimicrobial Agents via a Controlled Release Vehicle Into Diseased Crevicular Tissue, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Special Note for D4910: **<u>Pre Nov 2000 Plans (*)</u> - Covered once per year, no history of periodontal surgery required.** **<u>DMO Standard Plans (#)</u> - Periodontal Maintenance Procedures are covered twice per year only when there is a history of periodontal surgery. (Effective 04/01/2023, D4341 and D4342 have been added to the DMO list of procedure codes that will allow for future D4910.) If there is no history of periodontal surgery, an allowance for D1110 applies, provided prophy frequency of 2 per year has not been met. Dentist may charge the difference between their Usual and Customary fees for D1110 and D4910.** **If the prophy frequency has been met or there has been a combination of any two D1110 or D4910 done, then the procedure is not covered. The patient is responsible for the dentist's Usual and Customary fee for the service.**								
D4910	Periodontal Maintenance	(See Special Note above)	$65	$65	$49	$20	$33	$25	$43	$48
D4920	Unscheduled Dressing Change (by Someone Other than Treating Dentist or Their Staff)		$11	$11	$11	$11	$11	$11	$11	$11
D4921	Gingival Irrigation – per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Special Note for D4999: **Laser may not be submitted as D4999. The use of laser is not a procedure in and of itself; therefore, the patient may not be charged separately for this. Laser is considered inclusive with the service performed.**								
D4999	Unspecified Periodontal Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
		Removable Prosthetic Codes **<u>Effective 1/1/2024, the "initial placement rule" is removed.</u>** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **<u>Prior to 1/1/2024</u>** - Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does <u>not</u> apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. **Note – Benefit includes all adjustments, relines and rebases occurring within 6 months of insertion (exception D5130 & D5140).** **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.**								
D5110	Complete Denture – Maxillary		$347	$347	$318	$300	$318	$231	$370	$318

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D5120	Complete Denture – Mandibular		$347	$347	$318	$300	$318	$231	$370	$318
D5130	Immediate Denture – Maxillary	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$347	$347	$331	$300	$342	$237	$348	$332
D5140	Immediate Denture – Mandibular	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$347	$347	$331	$300	$342	$237	$348	$332
D5211	Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		$347	$347	$318	$300	$318	$231	$370	$318
D5212	Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		$347	$347	$318	$300	$318	$231	$370	$318
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		$420	$420	$368	$300	$342	$237	$421	$368
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		$420	$420	$368	$300	$342	$237	$421	$368
D5221	Immediate Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$399	$399	$366	$366	$366	$266	$426	$366
D5222	Immediate Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$399	$399	$366	$366	$366	$266	$426	$366
D5223	Immediate Maxillary Partial Denture – Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$483	$483	$423	$393	$393	$273	$484	$423
D5224	Immediate Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$483	$483	$423	$393	$393	$273	$484	$423
D5225	Maxillary Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		$396	$396	$363	$363	$363	$264	$422	$363
D5226	Mandibular Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		$396	$396	$363	$363	$363	$264	$422	$363
D5227	Immediate Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)		$396	$396	$363	$363	$363	$264	$422	$363
D5228	Immediate Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)		$396	$396	$363	$363	$363	$264	$422	$363
D5282	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), maxillary		$347	$347	$318	$318	$318	$231	$370	$318

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D5283	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), mandibular		$347	$347	$318	$318	$318	$231	$370	$318
D5284	Removable unilateral partial denture – one-piece flexible base (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		$198	$198	$182	$182	$182	$132	$211	$182
D5286	Removable unilateral partial denture – one-piece resin (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		$174	$174	$159	$150	$159	$116	$185	$159
D5410	Adjust Complete Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	$11	$10	$11	$11	$11	$11	$11	$11
D5411	Adjust Complete Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	$11	$10	$11	$11	$11	$11	$11	$11
D5421	Adjust Partial Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	$11	$10	$11	$11	$11	$11	$11	$11
D5422	Adjust Partial Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	$11	$10	$11	$11	$11	$11	$11	$11
D5511	Repair Broken Complete Denture Base, Mandibular		$40	$40	$40	$15	$40	$35	$45	$40
D5512	Repair Broken Complete Denture Base, Maxillary		$40	$40	$40	$15	$40	$35	$45	$40
D5520	Replace Missing or Broken Teeth – Complete Denture - per Tooth		$30	$30	$25	$15	$40	$30	$45	$25
D5611	Repair Resin Partial Denture Base, Mandibular		$40	$40	$40	$40	$40	$35	$45	$40
D5612	Repair Resin Partial Denture Base, Maxillary		$40	$40	$40	$40	$40	$35	$45	$40
D5621	Repair Cast Partial Framework, Mandibular		$40	$40	$40	$40	$40	$35	$45	$40
D5622	Repair Cast Partial Framework, Maxillary		$40	$40	$40	$40	$40	$35	$45	$40
D5630	Repair or Replace Broken Retentive/Clasping Materials - per Tooth		$40	$40	$40	$15	$40	$35	$45	$40
D5640	Replace Missing or Broken Teeth – Partial Denture - per Tooth		$40	$40	$40	$15	$40	$30	$50	$40
D5650	Add Tooth to Existing Partial Denture - per Tooth		$40	$40	$40	$30	$40	$35	$45	$40
D5660	Add Clasp to Existing Partial Denture - per Tooth		$50	$50	$44	$44	$44	$33	$50	$44
D5670 - D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary or Mandibular)		$110	$110	$110	$110	$110	$110	$110	$110
D5710 - D5711	Rebase Complete Maxillary or Mandibular Denture	Includes all adjustments within 6 months after insertion	$110	$110	$110	$110	$110	$110	$110	$110
D5720 - D5721	Rebase Maxillary or Mandibular Partial Denture	Includes all adjustments within 6 months after insertion	$110	$110	$110	$110	$110	$110	$110	$110
D5725	Rebase Hybrid Prosthesis		$110	$110	$110	$110	$110	$110	$110	$110
D5730	Reline Complete Maxillary Denture (Direct)	Includes all adjustments within 6 months after insertion	$55	$55	$50	$44	$44	$0	$66	$50
D5731	Reline Complete Mandibular Denture (Direct)	Includes all adjustments within 6 months after insertion	$55	$55	$50	$44	$44	$0	$66	$50
D5740	Reline Maxillary Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	$55	$55	$50	$44	$44	$0	$66	$50

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D5741	Reline Mandibular Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	$55	$55	$50	$44	$44	$0	$66	$50
D5750	Reline Complete Maxillary Denture (Indirect)	Includes all adjustments within 6 months after insertion	$125	$125	$112	$35	$99	$53	$110	$112
D5751	Reline Complete Mandibular Denture (Indirect)	Includes all adjustments within 6 months after insertion	$125	$125	$112	$35	$99	$53	$110	$112
D5760	Reline Maxillary Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	$125	$125	$112	$35	$99	$53	$110	$112
D5761	Reline Mandibular Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	$125	$125	$112	$35	$99	$53	$110	$112
D5765	Soft Liner for Complete or Partial Removable Denture – Indirect		$125	$125	$112	$35	$99	$53	$110	$112
D5810 - D5811	Interim Complete Denture (Maxillary or Mandibular)	Plan benefit and patient copay for permanent to include all interim Provisional charges	$0	$0	$0	$0	$0	$0	$0	$0
D5820	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Maxillary	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	$157	$157	$99	$99	$99	$99	$132	$99
D5821	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Mandibular	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	$157	$157	$99	$99	$99	$99	$132	$99
D5850 - D5851	Tissue Conditioning, Maxillary or Mandibular	Inclusive with prosthesis within 6 months after insertion	$55	$55	$44	$30	$44	$44	$61	$44
D5862	Precision Attachment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5863	Overdenture – Complete Maxillary	Not covered – Alternate benefit based on D5110	$347	$347	$318	$318	$318	$231	$370	$318
D5864	Overdenture – Partial Maxillary	Not covered – Alternate benefit based on D5211	$347	$347	$318	$318	$318	$231	$370	$318
D5865	Overdenture – Complete Mandibular	Not covered – Alternate benefit based on D5120	$347	$347	$318	$318	$318	$231	$370	$318
D5866	Overdenture – Partial Mandibular	Not covered – Alternate benefit based on D5212	$347	$347	$318	$318	$318	$231	$370	$318
D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5875	Modification of Removable Prosthesis Following Implant Surgery	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5876	Add Metal Substructure to Acrylic Full Denture (per Arch)		$40	$40	$40	$40	$40	$35	$45	$40
D5899	Unspecified Removable Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5911 - D5993	Maxillofacial Prosthetics	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5994	Periodontal Medicament Carrier with Peripheral Seal – Laboratory Processed	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D5999	Unspecified Maxillofacial Prosthesis, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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		Fixed Prosthetic Codes **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Effective 1/1/2024, the "initial placement rule" is removed.** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **Prior to 1/1/2024** - Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does not apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. **Facings on molars are not covered.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)** **Additional $125 patient copayment per unit for treatment of 6 or more units of covered crown/bridge in the same treatment plan.**								
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.								
D6010	Surgical Placement of Implant Body: Endosteal Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth). Member Copay Change for i Plans Effective 04/01/2016	N/C $1,375 [4] $1,215 [5]	$1,215	N/C $1,375 [4] $1,215 [5]	$1,215	N/C $1,375 [4] $1,215 [5]	N/C $1,375 [4] $1,215 [5]	N/C $1,375 [4] $1,215 [5]	N/C $1,375 [4] $1,215 [5]
D6011	Second Stage Implant Surgery	Not covered unless plan covers implants. For plans covering implants, this is inclusive to surgical placement of implant.	N/C $0	$0	N/C $0	N/C $0	N/C $0	N/C $0	N/C $0	N/C $0
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6013	Surgical Placement of Mini Implant	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth).	$756	$756	$756	$756	$756	$756	$756	$756
D6040	Surgical Placement: Eposteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6050	Surgical Placement: Transosteal Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6051	Placement of Interim Implant Abutment	For plans covering implants, plan benefit and patient copay for permanent restoration includes all interim charges.	$0	$0	$0	$0	$0	$0	$0	$0
D6052	Semi-Precision Attachment Abutment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6055	Connecting Bar - Implant Supported or Abutment Supported	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6056	Prefabricated Abutment - Includes Modification and Placement	Not covered unless plan covers implants. If plan covers implants, limited to 2 paid occurrences per year (on different teeth). Member Copay Change for i Plans Effective 04/01/2016	N/C $785 [4] $440 [5]	$440	N/C $785 [4] $440 [5]	$440	N/C $785 [4] $440 [5]	N/C $785 [4] $440 [5]	N/C $785 [4] $440 [5]	N/C $785 [4] $440 [5]
D6057	Custom Fabricated Abutment – Includes Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6058	Abutment Supported Porcelain/Ceramic Crown		$362	$362	$293	$259	$259	$207	$362	$293
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293

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D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6064	Abutment Supported Cast Metal Crown (Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6065	Implant Supported Porcelain/Ceramic Crown		$362	$362	$293	$259	$259	$207	$362	$293
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD		$362	$362	$293	$259	$259	$207	$362	$293
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6075	Implant Supported Retainer for Ceramic FPD		$362	$362	$293	$259	$259	$207	$362	$293
D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		$362	$362	$293	$259	$259	$207	$362	$293
D6080	Implant Maintenance Procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments		N/C $88	$88	N/C $88	$88	N/C $88	N/C $88	N/C $88	N/C $88
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths: includes cleaning of the implant surfaces, without flap entry and closure		N/C $18	$18	N/C $17	$16	N/C $16	N/C $11	N/C $19	N/C $20

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D6082	Implant supported crown – porcelain fused to predominantly base alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6083	Implant supported crown – porcelain fused to noble alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6085	Provisional implant crown		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6086	Implant supported crown – predominantly base alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6087	Implant supported crown – noble alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6088	Implant supported crown – titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6089	Accessing and Retorquing Loose Implant Screw - per Screw	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6090	Repair of Implant/Abutment Supported Prosthesis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6091	Replacement of Semi-Precision or Precision Attachment of Implant/Abutment Supported Prosthesis, per Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6092	Re-cement Or Re-bond Implant/Abutment Supported Crown		$24	$24	$24	$24	$24	$24	$24	$24
D6093	Re-cement Or Re-bond Implant/Abutment Supported Fixed Partial Denture		$26	$26	$26	$26	$26	$26	$26	$26
D6094	Abutment Supported Crown (Titanium)		$362	$362	$293	$259	$259	$207	$362	$293
D6095	Repair Implant Abutment, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6096	Remove Broken Implant Retaining Screw	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6098	Implant supported retainer – porcelain fused to predominantly base alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6100	Implant Removal, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6102	Debridement and osseous contouring of a periimplant defect: includes surface cleaning of exposed implant surfaces and flap entry and closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6104	Bone graft at time of implant placement		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D6105	Removal of Implant Body not Requiring Bone Removal or Flap Elevation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6106	Guided Rissue Regeneration – Resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6107	Guided Rissue Regeneration – Non-resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6110	Implant /Abutment Supported Removable Denture for Edentulous Arch – Maxillary		$347	$347	$318	$318	$318	$231	$370	$318
D6111	Implant /Abutment Supported Removable Denture for Edentulous Arch – Mandibular		$347	$347	$318	$318	$318	$231	$370	$318
D6112	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Maxillary		$347	$347	$318	$318	$318	$231	$370	$318
D6113	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Mandibular		$347	$347	$318	$318	$318	$231	$370	$318
D6114	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Maxillary		$347	$347	$318	$318	$318	$231	$370	$318
D6115	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Mandibular		$347	$347	$318	$318	$318	$231	$370	$318
D6116	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Maxillary		$347	$347	$318	$318	$318	$231	$370	$318
D6117	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Mandibular		$347	$347	$318	$318	$318	$231	$370	$318
D6118	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Mandibular	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6119	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Maxillary	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6121	Implant supported retainer for metal FPD – predominantly base alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6122	Implant supported retainer for metal FPD – noble alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	This procedure includes active debriding of the implant(s) and prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s). Only covered if Plan has implant coverage.	N/C $22	$22	N/C $22	$22	N/C $22	N/C $22	N/C $22	N/C $22
D6190	Radiographic / Surgical Implant Index, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6191	Semi-precision abutment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6192	Semi-precision attachment – placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6193	Replacement of an Implant Screw	If D6193 is eligible, D6096 on same day is inclusive (not separately eligible).	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D6194	Abutment Supported Retainer Crown for FPD (Titanium)		$362	$362	$293	$259	$259	$207	$362	$293
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6197	Replacement of Restorative Material Used to Close an Access Opening of a Screw-retained Implant Supported Prosthesis, per Implant		$63	$63	$49	$46	$49	$49	$49	$49
D6198	Remove Interim Implant Component	Inclusive to permanent restoration	$0	$0	$0	$0	$0	$0	$0	$0
D6199	Unspecified Implant Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6205	Pontic – Indirect Resin Based Composite		$362	$362	$293	$259	$259	$207	$362	$293
D6210	Pontic – Cast High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6211	Pontic – Cast Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6212	Pontic – Cast Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6214	Pontic – Titanium		$362	$362	$293	$259	$259	$207	$362	$293
D6240	Pontic – Porcelain Fused to High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6241	Pontic – Porcelain Fused to Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6242	Pontic – Porcelain Fused to Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6243	Pontic – porcelain fused to titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6245	Pontic – Porcelain/Ceramic		$362	$362	$293	$259	$259	$207	$362	$293
D6250	Pontic – Resin with High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6251	Pontic – Resin with Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6252	Pontic – Resin with Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6253	Provisional Pontic– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan benefit and patient copay for permanent to include all provisional charges	$0	$0	$0	$0	$0	$0	$0	$0
D6545	Retainer – Cast Metal for Resin-Bonded Fixed Prosthesis		$236	$236	$205	$200	$200	$189	$236	$205
D6548	Retainer – Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis		$236	$236	$205	$200	$200	$189	$236	$205
D6549	Resin Retainer – for Resin Bonded Fixed Prosthesis		$181	$181	$147	$130	$130	$104	$181	$147
D6600	Retainer Inlay – Porcelain/Ceramic, 2 Surfaces		$236	$236	$205	$200	$200	$189	$236	$205
D6601	Retainer Inlay – Porcelain/Ceramic, 3 or More Surfaces		$236	$236	$205	$200	$200	$189	$236	$205
D6602	Retainer Inlay – Cast High Noble Metal, 2 Surfaces		$257	$257	$226	$221	$221	$210	$257	$226
D6603	Retainer Inlay – Cast High Noble Metal, 3 or More Surfaces		$257	$257	$226	$221	$221	$210	$257	$226
D6604	Retainer Inlay – Cast Predominantly Base Metal, 2 Surfaces		$236	$236	$205	$200	$200	$189	$236	$205
D6605	Retainer Inlay – Cast Predominantly Base Metal, 3 or More Surfaces		$236	$236	$205	$200	$200	$189	$236	$205

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D6606	Retainer Inlay – Cast Noble Metal, 2 Surfaces		$257	$257	$226	$221	$221	$210	$257	$226
D6607	Retainer Inlay – Cast Noble Metal, 3 or More Surfaces		$257	$257	$226	$221	$221	$210	$257	$226
D6608	Retainer Onlay – Porcelain/Ceramic, 2 Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D6609	Retainer Onlay – Porcelain/Ceramic, 3 or More Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D6610	Retainer Onlay – Cast High Noble Metal, 2 Surfaces		$273	$273	$242	$231	$231	$221	$274	$242
D6611	Retainer Onlay – Cast High Noble Metal, 3 or More Surfaces		$273	$273	$242	$231	$231	$221	$274	$242
D6612	Retainer Onlay – Cast Predominantly Base Metal, 2 Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D6613	Retainer Onlay – Cast Predominantly Base Metal, 3 or More Surfaces		$252	$252	$221	$210	$210	$200	$253	$221
D6614	Retainer Onlay – Cast Noble Metal, 2 Surfaces		$273	$273	$242	$231	$231	$221	$274	$242
D6615	Retainer Onlay – Cast Noble Metal, 3 or More Surfaces		$273	$273	$242	$231	$231	$221	$274	$242
D6624	Retainer Inlay – Titanium		$257	$257	$226	$221	$221	$210	$257	$226
D6634	Retainer Onlay – Titanium		$273	$273	$242	$231	$231	$221	$274	$242
D6710	Retainer Crown – Indirect Resin Based Composite		$362	$362	$293	$259	$259	$207	$362	$293
D6720	Retainer Crown – Resin with High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6721	Retainer Crown – Resin with Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6722	Retainer Crown – Resin with Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6740	Retainer Crown – Porcelain/Ceramic		$362	$362	$293	$259	$259	$207	$362	$293
D6750	Retainer Crown – Porcelain Fused to High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6751	Retainer Crown – Porcelain Fused to Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6752	Retainer Crown – Porcelain Fused to Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6753	Retainer crown – porcelain fused to titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6780	Retainer Crown – 3/4 Cast High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6781	Retainer Crown – 3/4 Cast Predominantly Based Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6782	Retainer Crown – 3/4 Cast Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6783	Retainer Crown – 3/4 Porcelain/Ceramic		$362	$362	$293	$259	$259	$207	$362	$293
D6784	Retainer crown 3/4 – titanium and titanium alloys		$362	$362	$293	$259	$259	$207	$362	$293
D6790	Retainer Crown – Full Cast High Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6791	Retainer Crown – Full Cast Predominantly Base Metal		$362	$362	$293	$259	$259	$207	$362	$293
D6792	Retainer Crown – Full Cast Noble Metal		$362	$362	$293	$259	$259	$207	$362	$293

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D6793	Provisional Retainer Crown–Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan benefits and patient copay for permanent to include all provisional charges.	$0	$0	$0	$0	$0	$0	$0	$0
D6794	Retainer Crown – Titanium		$362	$362	$293	$259	$259	$207	$362	$293
D6920	Connector Bar	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6930	Re-cement or Re-bond Fixed Partial Denture		$25	$10	$20	$10	$20	$20	$25	$20
D6940	Stress Breaker	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6950	Precision Attachment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D6985	Pediatric Partial Denture, Fixed	Eligible for anterior teeth. Not Covered for teeth other than anterior.	$157	$157	$99	$99	$99	$99	$132	$99
D6999	Unspecified Fixed Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7111	Extraction, Coronal Remnants – Primary Tooth	Includes extractions for orthodontic purposes.	$8	$0	$5	$0	$0	$0	$0	$0
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	Includes extractions for orthodontic purposes.	$17	$17	$12	$0	$0	$0	$0	$0
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth and Including Elevation of Mucoperiosteal Flap if Indicated	Includes extractions for orthodontic purposes.	$41	$41	$32	$0	$0	$0	$57	$32
D7220	Removal of Impacted Tooth – Soft Tissue	Includes extractions for orthodontic purposes.	$65	$25	$50	$0	$0	$0	$65	$50
D7230	Removal of Impacted Tooth – Partially Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$85	$50	$69	$55	$55	$55	$94	$69
D7240	Removal of Impacted Tooth – Completely Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$155	$75	$142	$85	$85	$85	$145	$142
D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$155	$155	$142	$85	$85	$85	$145	$142
D7250	Removal of Residual Tooth Roots (Cutting Procedure)		$37	$37	$26	$16	$16	$16	$59	$27
D7251	Coronectomy - Intentional Partial Tooth Removal	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$70	$70	$65	$39	$39	$39	$66	$65
D7252	Partial Extraction for Immediate Implant Placement		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7259	Nerve Dissection		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7260	Oroantral Fistula Closure	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7261	Primary Closure of a Sinus Perforation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7272	Tooth Transplantation (Includes Reimplantation from One Site to Another & Splinting and/or Stabilization)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7280	Exposure of an Unerupted Tooth		$63	$63	$27	$27	$27	$27	$62	$27

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D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption		$77	$77	$33	$33	$33	$33	$77	$33
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth		$15	$15	$7	$7	$7	$7	$15	$7
D7284	Excisional Biopsy of Minor Salivary Glands		$293	$293	$125	$83	$83	$83	$132	$125
D7285	Incisional Biopsy of Oral Tissue – Hard (Bone, Tooth)		$195	$195	$83	$55	$55	$55	$88	$83
D7286	Incisional Biopsy of Oral Tissue – Soft		$195	$195	$83	$55	$55	$55	$88	$83
D7287	Exfoliative Cytological Sample Collection		$110	$110	$42	$28	$28	$28	$44	$42
D7288	Brush Biopsy – Transepithelial Sample Collection	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7290	Surgical Repositioning of Teeth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7291	Transseptal Fiberotomy/ Supra Crestal Fiberotomy, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7292	Placement of Temporary Anchorage Device [Screw Retained Plate] Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7293	Placement of Temporary Anchorage Device Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7294	Placement of Temporary Anchorage Device Without Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7295	Harvest of Bone for Use in Autogenous Grafting Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7296	Corticotomy - One to Three Teeth or Tooth Spaces, per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7297	Corticotomy – Four or More Teeth or Tooth Spaces, per Quadrant	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7298	Removal of Temporary Anchorage Device [Screw Retained Plate], Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0	$0	$0	$0	$0	$0
D7299	Removal of Temporary Anchorage Device, Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0	$0	$0	$0	$0	$0
D7300	Removal of Temporary Anchorage Device Without Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0	$0	$0	$0	$0	$0
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	$39	$25	$28	$20	$20	$20	$66	$28
D7311	Alveoloplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		$20	$20	$14	$10	$10	$10	$33	$14
D7320	Alveoloplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	$66	$25	$44	$28	$28	$28	$83	$44
D7321	Alveoloplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		$33	$33	$22	$14	$14	$14	$42	$22
D7340	Vestibuloplasty – Ridge Extension (Secondary Epithelialization)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7350	Vestibuloplasty – Ridge Extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7410	Excision of Benign Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7411	Excision of Benign Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7412	Excision of Benign Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7413	Excision of Malignant Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7414	Excision of Malignant Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7415	Excision of Malignant Lesion, Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7440	Excision Malignant Tumor - Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7441	Excision Malignant Tumor Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7450	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7451	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7460	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7461	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7465	Destruction of Lesion(s) by Physical or Chemical Method, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7472	Removal of Torus Palatinus	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7473	Removal of Torus Mandibularis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7485	Reduction of Osseous Tuberosity	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7490	Radical Resection of Maxilla or Mandible	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7509	Marsupialization of Odontogenic Cyst	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue		$33	$18	$22	$11	$11	$22	$33	$22
D7511	Incision and Drainage of Abscess – Intraoral Soft Tissue - Complicated		$36	$36	$24	$12	$12	$24	$36	$24
D7520	Incision and Drainage of Abscess – Extraoral Soft Tissue	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7521	Incision and Drainage of Abscess – Extraoral Soft Tissue - Complicated	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7530	Removal of Foreign Body from Mucosa, Skin or Subcutaneous Alveolar Tissue	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7550	Partial Ostectomy/ Sequestrectomy for Removal of Non-Vital Bone	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7610-D7820	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7830	Manipulation Under Anesthesia	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7840-D7870	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7871	Non-Arthroscopic Lysis and Lavage	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7872-D7877	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7880	Occlusal Orthotic Device, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7881	Occlusal Orthotic Device Adjustment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7899	Unspecified TMD Therapy, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7910	Suture of Recent Small Wound up to 5 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7911	Complicated Suture - Up to 5 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7912	Complicated Suture - greater than 5 cm	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7920-D7921	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Inclusive to the extraction Patient cannot be billed	$0	$0	$0	$0	$0	$0	$0	$0
D7939	Indexing for Osteotomy using Dynamic Robotic Assisted or Dynamic Navigation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7940-D7952	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7953	Bone Replacement Graft for Ridge Preservation – Per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7956	Guided Tissue Regeneration, Edentulous Area – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7957	Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7961	Buccal / labial frenectomy (frenulectomy)		$99	$99	$37	$26	$26	$26	$99	$37
D7962	Lingual frenectomy (frenulectomy)		$99	$99	$37	$26	$26	$26	$99	$37
D7963	Frenuloplasty		$105	$105	$40	$28	$28	$28	$105	$40
D7970	Excision of Hyperplastic Tissue – Per Arch	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7971	Excision of Pericoronal Gingiva	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7972	Surgical Reduction of Fibrous Tuberosity	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7979	Non-Surgical Sialolithotomy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7980	Surgical Sialolithotomy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7981	Excision Of Salivary Gland, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7982	Sialodochoplasty	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D7983	Closure of Salivary Fistula	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7990-D7998	Other Surgical Procedures	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D7999	Unspecified Oral Surgery Procedure, By Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D8210	Removable Appliance Therapy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D8220	Fixed Appliance Therapy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D8695	Removal of Fixed Orthodontic Appliances for Reasons other than Completion of Treatment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	Inclusive when performed on the same date of service as definitive treatment; member cannot be billed. Definitive treatment is the treatment which resolves the pain permanently - this is the final measure taken to eliminate the pain.	$11	$11	$11	$11	$11	$11	$11	$11
D9120	Fixed Partial Denture Sectioning	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9130	Temporomandibular Joint Dysfunction – Non-invasive physical Therapies	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9210	Local Anesthesia, Not in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	$0	$0	$0	$0	$0	$0	$0	$0
D9211	Regional Block Anesthesia	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0	$0	$0
D9212	Trigeminal Division Block Anesthesia	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	$0	$0	$0	$0	$0	$0	$0	$0
D9219[3]	Evaluation For Moderate Sedation, Deep Sedation or General Anesthesia	When rendered by anesthesiologist	$0	$0	$0	$0	$0	$0	$0	$0
D9222	Deep Sedation/General Anesthesia – First 15 Minutes		$109	$109	$109	$109	$109	$109	$109	$109
D9223	Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	$87	$87	$87	$87	$87	$87	$87	$87
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia – First 15 Minutes		$109	$109	$109	$109	$109	$109	$109	$109
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	$87	$87	$87	$87	$87	$87	$87	$87
D9248	Non-Intravenous Conscious Sedation	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician	For Second Opinions only	$0	$0	$0	$0	$0	$0	$0	$0
D9311	Consultation with a medical health care professional		$0	$0	$0	$0	$0	$0	$0	$0
D9410	House/Extended Care Facility Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9420	Hospital or Ambulatory Surgical Center Call	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0	$0	$0
D9440	Office Visit - After Regularly Scheduled Hours	Not Covered (Covered in Texas)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)	N/C ($0)
D9450	Case Presentation, Detailed and Extensive Treatment Planning	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0	$0	$0
D9610	Therapeutic Parenteral Drug, Single Administration	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9612	Therapeutic Parenteral Drugs, 2 or more Administrations, Different Medications	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9613	Infiltration of Sustained Release Therapeutic Drug	Eligible when performed in conjunction with procedure codes D7220, D7230, D7240, D7241, or D7251 on third molars (teeth #'s 01, 16, 17, or 32).	$0	$0	$0	$0	$0	$0	$0	$0
D9630	Drugs or Medicaments dispensed in the office for home use	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9910	Application of Desensitizing Medicament	Inclusive with the restoration being performed on the same date of service; member cannot be billed.	$0	$0	$0	$0	$0	$0	$0	$0
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9912	Pre-visit Patient Screening	Inclusive with record keeping requirements	$0	$0	$0	$0	$0	$0	$0	$0
D9913	Administration of Neuromodulators		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9914	Administration of Dermal Fillers		N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9920	Behavior Management, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9930	Treatment of Complications (Post-surgical) – Unusual Circumstances, by Report	Included in cost of underlying procedure	$0	$0	$0	$0	$0	$0	$0	$0
D9932	Cleaning and Inspection of Removable Complete Denture, Maxillary		$25	$25	$25	$25	$25	$25	$25	$25
D9933	Cleaning and Inspection of Removable Complete Denture, Mandibular		$25	$25	$25	$25	$25	$25	$25	$25
D9934	Cleaning and Inspection of Removable Partial Denture, Maxillary		$25	$25	$25	$25	$25	$25	$25	$25
D9935	Cleaning and Inspection of Removable Partial Denture, Mandibular		$25	$25	$25	$25	$25	$25	$25	$25
D9938	Fabrication of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9939	Placement of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9941	Fabrication of Athletic Mouthguard	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9942	Repair and/or Reline of Occlusal Guard		$22	$22	$22	$22	$22	$18	$24	$22
D9943	Occlusal Guard Adjustment	Fee for occlusal guard includes adjustments performed within 6 months of placement	$24	$24	$19	$19	$19	$19	$24	$19
D9944	Occlusal Guard – Hard Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$224	$224	$173	$173	$173	$173	$224	$173

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D9945	Occlusal Guard – Soft Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$195	$195	$150	$150	$150	$150	$195	$150
D9946	Occlusal Guard – Hard Appliance, Partial Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$117	$117	$90	$90	$90	$90	$117	$90
D9947	Custom Sleep Apnea Appliance Fabrication and Placement	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9948	Adjustment of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9949	Repair of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9950	Occlusion Analysis - Mounted Case	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9951	Occlusal Adjustment – Limited	Not separately eligible when performed in conjunction with a restoration, root canal therapy or appliance.	$53	$53	$35	$35	$35	$35	$53	$35
D9952	Occlusal Adjustment – Complete		$120	$120	$96	$96	$96	$96	$120	$96
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9954	Fabrication and Delivery of Oral Appliance Therapy (OAT) Morning Repositioning Device	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9955	Oral Appliance Therapy (OAT) Titration Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9956	Administration of Home Sleep Apnea Test	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9957	Screening for Sleep Related Breathing Disorders	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9959	Unspecified Sleep Apnea Services Procedure, by Report	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9961	Duplicate/Copy Patient's Records	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9970	Enamel Microabrasion	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9972	External Bleaching – per Arch - Performed in Office	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9973	External Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9974	Internal Bleaching – per Tooth	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9975	External Bleaching for Home Application, per Arch	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9985[2]	Sales Tax	Inclusive to service being taxed	$0	$0	$0	$0	$0	$0	$0	$0
D9986	Missed Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9987	Cancelled Appointment	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9990	Certified Translation or Sign-language Services per Visit	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9991	Dental case management - addressing appointment compliance barriers	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9992	Dental case management – care coordination	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9993	Dental case management – motivational interviewing	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9994	Dental case management – patient education to improve oral health literacy	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C

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D9995	Teledentistry – Synchronous; Real-Time Encounter	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9996	Teledentistry – Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review	Not Covered	N/C	N/C	N/C	N/C	N/C	N/C	N/C	N/C
D9997	Dental case management – patients with special health care needs	Inclusive to the primary service Patient cannot be billed	$0	$0	$0	$0	$0	$0	$0	$0
D9999	Unspecified Adjunctive Procedure, by Report	Used for procedure that is not adequately described by a code. Use of this code REQUIRES A WRITTEN NARRATIVE & supporting documentation								

[1] Current Dental Terminology ©American Dental Association. All rights reserved.
[2] Not separately eligible/inclusive - the patient cannot be billed for these services.
[3] Covered only when performed by anesthesiologist.
[4] Amount thru 03/31/2016
[5] Amount effective 04/01/2016

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	Office Visit Copay	Check Roster When an Office Visit copay applies, the DMO Patient Roster will show the amount under column "Office Copay" (i.e. 000 = $0.00; 005 = $5.00). When submitted, use ADA code D0999.			
	Infection Control	May not bill patient for infection control procedures			
		Frequency limits on Preventive and Diagnostic services are waived in Arizona, California and Texas if medically necessary.			
D0120	Periodic Oral Evaluation - Established Patient	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0
D0140	Limited Oral Evaluation - Problem Focused	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0
D0145	Oral Evaluation for a Patient under Three Years of Age and Counseling with a Primary Caregiver	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0
D0150	Comprehensive Oral Evaluation - New or Established Patient	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, by Report	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0
D0170	Re-Evaluation - Limited, Problem Focused (Established Patient; not Post-Operative Visit)	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0
D0171	Re-Evaluation - Post-Operative Office Visit	Inclusive to surgery. Patient cannot be billed.	$0	$0	$0
D0180	Comprehensive Periodontal Evaluation - New or Established Patient	Limited to 4x per year (All Evaluations Combined D0120 - D0180)	$0	$0	$0
D0190-D0191[2]	Screening / Assessment of a Patient	Inclusive to oral evaluation Patient cannot be billed	$0	$0	$0
D0210	Intraoral - Complete Series of Radiographic Images	FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0
D0220-D0230	Intraoral - Periapical Image		$0	$0	$0
D0240	Intraoral - Occlusal Radiographic Image		$0	$0	$0
D0250-D0251	Extra-Oral Image		$0	$0	$0
D0270-D0274	Bitewing Radiographic Image	1 series per year	$0	$0	$0
D0277	Vertical Bitewings - 7 to 8 Radiographic Images	1 series every 3 years	$0	$0	$0
D0310	Sialography	Not Covered	N/C	N/C	N/C
D0320-D0321	Temporomandibular Joint Image	Not Covered	N/C	N/C	N/C
D0322	Tomographic Survey	Not Covered	N/C	N/C	N/C
D0330	Panoramic Radiographic Image	FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0
D0340	2D Cephalometric Radiographic Image – Acquisition, Measurement and Analysis	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C
D0350	2D Oral/Facial Photographic Image Obtained Intra-orally or Extra-orally	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C
D0364-D0368	Cone Beam	Not Covered	N/C	N/C	N/C
D0369-D0371	Capture and Interpretation	Not Covered	N/C	N/C	N/C
D0372	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0

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D0373	Intraoral Tomosynthesis – Bitewing Radiographic Image	1 series per year	$0	$0	$0
D0374	Intraoral Tomosynthesis – Periapical Radiographic Image		$0	$0	$0
D0380-D0384	Cone Beam CT Image Capture	Not Covered	N/C	N/C	N/C
D0385-D0386	Cone Beam	Not Covered	N/C	N/C	N/C
D0387	Intraoral Tomosynthesis – Comprehensive Series of Radiographic Images – Image Capture Only	Benefit limited to one full image of the mouth once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0
D0388	Intraoral Tomosynthesis – Bitewing Radiographic Image – Image Capture Only	1 series per year	$0	$0	$0
D0389	Intraoral Tomosynthesis – Periapical Radiographic Image – Image Capture Only		$0	$0	$0
D0391	Interpretation of Diagnostic Image by Practitioner Not Associated with Capture of the Image, Including Report		$2	$4	$0
D0393-D0395	3D Images	Not Covered	N/C	N/C	N/C
D0396	3D printing of a 3D dental surface scan	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C
D0411	HbA1c In-office Point of Service Testing	Not Covered	N/C	N/C	N/C
D0412	Blood Glucose Level Test – In-office Using a Glucose Meter	Not Covered	N/C	N/C	N/C
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not Covered	N/C	N/C	N/C
D0415	Collection of Microorganisms	Not Covered	N/C	N/C	N/C
D0416	Viral Culture	Not Covered	N/C	N/C	N/C
D0417	Collection & Preparation of Saliva Sample	Not Covered	N/C	N/C	N/C
D0418	Analysis of Saliva Sample	Not Covered	N/C	N/C	N/C
D0419	Assessment of Salivary Flow by Measurement	Not Covered	N/C	N/C	N/C
D0422	Collection and Preparation of Genetic Sample Material for Laboratory Analysis and Report	Not Covered	N/C	N/C	N/C
D0423	Genetic Test for Susceptibility to Diseases – Specimen Analysis	Not Covered	N/C	N/C	N/C
D0425	Caries Susceptibility Test	Not Covered	N/C	N/C	N/C
D0431	Adjunctive Pre-Diagnostic Test	The use of any tools and/or devices that assist in a diagnosis to be an adjunctive technique that is part of the oral evaluation or primary service. Members cannot be billed for this service.	$0	$0	$0
D0460	Pulp Vitality Tests	Inclusive to oral evaluation Patient cannot be billed	$0	$0	$0
D0470	Diagnostic Casts		$0	$0	$0
D0472-D0474	Accession of Tissue		$0	$0	$0
D0475-D0502	Oral Pathology Laboratory Procedures	Not Covered	N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	Not Covered	N/C	N/C	N/C
D0601-D0603[2]	Caries Risk Assessment	Inclusive to oral evaluation	0	0	0
D0604	Antigen testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C
D0605	Antibody testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C
D0606	Molecular testing for a public health related pathogen including coronavirus	Not Covered	N/C	N/C	N/C
D0701	panoramic radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0330. FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0
D0702	2-D cephalometric radiographic image – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C
D0705	extra-oral posterior dental radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0251.	$0	$0	$0
D0706	intraoral – occlusal radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0240.	$0	$0	$0
D0707	intraoral – periapical radiographic image – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0220.	$0	$0	$0
D0708	intraoral – bitewing radiographic image – image capture only	Only eligible when submitted with D0391 Inclusive when submitted with D0270 1 series per year	$0	$0	$0
D0709	intraoral – complete series of radiographic images – image capture only	Only eligible when submitted with D0391. Inclusive when submitted with D0210. FMS or Panorex once every 3 years. (Frequency limit may be waived when done in connection with eligible Specialty Service)	$0	$0	$0
D0801	3D Intraoral Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C
D0802	3D Dental Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C
D0803	3D Facial Surface Scan – Direct	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C
D0804	3D Facial Surface Scan – Indirect	If done in conjunction with ortho, part of total case fee. Otherwise, not covered	N/C	N/C	N/C
D0999	Unspecified Diagnostic Procedure, by Report	Not Covered	N/C	N/C	N/C
D1110	Prophylaxis – Adult	Limited to 2 per year	$0	$0	$0
D1120	Prophylaxis – Child	Limited to 2 per year	$0	$0	$0
D1206	Topical Application of Fluoride Varnish	Pre Nov 2000 Plans (*) - No age or frequency limit DMO Standard Plans (#) – 1x per year for children under 16	$0	$0	$0
D1208	Topical Application of Fluoride – Excluding Varnish	Pre Nov 2000 Plans (*) - No age or frequency limit DMO Standard Plans (#) – 1x per year for children under 16	$0	$0	$0
D1301	Immunization Counseling	Not Covered	N/C	N/C	N/C

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D1310-D1321	Nutritional or Tobacco Counseling	Not Covered	N/C	N/C	N/C
D1330	Oral Hygiene Instruction		$0	$0	$0
D1351	Sealant – per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$5	$10	$0
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$5	$10	$0
D1353	Sealant Repair - per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to permanent molars and to covered persons under age 16 (not limited to dependent children).	$3	$5	$0
D1354	Application of Caries Arresting Medicament – per Tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$5	$10	$0
D1355	Caries preventive medicament application – per tooth	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years for permanent molars and to covered persons under age 16 (not limited to dependent children).	$4	$8	$0
D1510	Space Maintainer - Fixed, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion	$25	$60	$0
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion	$25	$60	$0
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion	$25	$60	$0
D1520	Space Maintainer - Removable, Unilateral - Per Quadrant	Includes all adjustments within 6 months after insertion	$25	$60	$0
D1526	Space Maintainer – Removable – Bilateral, Maxillary	Includes all adjustments within 6 months after insertion	$25	$60	$0
D1527	Space Maintainer – Removable – Bilateral, Mandibular	Includes all adjustments within 6 months after insertion	$25	$60	$0
D1551	Re-cement or re-bond bilateral space maintainer – maxillary		$10	$15	$12
D1552	Re-cement or re-bond bilateral space maintainer – mandibular		$10	$15	$12
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant		$5	$8	$6
D1556	Removal of fixed unilateral space maintainer – per quadrant		$5	$8	$6
D1557	Removal of fixed bilateral space maintainer – maxillary		$10	$15	$12
D1558	Removal of fixed bilateral space maintainer – mandibular		$10	$15	$12
D1575	Distal shoe space maintainer – fixed, unilateral - per quadrant		$28	$66	$0

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D1701 - D1714	Covid-19 vaccine administration	Not Covered	N/C	N/C	N/C
D1781 - D1783	Vaccine Administration – Human Papillomavirus	Not Covered	N/C	N/C	N/C
		Effective 11/1/2020 - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is considered part of the primary service done on the same day. Member cannot be charged. **Prior to 11/1/2020 - Personal Protective Equipment (PPE), aseptic technique, infection control, OSHA, biohazard disposal fee, barrier control and/or sterilization is not covered. The member will be responsible for the charge.**			
D1999	Unspecified Preventive Procedure, by Report	Not Covered	N/C	N/C	N/C
D2140	Amalgam – 1 Surface, Primary or Permanent		$0	$0	$0
D2150	Amalgam – 2 Surfaces, Primary or Permanent		$0	$0	$0
D2160	Amalgam – 3 Surfaces, Primary or Permanent		$0	$0	$0
D2161	Amalgam – 4+ Surfaces, Primary or Permanent		$0	$0	$0
D2330	Resin-Based Composite – 1 Surface, Anterior		$8	$20	$0
D2331	Resin-Based Composite – 2 Surfaces, Anterior		$8	$20	$0
D2332	Resin-Based Composite – 3 Surfaces, Anterior		$8	$20	$0
D2335	Resin-Based Composite – 4+ Surfaces or Involving Incisal Angle, Anterior		$20	$35	$0
D2390	Resin-Based Composite Crown, Anterior		$20	$35	$30
D2391	Resin-Based Composite – 1 Surface, Posterior		$20	$35	$30
D2392	Resin-Based Composite – 2 Surfaces, Posterior		$45	$75	$45
D2393	Resin-Based Composite – 3 Surfaces, Posterior		$50	$75	$55
D2394	Resin-Based Composite – 4+ Surfaces, Posterior		$60	$90	$70
D2410 - D2430	Gold Foil	Not Covered	N/C	N/C	N/C
		Crowns/Inlays Procedure Codes: **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Eligible for plan benefit when tooth cannot be restored with a filling. Plan benefit available for one crown once every 5 years per tooth.** **Facings on molar crowns and pontics will always be considered cosmetic.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)** **Additional $125.00 patient copayment per unit for treatment of 6 or more units of covered crown/bridge in the same treatment plan.**			
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. **The participating dentist is not permitted to bill the member for brand name materials.** **The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.**			
D2510	Inlay – Metallic - 1 Surface		$125	$175	$240
D2520	Inlay – Metallic - 2 Surfaces		$125	$175	$240
D2530	Inlay – Metallic - 3 or More Surfaces		$125	$175	$240

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D2542	Onlay – Metallic - 2 Surfaces		$120	$170	$250
D2543	Onlay – Metallic - 3 Surfaces		$120	$170	$250
D2544	Onlay - Metallic – 4 or More Surfaces		$120	$170	$250
D2610	Inlay, Porcelain/Ceramic – 1 Surface		$125	$175	$240
D2620	Inlay, Porcelain/Ceramic – 2 Surfaces		$125	$175	$240
D2630	Inlay, Porcelain/Ceramic – 3 or More Surfaces		$125	$175	$240
D2642	Onlay, Porcelain/Ceramic – 2 Surfaces		$120	$170	$250
D2643	Onlay, Porcelain/Ceramic – 3 Surfaces		$120	$170	$250
D2644	Onlay, Porcelain/Ceramic – 4 or More Surfaces		$120	$170	$250
D2650	Inlay, Resin Based Composite – 1 Surface		$125	$175	$240
D2651	Inlay, Resin Based Composite – 2 Surfaces		$125	$175	$240
D2652	Inlay, Resin Based Composite – 3 or more Surfaces		$125	$175	$240
D2662	Onlay, Resin Based Composite – 2 Surfaces		$120	$170	$250
D2663	Onlay, Resin Based Composite – 3 Surfaces		$120	$170	$250
D2664	Onlay, Resin Based Composite – 4 or More Surfaces		$120	$170	$250
D2710	Crown – Resin-Based Composite, Indirect		$125	$175	$250
D2712	Crown – 3/4 Resin-Based Composite, Indirect		$65	$95	$250
D2720	Crown – Resin with High Noble Metal		$125	$175	$250
D2721	Crown – Resin with Predominantly Base Metal		$125	$175	$250
D2722	Crown – Resin with Noble Metal		$125	$175	$250
D2740	Crown – Porcelain/ Ceramic		$125	$175	$250
D2750	Crown – Porcelain Fused to High Noble Metal		$125	$175	$250
D2751	Crown – Porcelain Fused to Predominantly Base Metal		$125	$175	$250
D2752	Crown – Porcelain Fused to Noble Metal		$125	$175	$250
D2753	Crown - porcelain fused to titanium and titanium alloys		$125	$175	$250
D2780	Crown – 3/4 Cast High Noble Metal		$125	$175	$250
D2781	Crown – 3/4 Cast Predominantly Base Metal		$125	$175	$250
D2782	Crown – 3/4 Cast Noble Metal		$125	$175	$250
D2783	Crown – 3/4 Cast Porcelain/Ceramic		$125	$175	$250
D2790	Crown – Full Cast High Noble Metal		$125	$175	$250
D2791	Crown – Full Cast Predominantly Base Metal		$125	$175	$250
D2792	Crown – Full Cast Noble Metal		$125	$175	$250
D2794	Crown – Titanium and Titanium Alloys		$125	$175	$250
D2799	Interim Crown – Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	$0	$0	$0
D2910	Re-cement Or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration		$5	$10	$0

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D2915	Re-Cement or Re-Bond Indirectly Fabricated or Prefabricated Post and Core		$5	$10	$0
D2920	Re-Cement or Re-Bond Crown		$5	$10	$0
D2921	Reattachment of Tooth Fragment, Incisal Edge or Cusp		$5	$5	$0
D2928	Prefabricated Porcelain/Ceramic Crown – Permanent Tooth	Inclusive in permanent crown fee when used as an interim restoration during the fabrication of the permanent restoration.	$0	$0	$0
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	Alternate benefit based on D2930	$20	$40	$0
D2930	Prefabricated Stainless Steel Crown – Primary Tooth		$20	$40	$0
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	When used as permanent crown, subject to crown frequency limit. Eligible as temp only when used as temp restoration until adult dentition is formed or when used due to accident away from home. Otherwise, temp is included in final restoration and not separately eligible.	$20	$40	$25
D2932	Prefabricated Resin Crown	Alternate benefit based on D2930 or D2931	$20	$40	$0 / $25
D2933	Prefabricated Stainless Steel Crown with Resin Window	Alternate benefit based on D2930 or D2931	$20	$40	$0 / $25
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	Alternate benefit based on D2930	$20	$40	$0
D2940	Placement of Interim Direct Restoration		$5	$15	$47
D2941	Interim Therapeutic Restoration – Primary Dentition		$0	$0	$21
D2949[2]	Restorative Foundation for an Indirect Restoration	Inclusive to permanent restoration	$0	$0	$0
D2950	Core Buildup, Including Any Pins When Required		$60	$90	$70
D2951	Pin Retention – Per Tooth, In Addition to Restoration		$10	$15	$14
D2952	Post & Core In Addition to Crown, Indirectly Fabricated		$30	$60	$55
D2953	Each Additional Indirectly Fabricated Post – Same Tooth		$30	$60	$55
D2954	Prefabricated Post & Core In Addition To Crown		$25	$40	$35
D2955	Post Removal	Included in cost of replacement post	$0	$0	$35
D2956	Removal of an Indirect Restoration on a Natural Tooth	Not to be used as a temporary or provisional restoration. Inclusive to any restorative service.	$0	$0	$0
D2957	Each Additional Prefabricated Post - Same Tooth		$25	$40	$70
D2960	Labial Veneer (Resin Laminate) – Chairside	Not Covered	N/C	N/C	N/C
D2961	Labial Veneer (Resin Laminate) – Laboratory	Not Covered	N/C	N/C	N/C
D2962	Labial Veneer (Porcelain Laminate) – Laboratory	Not Covered	N/C	N/C	N/C
D2971	Additional Procedures to Customize a Crown to Fit under an Existing Partial Denture Framework		$15	$20	$50
D2975	Coping	Not Covered	N/C	N/C	N/C
D2976	Band Stabilization – per Tooth	Not Covered	N/C	N/C	N/C
D2980	Crown Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C
D2981	Inlay Repair Necessitated by Restorative Material Failure	CAM	N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D2982	Onlay Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C
D2983	Veneer Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C
D2989	Excavation of a Tooth Resulting in the Determination of Non-restorability	Restorations, endodontics, and/or D4249 on same day/same tooth will be denied.	$0	$0	$0
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	Pre Nov 2000 DMO Fixed Dollar Copay plans (*) limited to children under age 15 (no frequency limit – not limited to Molars). DMO Standard Fixed Dollar Copay plans (#) limited to once every 3 years and to covered persons under age 16 (not limited to dependent children).	$5	$10	$0
D2991	Application of Hydroxyapatite Regeneration Medicament – per Tooth	One application per tooth, regardless of the number of appointments required to complete the full application. Once tooth application is completed, limited to once every 3 years for permanent teeth (1-32).	$8	$15	$0
D2999	Unspecified Restorative Procedure, by Report	Not Covered	N/C	N/C	N/C
D3110	Pulp Cap – Direct (Excluding Final Restoration)		$0	$0	$0
D3120	Pulp Cap – Indirect (Excluding Final Restoration)		$0	$0	$0
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	If done in conjunction with root canal therapy, included in cost of RCT	$5	$5	$0
D3221	Pulpal Debridement, Primary And Permanent Teeth	Considered inclusive with the Endodontic treatment when completed on the same day.	$10	$15	$14
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development		$10	$20	$50
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)		$15	$25	$0
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration)		$15	$25	$0
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)		$45	$75	$100
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)		$60	$105	$152
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)		$135	$180	$205
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access		$45	$75	$85
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth		$34	$56	$96
D3333	Internal Root Repair of Perforation Defects		$34	$56	$85
D3346	Retreatment of Previous Root Canal Therapy – Anterior		$80	$120	$175
D3347	Retreatment of Previous Root Canal Therapy – Premolar		$80	$120	$250
D3348	Retreatment of Previous Root Canal Therapy – Molar		$125	$175	$320
D3351	Apexification/Recalcification – Initial Visit	Not Covered	N/C	N/C	N/C

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D3352	Apexification/Recalcification – Interim Medication Replacement	Not Covered	N/C	N/C	N/C
D3353	Apexification/ Recalcification – Final Visit	Not Covered	N/C	N/C	N/C
D3355	Pulpal Regeneration - Initial Visit	Not Covered	N/C	N/C	N/C
D3356	Pulpal Regeneration – Interim Medication Replacement	Not Covered	N/C	N/C	N/C
D3357	Pulpal Regeneration – Completion of Treatment	Not Covered	N/C	N/C	N/C
D3410	Apicoectomy – Anterior		$55	$95	$95
D3421	Apicoectomy – Premolar (First Root)		$55	$95	$95
D3425	Apicoectomy – Molar (First Root)		$55	$95	$95
D3426	Apicoectomy – Each Additional Root		$55	$95	$60
D3428	Bone Graft In Conjunction With Periradicular Surgery - per Tooth, Single Site	Not Covered	N/C	N/C	N/C
D3429	Bone Graft in Conjunction with Periradicular Surgery - Each Additional Contiguous Tooth in the Same Surgical Site	Not Covered	N/C	N/C	N/C
D3430	Retrograde Filling – per Root		$30	$60	$60
D3431	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration in Conjunction With Periradicular Surgery	Not Covered	N/C	N/C	N/C
D3432	Guided Tissue Regeneration, Resorbable Barrier, per Site, In Conjunction with Periradicular Surgery	Not Covered	N/C	N/C	N/C
D3450	Root Amputation – per Root		$60	$90	$95
D3460	Endodontic Endosseous Implant	Not Covered	N/C	N/C	N/C
D3470	Intentional Re-Implantation (Including Necessary Splinting)	Not Covered	N/C	N/C	N/C
D3471	Surgical repair of root resorption - anterior		$0	$0	$43
D3472	Surgical repair of root resorption – premolar		$0	$0	$57
D3473	Surgical repair of root resorption – molar		$0	$0	$71
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior		$36	$54	$99
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar		$48	$72	$132
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar		$60	$90	$165
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	Not Covered	N/C	N/C	N/C
D3911	Intraorifice Barrier	Inclusive to root canals	$0	$0	$0
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	Not Covered	N/C	N/C	N/C
D3921	Decoronation or Submergence of an Erupted Tooth	Not Covered	N/C	N/C	N/C
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	If done in conjunction with root canal therapy, included in cost of RCT, unless performed by dentist other than who performed RCT or crown.	N/C	N/C	N/C
D3999	Unspecified Endodontic Procedure, by Report	Not Covered	N/C	N/C	N/C

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D4210	Gingivectomy or Gingivoplasty – 4 or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant	1 per quadrant every 3 years	$75	$120	$110
D4211	Gingivectomy or Gingivoplasty – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$20	$25	$83
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth	1 per quadrant every 3 years	$10	$15	$27
D4230	Anatomical Crown Exposure - 4 or More Contiguous Teeth per Quadrant	Not Covered	N/C	N/C	N/C
D4231	Anatomical Crown Exposure - 1 to 3 Teeth or Bounded Tooth Spaces per Quadrant	Not Covered	N/C	N/C	N/C
D4240	Gingival Flap Procedure, Including Root Planing – 4 or more Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$75	$120	$150
D4241	Gingival Flap Procedure, Including Root Planing – 1-3 Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$45	$75	$113
D4245	Apically Positioned Flap		$60	$90	$165
D4249	Clinical Crown Lengthening – Hard Tissue		$100	$200	$150
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap And Closure) – Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	1 per quadrant every 3 years	$150	$205	$300
D4261	Osseous Surgery (Including Elevation of a Full Thickness Flap And Closure) – One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant	1 per quadrant every 3 years	$100	$200	$225
D4263	Bone Replacement Graft – retained natural tooth - First Site in Quadrant	Not Covered	N/C	N/C	N/C
D4264	Bone Replacement Graft – retained natural tooth - Each Additional Site in Quadrant	Not Covered	N/C	N/C	N/C
D4265	Biologic Materials to Aid in Soft And Osseous Tissue Regeneration	Not Covered	N/C	N/C	N/C
D4266	Guided Tissue Regeneration – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C
D4267	Guided Tissue Regeneration – Non-Resorbable Barrier, per Site (Includes Membrane Removal)	Not Covered	N/C	N/C	N/C
D4268	Surgical Revision Procedure, per Tooth		$100	$100	$125
D4270	Pedicle Soft Tissue Graft Procedure		$105	$140	$240
D4273	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) First Tooth, Implant or Edentulous Tooth Position		$75	$75	$80
D4274	Mesial/Distal Wedge Procedure, Single Tooth (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area)	Not Covered	N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site and Donor Material) First Tooth, Implant, or Edentulous Tooth Position in Graft		$170	$210	$361
D4276	Combined Connective Tissue and Pedicle Graft, per Tooth		$75	$75	$240
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) First Tooth, Implant, or Edentulous Tooth Position in Graft		$165	$165	$120
D4278	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) Each Additional Contiguous Tooth, Implant, or Edentulous Tooth Position in Same Graft Site		$85	$85	$60
D4283	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		$41	$41	$44
D4285	Non Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site And Donor Material) – Each Additional Contiguous Tooth, Implant or Edentulous Tooth Position in Same Graft Site		$94	$116	$199
D4286	Removal of Non-resorbable Barrier	Inclusive with D7957 - Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	$0	$0	$0
D4322	Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C
D4323	Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns	Not Covered	N/C	N/C	N/C
D4341	Periodontal Scaling and Root Planing, 4 or More Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	$20	$35	$50
D4342	Periodontal Scaling and Root Planing – 1-3 Teeth per Quadrant	Pre Nov 2000 Plans (*) - Limited to 4 separate quadrants per year DMO Standard Plans (#) – Limited to 4 separate quadrants every 2 years	$10	$20	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		$18	$25	$8
D4355	Full Mouth Debridement to Enable Comprehensive Oral Evaluation and Diagnosis on a Subsequent Visit	Once per lifetime when covered under Aetna dental plans •D0150, D0160 and D0180 will be denied when performed on the same date of service as D4355. •D1110, D1120, D4341, D4342 and D4346 will be denied when performed on the same date of service as D4355.	$35	$50	$15
D4381	Localized Delivery of Antimicrobial Agents via a Controlled Release Vehicle Into Diseased Crevicular Tissue, per Tooth	Not Covered	N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
		Special Note for D4910: **Periodontal Maintenance Procedures are covered twice per year only when there is a history of periodontal surgery. (Effective 04/01/2023, D4341 and D4342 have been added to the DMO list of procedure codes that will allow for future D4910.) If there is no history of periodontal surgery, an allowance for D1110 applies, provided prophy frequency of 2 per year has not been met. Dentist may charge the difference between their Usual and Customary fees for D1110 and D4910.** **If the prophy frequency has been met or there has been a combination of any two D1110 or D4910 done, then the procedure is not covered. The patient is responsible for the dentist's Usual and Customary fee for the service.**			
D4910	Periodontal Maintenance	(See Special Note above)	$20	$30	$30
D4920	Unscheduled Dressing Change (by Someone Other than Treating Dentist or Their Staff)		$10	$10	$10
D4921	Gingival Irrigation – per Quadrant	Not Covered	N/C	N/C	N/C
		Special Note for D4999: **Laser may not be submitted as D4999. The use of laser is not a procedure in and of itself; therefore, the patient may not be charged separately for this. Laser is considered inclusive with the service performed.**			
D4999	Unspecified Periodontal Procedure, by Report	Not Covered	N/C	N/C	N/C
		Removable Prosthetic Codes **Effective 1/1/2024, the "initial placement rule" is removed.** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **Prior to 1/1/2024** - Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does not apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. **Note – Benefit includes all adjustments, relines and rebases occurring within 6 months of insertion (exception D5130 & D5140).** **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.**			
D5110	Complete Denture – Maxillary		$125	$175	$390
D5120	Complete Denture – Mandibular		$125	$175	$390
D5130	Immediate Denture – Maxillary	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$155	$200	$410
D5140	Immediate Denture – Mandibular	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$155	$200	$410
D5211	Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		$125	$175	$390
D5212	Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)		$125	$175	$390
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		$155	$200	$410
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)		$155	$200	$410
D5221	Immediate Maxillary Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$144	$201	$449

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D5222	Immediate Mandibular Partial Denture – Resin Base (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$144	$201	$449
D5223	Immediate Maxillary Partial Denture – Cast Metal Framework With Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$178	$230	$472
D5224	Immediate Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (Including Retentive/Clasping Materials, Rests and Teeth)	Relines/Rebases are separately eligible within 6 Months of placement of the Immediate Denture	$178	$230	$472
D5225	Maxillary Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		$150	$175	$394
D5226	Mandibular Partial Denture – Flexible Base (Including any Clasps, Rests and Teeth)		$150	$175	$394
D5227	Immediate Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)		$150	$175	$394
D5228	Immediate Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)		$150	$175	$394
D5282	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), maxillary		$125	$175	$390
D5283	removable unilateral partial denture one piece cast metal (Including Retentive/Clasping Materials, Rests, and Teeth), mandibular		$125	$175	$390
D5284	Removable unilateral partial denture – one-piece flexible base (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		$75	$88	$197
D5286	Removable unilateral partial denture – one-piece resin (Including Retentive/Clasping Materials, Rests, and Teeth) – per quadrant		$63	$88	$195
D5410	Adjust Complete Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	$10	$15	$10
D5411	Adjust Complete Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	$10	$15	$10
D5421	Adjust Partial Denture – Maxillary	Fee for Denture to include all adjustments performed within 6 months of insertion	$10	$15	$10
D5422	Adjust Partial Denture – Mandibular	Fee for Denture to include all adjustments performed within 6 months of insertion	$10	$15	$10
D5511	Repair Broken Complete Denture Base, Mandibular		$20	$30	$40
D5512	Repair Broken Complete Denture Base, Maxillary		$20	$30	$40
D5520	Replace Missing or Broken Teeth – Complete Denture - per Tooth		$15	$25	$40
D5611	Repair Resin Partial Denture Base, Mandibular		$20	$30	$40
D5612	Repair Resin Partial Denture Base, Maxillary		$20	$30	$40
D5621	Repair Cast Partial Framework, Mandibular		$20	$30	$40
D5622	Repair Cast Partial Framework, Maxillary		$20	$30	$40

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D5630	Repair or Replace Broken Retentive/Clasping Materials - per Tooth		$20	$30	$40
D5640	Replace Missing or Broken Teeth – Partial Denture - per Tooth		$15	$25	$40
D5650	Add Tooth to Existing Partial Denture - per Tooth		$20	$30	$40
D5660	Add Clasp to Existing Partial Denture - per Tooth		$20	$30	$40
D5670 - D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary or Mandibular)		$125	$175	$160
D5710 - D5711	Rebase Complete Maxillary or Mandibular Denture	Includes all adjustments within 6 months after insertion	$50	$95	$160
D5720 - D5721	Rebase Maxillary or Mandibular Partial Denture	Includes all adjustments within 6 months after insertion	$50	$95	$160
D5725	Rebase Hybrid Prosthesis		$50	$95	$160
D5730	Reline Complete Maxillary Denture (Direct)	Includes all adjustments within 6 months after insertion	$20	$40	$60
D5731	Reline Complete Mandibular Denture (Direct)	Includes all adjustments within 6 months after insertion	$20	$40	$60
D5740	Reline Maxillary Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	$20	$40	$60
D5741	Reline Mandibular Partial Denture (Direct)	Includes all adjustments within 6 months after insertion	$20	$40	$60
D5750	Reline Complete Maxillary Denture (Indirect)	Includes all adjustments within 6 months after insertion	$40	$50	$90
D5751	Reline Complete Mandibular Denture (Indirect)	Includes all adjustments within 6 months after insertion	$40	$50	$90
D5760	Reline Maxillary Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	$40	$50	$90
D5761	Reline Mandibular Partial Denture (Indirect)	Includes all adjustments within 6 months after insertion	$40	$50	$90
D5765	Soft Liner for Complete or Partial Removable Denture – Indirect		$40	$50	$90
D5810 - D5811	Interim Complete Denture (Maxillary or Mandibular)	Plan benefit and patient copay for permanent to include all interim Provisional charges	$0	$0	$0
D5820	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Maxillary	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	$70	$100	$90
D5821	Interim Partial Denture (Including Retentive/Clasping Materials, Rests and Teeth), Mandibular	Plan benefit and patient copay for permanent to include all interim provisional charges. Exception - separately eligible if replacing anteriors – not subject to frequency limit.	$70	$100	$90
D5850 - D5851	Tissue Conditioning, Maxillary or Mandibular	Inclusive with prosthesis within 6 months after insertion	$15	$25	$25
D5862	Precision Attachment, by Report	Not Covered	N/C	N/C	N/C
D5863	Overdenture – Complete Maxillary	Not covered – Alternate benefit based on D5110	$125	$175	$250
D5864	Overdenture – Partial Maxillary	Not covered – Alternate benefit based on D5211	$125	$175	$250
D5865	Overdenture – Complete Mandibular	Not covered – Alternate benefit based on D5120	$125	$175	$250
D5866	Overdenture – Partial Mandibular	Not covered – Alternate benefit based on D5212	$125	$175	$250
D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (Male or Female Component)	Not Covered	N/C	N/C	N/C
D5875	Modification of Removable Prosthesis Following Implant Surgery	Not Covered	N/C	N/C	N/C
D5876	Add Metal Substructure to Acrylic Full Denture (per Arch)		$20	$30	$40

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D5899	Unspecified Removable Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C
D5911 - D5993	Maxillofacial Prosthetics	Not Covered	N/C	N/C	N/C
D5994	Periodontal Medicament Carrier with Peripheral Seal – Laboratory Processed	Not Covered	N/C	N/C	N/C
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not Covered	N/C	N/C	N/C
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	Not Covered	N/C	N/C	N/C
D5999	Unspecified Maxillofacial Prosthesis, by Report	Not Covered	N/C	N/C	N/C
		Fixed Prosthetic Codes **Date of Service - the work is considered completed on the actual date the crown/denture/bridge is received by the patient.** **Effective 1/1/2024, the "initial placement rule" is removed.** Eligible for plan benefit for an initial placement or the replacement of an existing prosthesis that is over 5 years old. **Prior to 1/1/2024** - Eligible for Plan benefit if replacing teeth extracted while covered under the plan (initial placement rule does not apply in California, Texas or Plan Code -LM) or is a replacement of an existing prosthesis that is over 5 years old. **Facings on molars are not covered.** **No lab fees may be charged to the patient.** **DMO Standard Plans (New Standard Plans) - Roster Plan Code symbol indicated by a number sign (#) - These plans exclude crowns or pontics made with high noble metals or titanium. Metal upgrade is permitted on these plans. (Refer to Section IV - Examples of Optional Treatment Plans)** **Additional $125 patient copayment per unit for treatment of 6 or more units of covered crown/bridge in the same treatment plan.**			
		NOTE: Brand Name crown materials (e.g. Zirconia, Captek, Lava, Cerec, ProCeram, Empress, Cercon, Wol-Ceram, etc.) are not considered to be enhanced techniques. The participating dentist is not permitted to bill the member for brand name materials. The dentist is permitted to charge the applicable copayment based on the ADA crown procedure code.			
D6010	Surgical Placement of Implant Body: Endosteal Implant	Not Covered Member Copay Change for i Plans Effective 04/01/2016	N/C $1,375[4] $1,215[5]	N/C $1,375[4] $1,215[5]	N/C $1,375[4] $1,215[5]
D6011	Second Stage Implant Surgery	Not covered unless plan covers implants. For plans covering implants, this is inclusive to surgical placement of implant.	N/C $0	N/C $0	N/C $0
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant	Not Covered	N/C	N/C	N/C
D6013	Surgical Placement of Mini Implant	Not covered unless plan covers implants.	N/C $756	N/C $756	N/C $756
D6040	Surgical Placement: Eposteal Implant	Not Covered	N/C	N/C	N/C
D6050	Surgical Placement: Transosteal Implant	Not Covered	N/C	N/C	N/C
D6051	Placement of Interim Implant Abutment	For plans covering implants, plan benefit and patient copay for permanent restoration includes all interim charges.	$0	$0	$0
D6052	Semi-Precision Attachment Abutment	Not Covered	N/C	N/C	N/C
D6055	Connecting Bar - Implant Supported or Abutment Supported	Not Covered	N/C	N/C	N/C
D6056	Prefabricated Abutment - Includes Modification and Placement	Not Covered Member Copay Change for i Plans Effective 04/01/2016	N/C $785[4] $440[5]	N/C $785[4] $440[5]	N/C $785[4] $440[5]
D6057	Custom Fabricated Abutment – Includes Placement	Not Covered	N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D6058	Abutment Supported Porcelain/Ceramic Crown		$200	$200	$250
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)		$200	$200	$250
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)		$200	$200	$250
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)		$200	$200	$250
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)		$200	$200	$250
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)		$200	$200	$250
D6064	Abutment Supported Cast Metal Crown (Noble Metal)		$200	$200	$250
D6065	Implant Supported Porcelain/Ceramic Crown		$200	$200	$250
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		$200	$200	$250
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)		$200	$200	$250
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD		$200	$200	$250
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)		$200	$200	$250
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)		$200	$200	$250
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)		$200	$200	$250
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)		$200	$200	$250
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)		$200	$200	$250
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)		$200	$200	$250
D6075	Implant Supported Retainer for Ceramic FPD		$200	$200	$250
D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		$200	$200	$250
D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy or High Noble Metal)		$200	$200	$250
D6080	Implant Maintenance Procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments		N/C $88	N/C $88	N/C $88
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths: includes cleaning of the implant surfaces, without flap entry and closure		N/C $5	N/C $10	N/C $15

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D6082	Implant supported crown – porcelain fused to predominantly base alloys		$200	$200	$250
D6083	Implant supported crown – porcelain fused to noble alloys		$200	$200	$250
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys		$125	$175	$250
D6085	Provisional implant crown		N/C	N/C	N/C
D6086	Implant supported crown – predominantly base alloys		$200	$200	$250
D6087	Implant supported crown – noble alloys		$200	$200	$250
D6088	Implant supported crown – titanium and titanium alloys		$200	$200	$250
D6089	Accessing and Retorquing Loose Implant Screw - per Screw	Not Covered	N/C	N/C	N/C
D6090	Repair of Implant/Abutment Supported Prosthesis	Not Covered	N/C	N/C	N/C
D6091	Replacement of Semi-Precision or Precision Attachment of Implant/Abutment Supported Prosthesis, per Attachment	Not Covered	N/C	N/C	N/C
D6092	Re-cement Or Re-bond Implant/Abutment Supported Crown		$40	$60	$25
D6093	Re-cement Or Re-bond Implant/Abutment Supported Fixed Partial Denture		$40	$60	$25
D6094	Abutment Supported Crown (Titanium)		$200	$200	$250
D6095	Repair Implant Abutment, by Report	Not Covered	N/C	N/C	N/C
D6096	Remove Broken Implant Retaining Screw	Not Covered	N/C	N/C	N/C
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys		$125	$175	$250
D6098	Implant supported retainer – porcelain fused to predominantly base alloys		$200	$200	$250
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys		$200	$200	$250
D6100	Implant Removal, by Report	Not Covered	N/C	N/C	N/C
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	Not Covered	N/C	N/C	N/C
D6102	Debridement and osseous contouring of a periimplant defect: includes surface cleaning of exposed implant surfaces and flap entry and closure	Not Covered	N/C	N/C	N/C
D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	Not Covered	N/C	N/C	N/C
D6104	Bone graft at time of implant placement		N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D6105	Removal of Implant Body not Requiring Bone Removal or Flap Elevation	Not Covered	N/C	N/C	N/C
D6106	Guided Rissue Regeneration – Resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C
D6107	Guided Rissue Regeneration – Non-resorbable Barrier, per Implant	Not Covered	N/C	N/C	N/C
D6110	Implant /Abutment Supported Removable Denture for Edentulous Arch – Maxillary	Member Copay Change 1st Copay - Thru 01/31/2020 2nd Copay - Eff 02/01/2020	$200 $125	$200 $175	$250
D6111	Implant /Abutment Supported Removable Denture for Edentulous Arch – Mandibular	Member Copay Change 1st Copay - Thru 01/31/2020 2nd Copay - Eff 02/01/2020	$200 $125	$200 $175	$250
D6112	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Maxillary	Member Copay Change 1st Copay - Thru 01/31/2020 2nd Copay - Eff 02/01/2020	$200 $125	$200 $175	$250
D6113	Implant /Abutment Supported Removable Denture for Partially Edentulous Arch – Mandibular	Member Copay Change 1st Copay - Thru 01/31/2020 2nd Copay - Eff 02/01/2020	$200 $125	$200 $175	$250
D6114	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Maxillary		$125	$175	$250
D6115	Implant /Abutment Supported Fixed Denture for Edentulous Arch – Mandibular		$125	$175	$250
D6116	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Maxillary		$125	$175	$250
D6117	Implant /Abutment Supported Fixed Denture for Partially Edentulous Arch – Mandibular		$125	$175	$250
D6118	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Mandibular	Not Covered	N/C	N/C	N/C
D6119	Implant/Abutment Supported Interim Fixed Denture For Edentulous Arch – Maxillary	Not Covered	N/C	N/C	N/C
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		$125	$175	$250
D6121	Implant supported retainer for metal FPD – predominantly base alloys		$200	$200	$250
D6122	Implant supported retainer for metal FPD – noble alloys		$200	$200	$250
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		$200	$200	$250
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	This procedure includes active debriding of the implant(s) and prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s). Only covered if Plan has implant coverage.	N/C $22	N/C $22	N/C $22
D6190	Radiographic / Surgical Implant Index, by Report	Not Covered	N/C	N/C	N/C
D6191	Semi-precision abutment – placement	Not Covered	N/C	N/C	N/C
D6192	Semi-precision attachment – placement	Not Covered	N/C	N/C	N/C
D6193	Replacement of an Implant Screw	If D6193 is eligible, D6096 on same day is inclusive (not separately eligible).	N/C	N/C	N/C
D6194	Abutment Supported Retainer Crown for FPD (Titanium)		$200	$200	$250
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys		$125	$175	$250

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# DMO Standard Plan

Dental Procedure Guidelines
for DMO Primary Care Dentists

ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D6197	Replacement of Restorative Material Used to Close an Access Opening of a Screw-retained Implant Supported Prosthesis, per Implant		$20	$35	$30
D6198	Remove Interim Implant Component	Inclusive to permanent restoration	$0	$0	$0
D6199	Unspecified Implant Procedure, by Report	Not Covered	N/C	N/C	N/C
D6205	Pontic – Indirect Resin Based Composite		$125	$175	$250
D6210	Pontic – Cast High Noble Metal		$125	$175	$250
D6211	Pontic – Cast Predominantly Base Metal		$125	$175	$250
D6212	Pontic – Cast Noble Metal		$125	$175	$250
D6214	Pontic – Titanium		$125	$175	$250
D6240	Pontic – Porcelain Fused to High Noble Metal		$125	$175	$250
D6241	Pontic – Porcelain Fused to Predominantly Base Metal		$125	$175	$250
D6242	Pontic – Porcelain Fused to Noble Metal		$125	$175	$250
D6243	Pontic – porcelain fused to titanium and titanium alloys		$125	$175	$250
D6245	Pontic – Porcelain/Ceramic		$125	$175	$250
D6250	Pontic – Resin with High Noble Metal		$125	$175	$250
D6251	Pontic – Resin with Predominantly Base Metal		$125	$175	$250
D6252	Pontic – Resin with Noble Metal		$125	$175	$250
D6253	Provisional Pontic– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan benefit and patient copay for permanent to include all provisional charges	$0	$0	$0
D6545	Retainer – Cast Metal for Resin-Bonded Fixed Prosthesis		$125	$175	$240
D6548	Retainer – Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis		$125	$175	$240
D6549	Resin Retainer – for Resin Bonded Fixed Prosthesis		$63	$88	$125
D6600	Retainer Inlay – Porcelain/Ceramic, 2 Surfaces		$125	$175	$240
D6601	Retainer Inlay – Porcelain/Ceramic, 3 or More Surfaces		$125	$175	$240
D6602	Retainer Inlay – Cast High Noble Metal, 2 Surfaces		$115	$160	$240
D6603	Retainer Inlay – Cast High Noble Metal, 3 or More Surfaces		$115	$160	$240
D6604	Retainer Inlay – Cast Predominantly Base Metal, 2 Surfaces		$125	$175	$240
D6605	Retainer Inlay – Cast Predominantly Base Metal, 3 or More Surfaces		$125	$175	$240
D6606	Retainer Inlay – Cast Noble Metal, 2 Surfaces		$125	$175	$240
D6607	Retainer Inlay – Cast Noble Metal, 3 or More Surfaces		$125	$175	$240
D6608	Retainer Onlay – Porcelain/Ceramic, 2 Surfaces		$120	$170	$250
D6609	Retainer Onlay – Porcelain/Ceramic, 3 or More Surfaces		$120	$170	$250
D6610	Retainer Onlay – Cast High Noble Metal, 2 Surfaces		$120	$160	$240

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# DMO Standard Plan

Dental Procedure Guidelines
for DMO Primary Care Dentists

ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D6611	Retainer Onlay – Cast High Noble Metal, 3 or More Surfaces		$120	$160	$240
D6612	Retainer Onlay – Cast Predominantly Base Metal, 2 Surfaces		$120	$170	$250
D6613	Retainer Onlay – Cast Predominantly Base Metal, 3 or More Surfaces		$120	$170	$250
D6614	Retainer Onlay – Cast Noble Metal, 2 Surfaces		$115	$160	$240
D6615	Retainer Onlay – Cast Noble Metal, 3 or More Surfaces		$115	$160	$240
D6624	Retainer Inlay – Titanium		$115	$160	$240
D6634	Retainer Onlay – Titanium		$120	$170	$240
D6710	Retainer Crown – Indirect Resin Based Composite		$125	$175	$250
D6720	Retainer Crown – Resin with High Noble Metal		$125	$175	$250
D6721	Retainer Crown – Resin with Predominantly Base Metal		$125	$175	$250
D6722	Retainer Crown – Resin with Noble Metal		$125	$175	$250
D6740	Retainer Crown – Porcelain/Ceramic		$125	$175	$250
D6750	Retainer Crown – Porcelain Fused to High Noble Metal		$125	$175	$250
D6751	Retainer Crown – Porcelain Fused to Predominantly Base Metal		$125	$175	$250
D6752	Retainer Crown – Porcelain Fused to Noble Metal		$125	$175	$250
D6753	Retainer crown – porcelain fused to titanium and titanium alloys		$125	$175	$250
D6780	Retainer Crown – 3/4 Cast High Noble Metal		$125	$175	$250
D6781	Retainer Crown – 3/4 Cast Predominantly Based Metal		$125	$175	$250
D6782	Retainer Crown – 3/4 Cast Noble Metal		$125	$175	$250
D6783	Retainer Crown – 3/4 Porcelain/Ceramic		$125	$175	$250
D6784	Retainer crown 3/4 – titanium and titanium alloys		$125	$175	$250
D6790	Retainer Crown – Full Cast High Noble Metal		$125	$175	$250
D6791	Retainer Crown – Full Cast Predominantly Base Metal		$125	$175	$250
D6792	Retainer Crown – Full Cast Noble Metal		$125	$175	$250
D6793	Provisional Retainer Crown– Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression	Plan benefits and patient copay for permanent to include all provisional charges.	$0	$0	$0
D6794	Retainer Crown – Titanium		$125	$175	$250
D6920	Connector Bar	Not Covered	N/C	N/C	N/C
D6930	Re-cement or Re-bond Fixed Partial Denture		$20	$45	$0
D6940	Stress Breaker	Not Covered	N/C	N/C	N/C
D6950	Precision Attachment	Not Covered	N/C	N/C	N/C
D6980	Fixed Partial Denture Repair Necessitated by Restorative Material Failure	Not Covered	N/C	N/C	N/C
D6985	Pediatric Partial Denture, Fixed	Eligible for anterior teeth. Not Covered for teeth other than anterior.	$70	$100	$100
D6999	Unspecified Fixed Prosthodontic Procedure, by Report	Not Covered	N/C	N/C	N/C

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# DMO Standard Plan

Dental Procedure Guidelines
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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D7111	Extraction, Coronal Remnants – Primary Tooth	Includes extractions for orthodontic purposes.	$5	$10	$0
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	Includes extractions for orthodontic purposes.	$5	$10	$0
D7210	Extraction, Erupted Tooth Requiring Removal of Bone and/or Sectioning of Tooth and Including Elevation of Mucoperiosteal Flap if Indicated	Includes extractions for orthodontic purposes.	$10	$20	$0
D7220	Removal of Impacted Tooth – Soft Tissue	Includes extractions for orthodontic purposes.	$20	$40	$0
D7230	Removal of Impacted Tooth – Partially Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$45	$75	$65
D7240	Removal of Impacted Tooth – Completely Bony	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$60	$90	$75
D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$60	$90	$90
D7250	Removal of Residual Tooth Roots (Cutting Procedure)		$20	$45	$40
D7251	Coronectomy - Intentional Partial Tooth Removal	Extraction of asymptomatic 3rd molars (including those solely for orthodontic purposes) are not covered	$20	$30	$8
D7252	Partial Extraction for Immediate Implant Placement		N/C	N/C	N/C
D7259	Nerve Dissection		N/C	N/C	N/C
D7260	Oroantral Fistula Closure	Not Covered	N/C	N/C	N/C
D7261	Primary Closure of a Sinus Perforation	Not Covered	N/C	N/C	N/C
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	Not Covered	N/C	N/C	N/C
D7272	Tooth Transplantation (Includes Reimplantation from One Site to Another & Splinting and/or Stabilization)	Not Covered	N/C	N/C	N/C
D7280	Exposure of an Unerupted Tooth		$25	$40	$100
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption		$20	$25	$90
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth		$10	$10	$90
D7284	Excisional Biopsy of Minor Salivary Glands		$53	$75	$83
D7285	Incisional Biopsy of Oral Tissue – Hard (Bone, Tooth)		$35	$50	$145
D7286	Incisional Biopsy of Oral Tissue – Soft		$35	$50	$55
D7287	Exfoliative Cytological Sample Collection		$15	$25	$45
D7288	Brush Biopsy – Transepithelial Sample Collection	Not Covered	N/C	N/C	N/C
D7290	Surgical Repositioning of Teeth	Not Covered	N/C	N/C	N/C
D7291	Transseptal Fiberotomy/ Supra Crestal Fiberotomy, By Report	Not Covered	N/C	N/C	N/C
D7292	Placement of Temporary Anchorage Device [Screw Retained Plate] Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C
D7293	Placement of Temporary Anchorage Device Requiring Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C

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# DMO Standard Plan

Dental Procedure Guidelines
for DMO Primary Care Dentists

ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D7294	Placement of Temporary Anchorage Device Without Flap; Includes Device Removal	Not Covered	N/C	N/C	N/C
D7295	Harvest of Bone for Use in Autogenous Grafting Procedures	Not Covered	N/C	N/C	N/C
D7296	Corticotomy - One to Three Teeth or Tooth Spaces, per Quadrant	Not Covered	N/C	N/C	N/C
D7297	Corticotomy – Four or More Teeth or Tooth Spaces, per Quadrant	Not Covered	N/C	N/C	N/C
D7298	Removal of Temporary Anchorage Device [Screw Retained Plate], Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0
D7299	Removal of Temporary Anchorage Device, Requiring Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0
D7300	Removal of Temporary Anchorage Device Without Flap	Inclusive to placement of temporary anchorage device (D7292, D7293 & D7294)	$0	$0	$0
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	$30	$50	$40
D7311	Alveoloplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		$20	$35	$10
D7320	Alveoloplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces, per Quadrant	Benefit per 4 or more teeth in the same quadrant	$20	$50	$60
D7321	Alveoloplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces, per Quadrant		$20	$35	$25
D7340	Vestibuloplasty – Ridge Extension (Secondary Epithelialization)	Not Covered	N/C	N/C	N/C
D7350	Vestibuloplasty – Ridge Extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Not Covered	N/C	N/C	N/C
D7410	Excision of Benign Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C
D7411	Excision of Benign Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C
D7412	Excision of Benign Lesion, Complicated	Not Covered	N/C	N/C	N/C
D7413	Excision of Malignant Lesion – up to 1.25 cm	Not Covered	N/C	N/C	N/C
D7414	Excision of Malignant Lesion – Greater than 1.25 cm	Not Covered	N/C	N/C	N/C
D7415	Excision of Malignant Lesion, Complicated	Not Covered	N/C	N/C	N/C
D7440	Excision Malignant Tumor - Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C
D7441	Excision Malignant Tumor Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C
D7450	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C
D7451	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C
D7460	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm	Not Covered	N/C	N/C	N/C

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# DMO Standard Plan

Dental Procedure Guidelines
for DMO Primary Care Dentists

ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D7461	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter greater than 1.25 cm	Not Covered	N/C	N/C	N/C
D7465	Destruction of Lesion(s) by Physical or Chemical Method, by Report	Not Covered	N/C	N/C	N/C
D7471	Removal of Lateral Exostosis (Maxilla or Mandible)	Not Covered	N/C	N/C	N/C
D7472	Removal of Torus Palatinus	Not Covered	N/C	N/C	N/C
D7473	Removal of Torus Mandibularis	Not Covered	N/C	N/C	N/C
D7485	Reduction of Osseous Tuberosity	Not Covered	N/C	N/C	N/C
D7490	Radical Resection of Maxilla or Mandible	Not Covered	N/C	N/C	N/C
D7509	Marsupialization of Odontogenic Cyst	Not Covered	N/C	N/C	N/C
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue		$10	$20	$35
D7511	Incision and Drainage of Abscess – Intraoral Soft Tissue - Complicated		$40	$60	$35
D7520	Incision and Drainage of Abscess – Extraoral Soft Tissue	Not Covered	N/C	N/C	N/C
D7521	Incision and Drainage of Abscess – Extraoral Soft Tissue - Complicated	Not Covered	N/C	N/C	N/C
D7530	Removal of Foreign Body from Mucosa, Skin or Subcutaneous Alveolar Tissue	Not Covered	N/C	N/C	N/C
D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System	Not Covered	N/C	N/C	N/C
D7550	Partial Ostectomy/ Sequestrectomy for Removal of Non-Vital Bone	Not Covered	N/C	N/C	N/C
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	Not Covered	N/C	N/C	N/C
D7610-D7820	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C
D7830	Manipulation Under Anesthesia	Not Covered	N/C	N/C	N/C
D7840-D7870	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C
D7871	Non-Arthroscopic Lysis and Lavage	Not Covered	N/C	N/C	N/C
D7872-D7877	Fractures/TMJD codes	Not Covered	N/C	N/C	N/C
D7880	Occlusal Orthotic Device, by Report	Not Covered	N/C	N/C	N/C
D7881	Occlusal Orthotic Device Adjustment	Not Covered	N/C	N/C	N/C
D7899	Unspecified TMD Therapy, by Report	Not Covered	N/C	N/C	N/C
D7910	Suture of Recent Small Wound up to 5 cm	Not Covered	N/C	N/C	N/C
D7911	Complicated Suture - Up to 5 cm	Not Covered	N/C	N/C	N/C
D7912	Complicated Suture - greater than 5 cm	Not Covered	N/C	N/C	N/C
D7920-D7921	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Inclusive to the extraction Patient cannot be billed	$0	$0	$0
D7939	Indexing for Osteotomy using Dynamic Robotic Assisted or Dynamic Navigation	Not Covered	N/C	N/C	N/C
D7940-D7952	Other Surgical Repair Codes	Not Covered	N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D7953	Bone Replacement Graft for Ridge Preservation – Per Site	Not Covered	N/C	N/C	N/C
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect	Not Covered	N/C	N/C	N/C
D7956	Guided Tissue Regeneration, Edentulous Area – Resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C
D7957	Guided Tissue Regeneration, Edentulous Area – Non-resorbable Barrier, per Site	Not Covered	N/C	N/C	N/C
D7961	Buccal / labial frenectomy (frenulectomy)		$30	$50	$50
D7962	Lingual frenectomy (frenulectomy)		$30	$50	$50
D7963	Frenuloplasty		$20	$50	$50
D7970	Excision of Hyperplastic Tissue – Per Arch	Not Covered	N/C	N/C	N/C
D7971	Excision of Pericoronal Gingiva	Not Covered	N/C	N/C	N/C
D7972	Surgical Reduction of Fibrous Tuberosity	Not Covered	N/C	N/C	N/C
D7979	Non-Surgical Sialolithotomy	Not Covered	N/C	N/C	N/C
D7980	Surgical Sialolithotomy	Not Covered	N/C	N/C	N/C
D7981	Excision Of Salivary Gland, By Report	Not Covered	N/C	N/C	N/C
D7982	Sialodochoplasty	Not Covered	N/C	N/C	N/C
D7983	Closure of Salivary Fistula	Not Covered	N/C	N/C	N/C
D7990-D7998	Other Surgical Procedures	Not Covered	N/C	N/C	N/C
D7999	Unspecified Oral Surgery Procedure, By Report	Not Covered	N/C	N/C	N/C
D8210	Removable Appliance Therapy	Not Covered	N/C	N/C	N/C
D8220	Fixed Appliance Therapy	Not Covered	N/C	N/C	N/C
D8695	Removal of Fixed Orthodontic Appliances for Reasons other than Completion of Treatment	Not Covered	N/C	N/C	N/C
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	Inclusive when performed on the same date of service as definitive treatment; member cannot be billed. Definitive treatment is the treatment which resolves the pain permanently - this is the final measure taken to eliminate the pain.	$10	$15	$10
D9120	Fixed Partial Denture Sectioning	Not Covered	N/C	N/C	N/C
D9130	Temporomandibular Joint Dysfunction – Non-invasive physical Therapies	Not Covered	N/C	N/C	N/C
D9210	Local Anesthesia, Not in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	$0	$0	$0
D9211	Regional Block Anesthesia	Included in cost of underlying procedure	$0	$0	$0
D9212	Trigeminal Division Block Anesthesia	Not Covered	N/C	N/C	N/C
D9215	Local Anesthesia in Conjunction with Operative or Surgical Procedures	May not charge patient for local anesthesia delivered in conjunction with a covered procedure	$0	$0	$0
D9219[3]	Evaluation For Moderate Sedation, Deep Sedation or General Anesthesia	When rendered by anesthesiologist	$0	$0	$0
D9222	Deep Sedation/General Anesthesia – First 15 Minutes		$100	$104	$94
D9223	Deep Sedation/General Anesthesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	$80	$83	$75

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	Not Covered	N/C	N/C	N/C
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia – First 15 Minutes		$100	$104	$94
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each Subsequent 15 Minute Increment	Covered for certain procedures and clinical conditions	$80	$83	$75
D9248	Non-Intravenous Conscious Sedation	Not Covered	N/C	N/C	N/C
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician	For Second Opinions only	$5	$10	$0
D9311	Consultation with a medical health care professional		$5	$10	$0
D9410	House/Extended Care Facility Call	Not Covered	N/C	N/C	N/C
D9420	Hospital or Ambulatory Surgical Center Call	Not Covered	N/C	N/C	N/C
D9430	Office Visit for Observation (During Regularly Scheduled Hours) – No Other Services Performed	Included in cost of underlying procedure	$0	$0	$0
D9440	Office Visit - After Regularly Scheduled Hours	Not Covered (Covered in Texas)	N/C (0)	N/C (0)	N/C (0)
D9450	Case Presentation, Detailed and Extensive Treatment Planning	Included in cost of underlying procedure	$0	$0	$0
D9610	Therapeutic Parenteral Drug, Single Administration	Not Covered	N/C	N/C	N/C
D9612	Therapeutic Parenteral Drugs, 2 or more Administrations, Different Medications	Not Covered	N/C	N/C	N/C
D9613	Infiltration of Sustained Release Therapeutic Drug	Eligible when performed in conjunction with procedure codes D7220, D7230, D7240, D7241, or D7251 on third molars (teeth #'s 01, 16, 17, or 32).	$0	$0	$0
D9630	Drugs or Medicaments dispensed in the office for home use	Not Covered	N/C	N/C	N/C
D9910	Application of Desensitizing Medicament	Inclusive with the restoration being performed on the same date of service; member cannot be billed.	$0	$0	$0
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, per Tooth	Not Covered	N/C	N/C	N/C
D9912	Pre-visit Patient Screening	Inclusive with record keeping requirements	$0	$0	$0
D9913	Administration of Neuromodulators		N/C	N/C	N/C
D9914	Administration of Dermal Fillers		N/C	N/C	N/C
D9920	Behavior Management, by Report	Not Covered	N/C	N/C	N/C
D9930	Treatment of Complications (Post-surgical) – Unusual Circumstances, by Report	Included in cost of underlying procedure	$0	$0	$0
D9932	Cleaning and Inspection of Removable Complete Denture, Maxillary		$25	$25	$25
D9933	Cleaning and Inspection of Removable Complete Denture, Mandibular		$25	$25	$25
D9934	Cleaning and Inspection of Removable Partial Denture, Maxillary		$25	$25	$25
D9935	Cleaning and Inspection of Removable Partial Denture, Mandibular		$25	$25	$25
D9938	Fabrication of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C

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ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D9939	Placement of a Custom Removable Clear Plastic Temporary Aesthetic Appliance	Not Covered	N/C	N/C	N/C
D9941	Fabrication of Athletic Mouthguard	Not Covered	N/C	N/C	N/C
D9942	Repair and/or Reline of Occlusal Guard		$50	$60	$40
D9943	Occlusal Guard Adjustment	Fee for occlusal guard includes adjustments performed within 6 months of placement	$16	$22	$20
D9944	Occlusal Guard – Hard Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$144	$201	$184
D9945	Occlusal Guard – Soft Appliance, Full Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$125	$175	$160
D9946	Occlusal Guard – Hard Appliance, Partial Arch	Covered for bruxism only; if for other reasons – not covered DMO Standard Plans (#) – Limited to 1 every 3 years	$75	$105	$96
D9947	Custom Sleep Apnea Appliance Fabrication and Placement	Not Covered	N/C	N/C	N/C
D9948	Adjustment of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C
D9949	Repair of Custom Sleep Apnea Appliance	Not Covered	N/C	N/C	N/C
D9950	Occlusion Analysis - Mounted Case	Not Covered	N/C	N/C	N/C
D9951	Occlusal Adjustment – Limited	Not separately eligible when performed in conjunction with a restoration, root canal therapy or appliance.	$10	$20	$30
D9952	Occlusal Adjustment – Complete		$30	$40	$100
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	Not Covered	N/C	N/C	N/C
D9954	Fabrication and Delivery of Oral Appliance Therapy (OAT) Morning Repositioning Device	Not Covered	N/C	N/C	N/C
D9955	Oral Appliance Therapy (OAT) Titration Visit	Not Covered	N/C	N/C	N/C
D9956	Administration of Home Sleep Apnea Test	Not Covered	N/C	N/C	N/C
D9957	Screening for Sleep Related Breathing Disorders	Not Covered	N/C	N/C	N/C
D9959	Unspecified Sleep Apnea Services Procedure, by Report	Not Covered	N/C	N/C	N/C
D9961	Duplicate/Copy Patient's Records	Not Covered	N/C	N/C	N/C
D9970	Enamel Microabrasion	Not Covered	N/C	N/C	N/C
D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections	Not Covered	N/C	N/C	N/C
D9972	External Bleaching – per Arch - Performed in Office	Not Covered	N/C	N/C	N/C
D9973	External Bleaching – per Tooth	Not Covered	N/C	N/C	N/C
D9974	Internal Bleaching – per Tooth	Not Covered	N/C	N/C	N/C
D9975	External Bleaching for Home Application, per Arch	Not Covered	N/C	N/C	N/C
D9985[2]	Sales Tax	Inclusive to service being taxed	$0	$0	$0
D9986	Missed Appointment	Not Covered	N/C	N/C	N/C
D9987	Cancelled Appointment	Not Covered	N/C	N/C	N/C
D9990	Certified Translation or Sign-language Services per Visit	Not Covered	N/C	N/C	N/C
D9991	Dental case management - addressing appointment compliance barriers	Not Covered	N/C	N/C	N/C

Plan Code - The symbol shown on the roster before the plan code indicates the applicable plan provisions.
* Pre November 1, 2000 Plan
# DMO Standard Plan

Dental Procedure Guidelines
for DMO Primary Care Dentists

ADA CODE[1]	NOMENCLATURE	GUIDELINES	CAM CMI	CAL CLI	SFL SFi
D9992	Dental case management – care coordination	Not Covered	N/C	N/C	N/C
D9993	Dental case management – motivational interviewing	Not Covered	N/C	N/C	N/C
D9994	Dental case management – patient education to improve oral health literacy	Not Covered	N/C	N/C	N/C
D9995	Teledentistry – Synchronous; Real-Time Encounter	Not Covered	N/C	N/C	N/C
D9996	Teledentistry – Asynchronous; Information Stored and Forwarded to Dentist for Subsequent Review	Not Covered	N/C	N/C	N/C
D9997	Dental case management – patients with special health care needs	Inclusive to the primary service Patient cannot be billed	$0	$0	$0
D9999	Unspecified Adjunctive Procedure, by Report	Used for procedure that is not adequately described by a code. Use of this code REQUIRES A WRITTEN NARRATIVE & supporting documentation			

[1] Current Dental Terminology ©American Dental Association. All rights reserved.

[2] Not separately eligible/inclusive - the patient cannot be billed for these services.

[3] Covered only when performed by anesthesiologist.

[4] Amount through 03/31/2016

[5] Amount effective 04/01/2016

Plan Code - The symbol shown on the roster before the plan code indicates the applicable plan provisions.
* Pre November 1, 2000 Plan
# DMO Standard Plan