CareFirst BlueChoice, Inc.
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PLAN - INDIVIDUAL SELECT

ADA	Procedure Name	Copayment
	BASIC DENTAL SERVICE	
	Per Office Visit Copay	**$20**
	Includes the following services (ADA Codes): all examinations (0120; 0140; 0150; 0170, and 0180), prophylaxis (1110 and 1120), x-rays (0210; 0220; 0230; 0240; 0270; 0272; 0274; 0277; 0330; 0340), pulp vitality test (0460), diagnostic casts (0470), oral hygiene instructions (1330), fluoride treatments (1203 and 1204), sealants (1351), pulp caps (3110 and 3120), amalgam and composite restorations (2140; 2150; 2160; 2161; 2330; 2331; 2332; 2335; 2391; 2392; 2393; and 2394), sedative fillings (2940), extractions (7111 and 7140), recementation of space maintainers, inlay(s), crown(s) or bridge (1550; 2910; 2920 and 6930), pin retention (2951), complete or partial denture adjustments (5410; 5411; 5421; and 5422), palliative treatment (9110), and follow-up visits for Major Dental Services (listed below).	
	SOFT TISSUE MANAGEMENT	
	Per Office Visit Copay	**$70**
	Includes the following services (ADA Codes): all periodontal scaling and root planning (4341 and 4342), full mouth debridement (4355), and periodontal maintenance procedures following active therapy (4910).	
	MAJOR DENTAL SERVICES	
	SPACE MAINTENANCE (PASSIVE APPLIANCES)	
1510	Space Maintainer - Fixed Unilateral	120
1515	Space Maintainer - Fixed Bilateral	160
1520	Space Maintainer – Removable Unilateral	90
1525	Space Maintainer – Removable Bilateral	160
	INLAY/ONLAY RESTORATIONS	
2510	Inlay metallic - one surface	210
2520	Inlay - metallic - two surfaces	250
2530	Inlay - metallic - three or more surfaces	300
2543	Onlay - metallic - three surfaces	60
2544	Onlays - metallic - four or more surfaces	75
2610	Inlay - porcelain/ceramic - one surface	230
2620	Inlay - porcelain/ceramic - two surfaces	270
	CROWNS - SINGLE RESTORATION ONLY	
2710	Crown – resin-based composite (Indirect)	130
2740	Crown - porcelain/ceramic substrate	460
2750	Crown - porcelain fused to high noble metal	460
2751	Crown - porcelain fused to predominantly base metal	415
2752	Crown - porcelain fused to noble metal	435
2790	Crown - full cast high noble metal	460
2791	Crown - full cast predominantly base metal	415
2792	Crown - full cast noble metal	435
2799	Provisional Crown – at least six months	100
	OTHER RESTORATIVE SERVICES	

ADA	Procedure Name	Copayment
2930	Prefabricated stainless steel crown – primary tooth	110
2931	Prefabricated stainless steel crown – permanent tooth	110
2933	Prefabricated stainless steel crown with resin window	125
2950	Core buildup, including any pins	95
2952	Post and core in addition to crown, indirectly fabricated	105
2953	Each additional indirectly fabricated post — same tooth	55
2954	Prefabricated post and core in addition to crown	100
2957	Additional prefabricated post and core	50
2970	Temporary crown (fractured tooth)	95
	PULPOTOMY	
3220	Therapeutic Pulpotomy (excluding final restoration)	65 / 90 *****
	ENDODONTIC THERAPY ON PRIMARY TEETH	
3230	Pupal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	70 / 100 *****
3240	Pupal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	85 / 125 *****
	ROOT CANAL/ ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE	
3310	Anterior (excluding final restoration)	300 / 400 *****
3320	Bicuspid (excluding final restoration)	375 / 475 *****
3330	Molar (excluding final restoration)	450 / 600 *****
3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	198 / 264 *****
	ENDODONTIC RETREATMENT	
3346	Retreatment of previous root canal therapy - anterior	340 / 475 *
3347	Retreatment of previous root canal therapy - bicuspid	390 / 580 *
3348	Retreatment of previous root canal therapy – molar	475 / 675 *
	APICOECTOMY/PERIAPICAL SERVICES	
3410	Apicoectomy/Periradicular surgery – anterior	210 / 300 *****
3421	Apicoectomy/Periradicular surgery – bicuspid (first root)	260 / 350 *****
3425	Apicoectomy/Periradicular surgery – molar (first root)	310 / 400 *****
3426	Apicoectomy/Periradicular surgery - (each additional root)	100 / 170 *****
3430	Retrograde Filling - per root	70 / 80 *****
3450	Root amputation - per root	120 / 170 *****
	OTHER ENDODONTIC PROCEDURES	
3910	Surgical procedure for isolation of tooth with rubber dam	100 / 120 *****
3920	Hemisection (incl. any root removal) not including root canal therapy	135 / 150 *****
	SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE SERVICES)	
4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	170 / 350 *****
4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	50 / 200 *****
4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	210 / 425 *****
4249	Clinical crown lengthening - hard tissue	140 / 300 *****
4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	420 / 600 *****
4263	Bone replacement graft - first site in quadrant	450 / 600 *****
4264	Bone replacement graft - each additional site in quadrant	175 / 275 *****
4270	Pedicle soft tissue graft procedure	260 / 425 *****
4271	Free soft tissue graft procedure - including donor site surgery	295 / 475 *
4273	Subepithelial connective tissue graft procedures, per tooth	200 / 350 *
4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	75 / 110 *****
	ADJUNCTIVE PERIODONTAL SERVICES	

ADA	Procedure Name	Copayment
4320	Provisional splinting – intracoronal	70 / 120 *
4321	Provisional splinting – extracoronal	84 / 135 *
	COMPLETE DENTURES (Including Routine Post-Delivery Care)	
5110	Complete denture – maxillary	495
5120	Complete denture – mandibular	495
5130	Immediate denture – maxillary	560
5140	Immediate denture – mandibular	560
	PARTIAL DENTURES (Including Routine Post-Delivery Care)	
5211	Maxillary partial denture – resin base- including any conventional clasps, rests & teeth	450
5212	Mandibular partial denture – resin base – including any conventional clasps, rests & teeth	450
5213	Maxillary partial denture - cast metal framework with resin denture bases - including any conventional clasps, rests & teeth	550
5214	Mandibular partial denture – cast metal framework with resin denture bases - including any conventional clasps, rests & teeth	550
5281	Removable unilateral partial denture - one piece cast metal - including clasps & teeth	150
	REPAIRS TO COMPLETE DENTURES	
5510	Repair broken complete denture base	60
5520	Replace missing or broken teeth – complete denture (each tooth)	50
	REPAIRS TO PARTIAL DENTURES	
5610	Repair resin denture base	60
5620	Repair cast framework	65
5630	Repair or replace broken clasp	55
5640	Replace broken teeth - per tooth	55
5650	Add tooth to existing partial denture	65
5660	Add clasp to existing partial denture	70
	DENTURE REBASE PROCEDURES	
5710	Rebase complete maxillary denture	140
5711	Rebase complete mandibular denture	140
5720	Rebase maxillary partial denture	120
5721	Rebase mandibular partial denture	120
	DENTURE RELINE PROCEDURES	
5730	Reline complete maxillary denture (chairside)	120
5731	Reline complete mandibular denture (chairside)	120
5740	Reline maxillary partial denture (chairside)	110
5741	Reline mandibular partial denture (chairside)	110
5750	Reline complete maxillary denture (laboratory)	145
5751	Reline complete mandibular denture (laboratory)	145
5760	Reline maxillary partial denture (laboratory)	125
5761	Reline mandibular partial denture (laboratory)	125
	OTHER REMOVABLE PROSTHETIC SERVICES	
5810	Interim complete denture (maxillary)	200
5811	Interim complete denture (mandibular)	200
5820	Interim partial denture (maxillary)	180
5821	Interim partial denture (mandibular)	180
5850	Tissue conditioning – maxillary	60
5851	Tissue conditioning – mandibular	60
	FIXED PARTIAL DENTURE PONTICS	
6210	Pontic - cast high noble metal	460
6211	Pontic - cast predominantly base metal	415
6212	Pontic - cast noble metal	435
6240	Pontic - porcelain fused to high noble metal	460

ADA	Procedure Name	Copayment
6241	Pontic - porcelain fused to predominantly base metal	415
6242	Pontic - porcelain fused to noble metal	435
	RETAINERS	
6545	Retainers - cast metal for resin bonded fixed prosthesis	170
	FIXED PARTIAL DENTURE RETAINERS - CROWN	
6750	Crown - porcelain fused to high noble metal	460
6751	Crown - porcelain fused to predominantly base metal	415
6752	Crown - porcelain fused to noble metal	435
6780	Crown - 3/4 cast high noble metal	390
6790	Crown - full cast high noble metal	460
6791	Crown - full cast predominantly base metal	415
6792	Crown – full cast noble metal	435
	OTHER FIXED PARTIAL DENTURE SERVICES	
6940	Stress breaker	70
6950	Precision attachment	150
6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	115
6972	Prefabricated Post and Core in addition to fixed partial denture retainer	100
6973	Core build up for retainer, including any pins	95
6976	Each additional indirectly fabricated post — same tooth	58
6977	Each additional prefabricated post and core	50
	SURGICAL EXTRACTIONS **(Includes Local Anesthesia, Suturing, if Needed and Routine Post Operative Care)**	
7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	80 / 110 *****
7220	Removal of impacted tooth – soft tissue	105 / 150 *****
7230	Removal of impacted tooth – partially bony	140 / 170 *****
7240	Removal of impacted tooth – completely bony	165 / 200 *****
7241	Removal of impacted tooth – completely bony with unusual surgical complications	225
7250	Surgical removal of residual tooth roots (cutting procedure)	100
	OTHER SURGICAL PROCEDURES	
7280	Surgical access of an unerupted tooth	250
7286	Biopsy of oral tissue - soft	100
	ALVEOLOPLASTY - Surgical Preparation of Ridge for Dentures	
7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant	90
7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces per quadrant	95
	SURGICAL INCISION	
7510	Incision & drainage of abscess – intraoral soft tissue	70
7520	Incision & drainage of abscess – extraoral soft tissue	60
	OTHER REPAIR PROCEDURES	
7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	120
7971	Excision of pericoronal gingiva	100
	LIMITED ORTHODONTIC TREATMENT	
8010	Limited orthodontic treatment of the primary dentition	600
8020	Limited orthodontic treatment of the transitional dentition	650
8030	Limited orthodontic treatment of the adolescent dentition	700
8040	Limited orthodontic treatment of the adult dentition	750
	INTERCEPTIVE ORTHODONTIC TREATMENT	
8050	Interceptive orthodontic treatment of the primary dentition	850
8060	Interceptive orthodontic treatment of the transitional dentition	950

ADA	Procedure Name	Copayment
	COMPREHENSIVE ORTHODONTIC TREATMENT	
8070	Comprehensive orthodontic treatment of the transitional dentition	2,300
8080	Comprehensive orthodontic treatment of the adolescent dentition	2,500
8090	Comprehensive orthodontic treatment of the adult dentition	2,700
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
8210	Removable appliance therapy	500
8220	Fixed appliance therapy	450
	OTHER ORTHODONTIC SERVICES	
8660	Pre-orthodontic treatment visit	150
8670	Periodic orthodontic treatment visit (as part of contract)	85
8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	250
	ANESTHESIA	
9230	Analgesia (Nitrous Oxide)	35
9241	Intraveneous Sedation – first 30 minutes	150
9242	Intraveneous Sedation – each additional 15 minutes	60
	PROFESSIONAL CONSULTATION	
9310	Consultation — diagnostic service provided by dentist or physician other than requesting dentist or physician	50
	PROFESSIONAL VISITS	
9400	Broken appointment charge – per 15 minutes (without 24 hours prior notice)	10
	MISCELLANEOUS SERVICES	
9910	Application of desensitizing medicament	10
9911	Application of desensitizing resin (cervical and/or root surface)	10
9940	Occlusal guard, by report	275
9951	Occlusal adjustment - limited	85
9952	Occlusal adjustment - complete	180
9974	Internal Bleaching – per tooth	170

***** ***Note:*** *When two Dental Copayment charges are listed on this Schedule of Benefits for one ADA code, the Primary Dentist will provide the service at the lower Dental Copayment (on the left side of the column), and the Specialty Care Dentist will provide the service at the higher Dental Copayment (on the right side of the column).*

PLAN LIMITATIONS -- IN-NETWORK

The following exclusions and limitations shall apply:

- Services for injuries and conditions which are covered under Workers' Compensation or Employers' Liability Laws;
- Services which are provided without cost to the Covered Individual and/or Dependent(s) by any municipality, county or other political subdivision (with the exception of Medicaid);
- Services which, in the opinion of the participating DENTIST, are not necessary for the Covered Individual and/or Dependent(s) health;
- Payment of any claim or bill will not be made for prohibited referrals;
- Cosmetic, elective, or aesthetic dentistry, which in the opinion of the participating DENTIST are not necessary for the patient's dental health;
- Oral surgery requiring the setting of fractures or dislocations;
- Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital or developmental malformations;
- Dispensing of drugs, except those used as a local anesthetic;
- Hospitalization for any dental procedure;
- Loss or theft of bridgework or dentures previously supplied under the PLAN;
- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed;
- Any implantation;
- General anesthesia;
- Services that cannot be performed because of the general health of the patient;
- Teeth Cleaning (Prophylaxis) at intervals of less than six (6) months;
- Unlisted procedures will be provided at the dentist's usual and customary fees;
- Services which are obtained outside the dental office in which enrolled and which are not pre-authorized by the PLAN. This does not apply to out-of-area emergency dental services;
- Services rendered by a Pedodontist (Pediatric Dentist) are considered Specialty Care and must be approved by the Covered Individual and/or Dependent('s) General Participating DENTIST; all services listed on the Schedule of Benefits and Copayments will be provided by a general Participating Dentist or an approved Specialist; provided, however, that a general DENTIST will refer the Covered Individual or Dependent to an approved Specialist or recommend that the Covered Individual or Dependent contact an approved Specialist if it is the judgment of the DENTIST that the service or procedure must be provided by an approved Specialist, with an exception for out-of-area emergency care, and a referral to a non-participating general dentist or specialist;
- Services which cannot be performed in the dental office of the "Personal Participating DENTIST" or "Approved Specialist" due to the special needs or health related conditions of the Covered Individual and/or Dependent(s).

OUT-OF-AREA EMERGENCY CARE: *Covered Individuals and/or Dependents are covered for emergency dental treatment to alleviate acute pain, along with treatment arising from accidental injury or illness while temporarily more than 50 miles from their regular place of residence and the nearest Plan Dental Office. Limited to $50 per Covered Individual and/or Dependent(s) per emergency.*

ALL PRICES ARE EXCLUSIVE OF GOLD