

DISCOUNT DENTAL PLAN—COMPLETE LISTING OF MEMBER COPAYMENTS

CDT CODE	PROCEDURE NAME	COPAYMENT
0120	PERIODIC ORAL EXAMINATION - ESTABLISHED PATIENT	20
0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	33
0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	38
0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)	21
0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT	38
0210	INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES	62
0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	13
0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	10
0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	19
0270	BITEWING, SINGLE RADIOGRAPHIC IMAGE	13
0272	BITEWINGS, TWO RADIOGRAPHIC IMAGES	20
0274	BITEWINGS, FOUR RADIOGRAPHIC IMAGES	30
0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	40
0330	PANORAMIC RADIOGRAPHIC IMAGE	55
0340	CEPHALOMETRIC RADIOGRAPHIC IMAGE	60
0460	PULP VITALITY TESTS	26
0470	DIAGNOSTIC CASTS	50
1110	PROPHYLAXIS - ADULT	45
1120	PROPHYLAXIS - CHILD	35
1208	TOPICAL APPLICATION OF FLUORIDE	18
1330	ORAL HYGIENE INSTRUCTIONS	NO CHARGE
1351	SEALANT - PER TOOTH	25
1510	SPACE MAINTAINER - FIXED - UNILATERAL	160
1515	SPACE MAINTAINER - FIXED - BILATERAL	230
1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL	190
1525	SPACE MAINTAINER - REMOVABLE - BILATERAL	265
1550	RE-CEMENTATION OF SPACE MAINTAINER	38
2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT	55
2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT	70
2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	85
2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	100
2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	65
2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	80
2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	95
2335	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	125
2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	75
2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	90
2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	115
2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	135

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2510	INLAY - METALLIC - ONE SURFACE	325
2520	INLAY - METALLIC - TWO SURFACES	410
2530	INLAY - METALLIC - THREE OR MORE SURFACES	475
2543	ONLAY - METALLIC - THREE SURFACES	520
2544	ONLAY - METALLIC - FOUR OR MORE SURFACES	580
2610	INLAY - PORCELAIN/CERAMIC - ONE SURFACE	410
2620	INLAY - PORCELAIN/CERAMIC - TWO SURFACES	450
2710	CROWN - RESIN-BASED COMPOSITE(INDIRECT)	350
2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	590
2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	590
2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	550
2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	570
2790	CROWN - FULL CAST HIGH NOBLE METAL	590
2791	CROWN - FULL CAST PREDOMINANTLY BASE	550
2792	CROWN - FULL CAST NOBLE METAL	570
2799	PROVISIONAL CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	250
2910	RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION	50
2920	RECEMENT CROWN	50
2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	135
2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	135
2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	135
2940	PROTECTIVE RESTORATION	45
2950	CORE BUILDUP, INCLUDING ANY PINS	130
2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	28
2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	220
2953	EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH	110
2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	160
2957	EACH ADDITIONAL PREFABRICATED POST- SAME TOOTH	80
3110	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)	25
3120	PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)	22
3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)- REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT	90
3230	PULPAL THERAPY (RESORABABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	100
3240	PULPAL THERAPY (RESORABABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	125
3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	420
3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)	525
3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	650
3332	INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH	275
3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR	500
3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID	590
3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR	700
3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR	40
3421	APICOECTOMY/PERIRADICULAR SURGERY - BICUSPID (FIRST ROOT)	450

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3425	APICTOMY/PERIRADICULAR SURGERY - MOLAR (FIRST ROOT)	500
3426	APICTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)	200
3430	RETROGRADE FILLING - PER ROOT	140
3450	ROOT AMPUTATION - PER ROOT	195
3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM	125
3920	HEMISECTION (INCLUDING ROOT REMOVAL),NOT INCLUDING ROOT CANAL THERAPY	210
4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	360
4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	210
4212	GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH	210
4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	450
4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	350
4260	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	675
4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	600
4264	BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT	300
4270	PEDICAL SOFT TISSUE GRAFT PROCEDURE	450
4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES, PER TOOTH	500
4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	260
4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), FIRST TOOTH OR EDENTULOUS TOOTH POSITION IN GRAFT	490
4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), EACH ADDITIONAL CONTIGUOUS TOOTH OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	340
4320	PROVISIONAL SPLINTING - INTRACORONAL	200
4321	PROVISIONAL SPLINTING - EXTRACORONAL	150
4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	125
4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT	90
4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS	100
4910	PERIODONTAL MAINTENANCE	75
5110	COMPLETE DENTURE - MAXILLARY	700
5120	COMPLETE DENTURE - MANDIBULAR	700
5130	IMMEDIATE DENTURE - MAXILLARY	775
5140	IMMEDIATE DENTURE - MANDIBULAR	775
5211	MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	600
5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	600
5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	750
5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	750
5281	REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)	375
5410	ADJUST COMPLETE DENTURE - MAXILLARY	42
5411	ADJUST COMPLETE DENTURE - MANDIBULAR	42

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5421	ADJUST PARTIAL DENTURE - MAXILLARY	42
5422	ADJUST PARTIAL DENTURE - MANDIBULAR	42
5510	REPAIR BROKEN COMPLETE DENTURE BASE	100
5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	80
5610	REPAIR RESIN DENTURE BASE	80
5620	REPAIR CAST FRAMEWORK	95
5630	REPAIR OR REPLACE BROKEN CLASP	90
5640	REPLACE BROKEN TEETH - PER TOOTH	80
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	95
5660	ADD CLASP TO EXISTING PARTIAL DENTURE	95
5710	REBASE COMPLETE MAXILLARY DENTURE	280
5711	REBASE COMPLETE MANDIBULAR DENTURE	280
5720	REBASE MAXILLARY PARTIAL DENTURE	270
5721	REBASE MANDIBULAR PARTIAL DENTURE	270
5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	180
5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	180
5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	170
5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	170
5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	220
5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	220
5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	210
5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	210
5810	INTERIM COMPLETE DENTURE (MAXILLARY)	300
5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	300
5820	INTERIM PARTIAL DENTURE (MAXILLARY)	275
5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	275
5850	TISSUE CONDITIONING, MAXILLARY	80
5851	TISSUE CONDITIONING, MANDIBULAR	80
6210	PONTIC - CAST HIGH NOBLE METAL	590
6211	PONTIC - CAST PREDOMINANTLY BASE METAL	550
6212	PONTIC - CAST NOBLE METAL	570
6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	590
6241	PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	550
6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	570
6545	RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	325
6750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	590
6751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	550
6752	CROWN - PORCELAIN FUSED TO NOBLE METAL	570
6780	CROWN - 3/4 CAST HIGH NOBLE METAL	590
6790	CROWN - FULL CAST HIGH NOBLE METAL	590
6791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	550
6792	CROWN - FULL CAST NOBLE METAL	570
6940	STRESS BREAKER	275
6950	PRECISION ATTACHMENT	375

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CDT CODE	PROCEDURE NAME	COPAYMENT
7111	EXTRACTION, CORONAL REMNANTS - DECIDIOUS TOOTH	65
7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	70
7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND EXCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	135
7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	160
7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	200
7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	250
7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	300
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PRCEDURE)	140
7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	300
7286	BIOPSY OF ORAL TISSUE - SOFT	140
7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	130
7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	200
7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE.	100
7520	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE	100
7960	FRENULECTOMY ALSO KNOWN AS FRENECTOMY OR FRENOTOMY - SEPARATE PROCEDURE NOT INCIDENTAL TO ANOTHER	200
7971	EXCISION OF PERICORONAL GINGIVA	120
8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	800
8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DETENTION	900
8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DETENTION	1000
8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION	1000
8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DETENTION	1100
8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DETENTION	1200
8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DETENTION	3000
8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DETENTION	3000
8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DETENTION	3000
8210	REMOVABLE APPLIANCE THERAPY	550
8220	FIXED APPLIANCE THERAPY	480
8660	PRE-ORTHODONTIC TREATMENT VISIT	170
8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)	100
8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S))	300
9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN, MINOR PROCEDURE	50
9230	INHALATION OF NITROUS OXIDE / ANXIOLYSIS, ANALGESIA	40
9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - FIRST 30 MINUTES	200
9242	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - EACH ADDITIONAL 15 MINUTES	75
9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN	65
9400	BROKEN APPOINTMENT CHARGE - PER 15 MINUTES (WITHOUT 24 HOURS PRIOR NOTICE)	10
9910	APPLICATION OF DESENSITIZING MEDICAMENT	20
9911	APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH	20
9940	OCCLUSAL GUARD, BY REPORT	325
9951	OCCLUSION ADJUSTMENT - LIMITED	100
9952	OCCLUSION ADJUSTMENT - COMPLETE	320
9974	INTERNAL BLEACHING - PER TOOTH	200

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 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'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) limited to twice per Contract Term (or Coverage Period);
- 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's General Participating DENTIST;
- All services listed on the Schedule of Benefits and Member 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;
- 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 Employee and/or Dependent(s).

ALL PRICES ARE EXCLUSIVE OF GOLD