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Dental Plan
CONCORDIA FLEX

Network
ADVANTAGE PLUS

Coverage Effective
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ACTIVE

Policy Information

Deductibles and Maximums

Benefit	Details
Individual Deductible	\$10 Per Calendar Year
Family Deductible	\$30 Per Calendar Year
Individual Maximum	\$1,750 Per Calendar Year

Coordination and Other Benefits

Coverage Type	Description
Age-related Benefits Cease	Unmarried Dependent ~ Age 19 And Older ~ Month End
Age-related Benefits Cease	Unmarried Dependent ~ Age 25 And Older ~ Month End
Coverage	Missing Tooth Clause - will not apply
Coordination Of Benefits Primary Determination	Standard Calculation Method ~ All Claims

Benefit Details By Procedure

Exams

Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D0120	Periodic Exam	Yes	100%	2 Per 12 Months	No	Yes
D0140	Limited Oral Exam	Yes	100%	--	No	Yes
D0145	Oral Exam Under Age 3	Yes	100%	2 Per 12 Months	No	Yes
D0150	Comprehensive Exam	Yes	100%	2 Per 12 Months	No	Yes
D0160	Extensive Oral Exam	Yes	100%	1 Per 12 Months ~ Per Dentist	No	Yes
D0170	Re-evaluation, Limited	Not Covered				
D0171	Post-operative Office Visit	No	0%	Not Covered - Integral Procedures	No	No
D0180	Periodontal Evaluation	Yes	100%	2 Per 12 Months	No	Yes
D0190	Screening	Not Covered				
D0191	Assessment	Not Covered				

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X-Rays						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D0210	Full Mouth Series X-rays	Yes	100%	1 Per 36 Months Age 5 And Older	No	Yes
D0220	Periapical (PA) First X-ray	Yes	100%	4 Per 12 Months	No	Yes
D0230	Periapical (PA) Additional X-ray	Yes	100%	4 Per 12 Months	No	Yes
D0240	Intraoral Occlusal X-ray	Not Covered				
D0250	Extra-oral 2d Image	Not Covered				
D0251	Extraoral Posterior Image	Not Covered				
D0270	Bitewing Single X-ray	Yes	100%	2 Per 12 Months 4 Per Day	No	Yes
D0272	Bitewing Two X-rays	Yes	100%	2 Per 12 Months 4 Per Day	No	Yes
D0273	Bitewings Three X-rays	Yes	100%	2 Per 12 Months 4 Per Day	No	Yes
D0274	Bitewings Four X-rays	Yes	100%	2 Per 12 Months 4 Per Day	No	Yes
D0277	Vertical Bitewing X-rays	Yes	100%	2 Per 12 Months 4 Per Day	No	Yes
D0310	Sialography	Not Covered				
D0320	Tmj Arthrogram	Not Covered				
D0321	Tmj X-rays By Report	Not Covered				
D0322	Tomographic Survey	Not Covered				
D0330	Panoramic (Pano) X-ray	Yes	100%	1 Per 36 Months Age 5 And Older	No	Yes
D0340	2d Cephalometric X-ray	Not Covered				
D0350	2d Photographic Image	Not Covered				
D0364	Cone Beam Ct	Yes	80%	1 Per 12 Months	Yes	Yes
D0365	Cone Beam Ct	Yes	80%	1 Per 12 Months	Yes	Yes
D0366	Cone Beam Ct	Yes	80%	1 Per 12 Months	Yes	Yes
D0367	Cone Beam Ct	Yes	80%	1 Per 12 Months	Yes	Yes
D0368	Cone Beam Ct	Not Covered				
D0369	Maxillofacial Mri	Not Covered				
D0370	Ultrasound	Not Covered				

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X-Rays						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D0371	Sialoendoscopy	Not Covered				
D0372	intraoral tomosynthesis - comprehensive series of X-rays	Yes	100%	1 Per 36 Months Will Apply Age 5 And Older	No	Yes
D0373	intraoral tomosynthesis - bitewing X-rays	Yes	100%	2 Per 12 Months Will Apply 4 Per Day	No	Yes
D0374	intraoral tomosynthesis - periapical (PA) X-ray	Yes	100%	4 Per 12 Months Will Apply	No	Yes
D0380	Cone Beam Ct Capture	Not Covered				
D0381	Cone Beam Ct Capture	Not Covered				
D0382	Cone Beam Ct Capture	Not Covered				
D0383	Cone Beam Ct Capture	Not Covered				
D0384	Cone Beam Ct Capture Tmj	Not Covered				
D0385	Mri Capture	Not Covered				
D0386	Ultrasound Capture	Not Covered				
D0387	intraoral tomosynthesis - comprehensive series of X-rays - image capture only	Not Covered				
D0388	intraoral tomosynthesis - bitewing X-ray - image capture only	Not Covered				
D0389	intraoral tomosynthesis - periapical (PA) X-ray - image capture only	Not Covered				
D0391	Image Interpretation	Not Covered				
D0393	3d Image Or Surface Scan	Not Covered				
D0394	3d Image Procedure	Not Covered				
D0395	3d Image Procedure	Not Covered				
D0396	3d Print Of Dental Surface Scan	No	0%	Not Covered - Integral Procedures	No	No

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Tests & Laboratory						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D0411	In-office Point Of Testing	Not Covered				
D0412	In-office Point Of Testing	Not Covered				
D0414	Lab Processing	Not Covered				
D0415	Collect Microorganism	Not Covered				
D0416	Viral Culture	Not Covered				
D0417	Collect Saliva Sample	Not Covered				
D0418	Analysis Of Saliva Sample	Not Covered				
D0419	Assessmnt Salivary Flow	Not Covered				
D0422	Genetic Sample Collection	Not Covered				
D0423	Genetic Specimen Analysis	Not Covered				
D0425	Caries Suscept. Test	Not Covered				
D0431	Adjunctive Prediag Test	Not Covered				
D0460	Pulp Vitality Test	Yes	100%	1 Per 30 Days	Yes	Yes
D0470	Diagnostic Casts	No	0%	Not Covered - Integral Procedures	No	No
D0472	Access Tissue	Not Covered				
D0473	Access Tissue Microscopic	Not Covered				
D0474	Access Tissue, Margins	Not Covered				
D0475	Decalcification Procedure	Not Covered				
D0476	Stains For Microorganism	Not Covered				
D0477	Other Special Stains	Not Covered				
D0478	Immunohistochemical Stain	Not Covered				
D0479	Tissue Hybridization	Not Covered				
D0480	Accession Cytology Smear	Not Covered				
D0481	Electron Microscopy	Not Covered				

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D0482	Direct Immunofluorescence	Not Covered				
D0483	Indirect Fluorescence	Not Covered				
D0484	Consultation On Slide	Not Covered				
D0485	Consult And Prepare Slide	Not Covered				
D0486	Lab Accession Of Sample	Not Covered				
D0502	Oral Pathology Procedure	Not Covered				
D0600	Diagnostic Procedure	Not Covered				
D0601	Caries Risk Assess Low	Yes	100%	1 Per 12 Months	Yes	Yes
D0602	Caries Risk Assess Mod	Yes	100%	1 Per 12 Months	Yes	Yes
D0603	Caries Risk Assess High	Yes	100%	1 Per 12 Months	Yes	Yes
D0604	Antigen Testing	Not Covered				
D0605	Antibody Testing	Not Covered				
D0606	Molecular Testing	No	0%	Not Covered - Medical Only	No	No
D0701	Panoramic Image Capture Only	Not Covered				
D0702	2d Cephalometric Image Capture	Not Covered				
D0703	2d Photographic Image Capture	Not Covered				
D0705	Extra-oral Image Capture Only	Not Covered				
D0706	Intraoral Occ Image Capture Only	Not Covered				
D0707	Intraoral Periap Image Capture	Not Covered				
D0708	Bw Radiographic Image Capture	Not Covered				
D0709	Compr Radiographic Series	Not Covered				

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D0801	3d Intraoral Surface Scan Direct	No	0%	Not Covered - Integral Procedures	No	No
D0802	3d Dental Surf Scan - Indirect	No	0%	Not Covered - Integral Procedures	No	No
D0803	3d Surface Scan - Direct	Not Covered				
D0804	3d Surface Scan - Indirect	Not Covered				
D0999	Unlisted Diag.procedure	Not Covered				

Cleanings & Fluoride						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D1110	Prophylaxis (Cleaning) Adult	Yes	100%	2 Per 12 Months	No	Yes
D1120	Prophylaxis (Cleaning) Child	Yes	100%	2 Per 12 Months	No	Yes
D1206	Topical Fluoride Varnish	Not Covered				
D1208	Topical Fluoride	Not Covered				
D1301	Immunization Counseling	No	0%	Not Covered - Integral Procedures	No	No
D1310	Nutritional Counseling	Not Covered				
D1320	Tobacco Counseling	Not Covered				
D1321	Substance Use Counseling	Not Covered				
D1330	Oral Hygiene Instructions	Not Covered				

Sealants						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D1351	Sealant Per Tooth	Not Covered				
D1352	Preventive Resin Rest	Not Covered				
D1353	Sealant Repair	Not Covered				

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Sealants						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D1354	Caries Medicament	Yes	100%	2 Per Calendar Year	No	Yes
D1355	Caries Medicament Application	Not Covered				

Space Maintainers						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D1510	Space Maintainer	Not Covered				
D1516	Space Maintainer	Not Covered				
D1517	Space Maintainer	Not Covered				
D1520	Space Maintainer	Not Covered				
D1526	Space Maintainer	Not Covered				
D1527	Space Maintainer	Not Covered				
D1551	Recement Space Maint/ Max	Yes	100%	1 Per Tooth ~ Integral Within 6 Months ~ By Same Dentist 1 Per Tooth ~ Per 12 Months	No	Yes
D1552	Recement Space Maint/mand	Yes	100%	1 Per Tooth ~ Integral Within 6 Months ~ By Same Dentist 1 Per Tooth ~ Per 12 Months	No	Yes
D1553	Recement Uni Space Main	Yes	100%	1 Per Tooth ~ Integral Within 6 Months ~ By Same Dentist 1 Per Tooth ~ Per 12 Months	No	Yes
D1556	Remove Fix Space Main	Yes	100%	--	No	Yes
D1557	Remove Space Maint/max	Yes	100%	--	No	Yes
D1558	Remove Space Main/mand	Yes	100%	--	No	Yes
D1575	Space Maintainer	Not Covered				
D1701	Pfizer First Admn	No	0%	Not Covered - Medical Only	No	No
D1702	Pfizer Second Admn	No	0%	Not Covered - Medical Only	No	No
D1703	Moderna First Admn	No	0%	Not Covered - Medical Only	No	No

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Space Maintainers						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D1704	Moderna Second Admn	No	0%	Not Covered - Medical Only	No	No
D1705	Astrazeneca First Admn	No	0%	Not Covered - Medical Only	No	No
D1706	Astrazeneca Scnd Admn	No	0%	Not Covered - Medical Only	No	No
D1707	Janssen Single Admn	No	0%	Not Covered - Medical Only	No	No
D1708	Pfizer Third Dose	No	0%	Not Covered - Medical Only	No	No
D1709	Pfizer Booster Dose	No	0%	Not Covered - Medical Only	No	No
D1710	Moderna Third Dose	No	0%	Not Covered - Medical Only	No	No
D1711	Moderna Booster Dose	No	0%	Not Covered - Medical Only	No	No
D1712	Janssen Booster Dose	No	0%	Not Covered - Medical Only	No	No
D1713	Pfizer Pediatric First Dose	No	0%	Not Covered - Medical Only	No	No
D1714	Pfizer Pediatric Second Dose	No	0%	Not Covered - Medical Only	No	No
D1781	Human Papillomavirus Dose 1	No	0%	Not Covered - Medical Only	No	No
D1782	Human Papillomavirus Dose 2	No	0%	Not Covered - Medical Only	No	No
D1783	Human Papillomavirus Dose 3	No	0%	Not Covered - Medical Only	No	No
D1999	Unspec Preventive Proc	Not Covered				

Fillings (Restorations)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D2140	One Surface Amalgam (Silver Color) Filling	Yes	80%	1 Per 24 Months	Yes	Yes
D2150	Two Surface Amalgam (Silver Color) Filling	Yes	80%	1 Per 24 Months	Yes	Yes

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Fillings (Restorations)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D2160	Three Surface Amalgam (Silver Color) Filling	Yes	80%	1 Per 24 Months	Yes	Yes
D2161	4 Or More Surface Amalgam (Silver Color) Filling	Yes	80%	1 Per 24 Months	Yes	Yes
D2330	1 Surface Resin (White Color) Anterior Filling	Yes	80%	1 Per 24 Months	Yes	Yes
D2331	2 Surface Resin (White Color) Anterior Filling	Yes	80%	1 Per 24 Months	Yes	Yes
D2332	3 Surface Resin (White Color) Anterior Filling	Yes	80%	1 Per 24 Months	Yes	Yes
D2335	4 Or More Surface Resin (White Color) Anterior Filling	Yes	80%	1 Per 24 Months	Yes	Yes
D2390	Resin Crown Anterior	Yes	80%	1 Per 24 Months	Yes	Yes
D2391	1 Surface Resin (White Color) Posterior Filling	Yes	80%	1 Per 24 Months No Alternate Benefit	Yes	Yes
D2392	2 Surface Resin (White Color) Posterior Filling	Yes	80%	1 Per 24 Months No Alternate Benefit	Yes	Yes
D2393	3 Surface Resin (White Color) Posterior Filling	Yes	80%	1 Per 24 Months No Alternate Benefit	Yes	Yes
D2394	4 Or More Surface Resin (White Color) Posterior Filling	Yes	80%	1 Per 24 Months No Alternate Benefit	Yes	Yes
D2410	Gold Foil 1 Surface	Not Covered				
D2420	Gold Foil 2 Surface	Not Covered				
D2430	Gold Foil 3 Surface	Not Covered				

Crowns (Caps), Inlays & Onlays						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D2510	Metal Inlay 1 Surface	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2520	Metal Inlay 2 Surfaces	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2530	Metal Inlay 3+ Surfaces	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D2542	Metal Onlay 2 Surfaces	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2543	Metal Onlay 3 Surfaces	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2544	Onlay Metal 4+ Surfaces	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2610	Porcelain Inlay 1 Surface	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2620	Porcelain Inlay 2 Surface	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2630	Porcelain Inlay 3+ Surf	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2642	Porcelain Onlay 2 Surface	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2643	Porcelain Onlay 3 Surface	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2644	Porcelain Onlay 4+ Surf	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2650	Resin Inlay 1 Surface	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2651	Resin Inlay 2 Surface	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2652	Resin Inlay 3+ Surf	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2662	Resin Onlay 2 Surf	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply	Yes	Yes
D2663	Resin Onlay 3 Surf	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2664	Resin Onlay 4+ Surf	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2710	Resin Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2712	3/4 Resin-based Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2720	Resin High Noble Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2721	Resin Base Metal Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes

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Crowns (Caps), Inlays & Onlays						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D2722	Resin Noble Metal Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2740	Porcelain Ceramic Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2750	Porc High Metal Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2751	Porc Base Metal Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2752	Porc Noble Metal Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2753	Porc Titanium Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2780	3/4 Cast High Noble Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2781	3/4 Cast Base Metal Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2782	3/4 Cast Noble Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2783	3/4 Porc/ceramic Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2790	Full High Noble Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2791	Full Base Metal Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2792	Full Noble Metal Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2794	Titanium Crown	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2799	Interim Crown	Not Covered				

Other Restorative Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D2910	Recement Inlay Or Onlay	Yes	80%	1 Per Tooth ~ Integral Within 12 Months ~ By Same Dentist 1 Per Tooth ~ Per 3 Years	Yes	Yes

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Other Restorative Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D2915	Recement Post And Core	Yes	80%	1 Per Tooth ~ Per 3 Years	Yes	Yes
D2920	Recement Crown	Yes	80%	1 Per Tooth ~ Integral Within 12 Months ~ By Same Dentist 1 Per Tooth ~ Per 3 Years	Yes	Yes
D2921	Reattach Tooth Fragment	Not Covered				
D2928	Prefab Porc/cer Crn Permnt Tooth	Not Covered				
D2929	Prefab Porc/cer Crn Prim	Not Covered				
D2930	Prefab S.steel Crown Prim	Yes	80%	1 Per Tooth ~ Per 24 Months	Yes	Yes
D2931	Prefab S.steel Crown Perm	Yes	80%	1 Per Tooth ~ Per 24 Months	Yes	Yes
D2932	Prefab Resin Crown	Yes	80%	1 Per Tooth ~ Per 24 Months Will Apply	Yes	Yes
D2933	S. Steel Crown W/resin	Yes	80%	1 Per Tooth ~ Per 24 Months Will Apply	Yes	Yes
D2934	Esthetic Primary Ss Crown	Yes	80%	1 Per Tooth ~ Per 24 Months Will Apply	Yes	Yes
D2940	Interim Direct Restoration	Yes	80%	1 Per Tooth ~ Per 90 Days	Yes	Yes
D2949	Foundation Indirect Rest	No	0%	Not Covered - Integral Procedures	No	No
D2950	Core Buildup	Yes	80%	1 Per Tooth ~ Per 60 Months Permanent Teeth	Yes	Yes
D2951	Pin Retention	Yes	80%	--	Yes	Yes
D2952	Post And Core	Yes	80%	1 Per Tooth ~ Per 60 Months Will Apply Permanent Teeth	Yes	Yes
D2953	Each Additional Post	No	0%	Not Covered - Integral Procedures	No	No
D2954	Prefabricated Post Core	Yes	80%	1 Per Tooth ~ Per 60 Months Permanent Teeth	Yes	Yes
D2955	Post Removal	Not Covered				

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D2956	Indirect Restoration Removal	No	0%	Not Covered - Integral Procedures	No	No
D2957	Additional Prefab Post	No	0%	Not Covered - Integral Procedures	No	No
D2960	Veneer Direct	Not Covered				
D2961	Veneer Resin Indirect	Not Covered				
D2962	Veneer Porcelain Indirect	Not Covered				
D2971	Addnl Crown Procedures	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D2975	Coping	Not Covered				
D2976	Band Stabilization Per Tooth	Not Covered				
D2980	Crown Repair	Yes	80%	1 Per Tooth ~ Per 12 Months 1 Per Tooth ~ Integral Within 24 Months ~ By Same Dentist	Yes	Yes
D2981	Inlay Repair	Yes	80%	--	Yes	Yes
D2982	Onlay Repair	Yes	80%	1 Per Tooth ~ Per 12 Months 1 Per Tooth ~ Integral Within 24 Months ~ By Same Dentist	Yes	Yes
D2983	Veneer Repair	Not Covered				
D2989	Excavation Of A Tooth	Not Covered				
D2990	Resin Infiltration	Not Covered				
D2991	Appl Of Medicament Per Tooth	Not Covered				
D2999	Unlisted Restorative Proc	Not Covered				

Root Canal (Endodontic) Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D3110	Pulp Cap Direct	No	0%	Not Covered - Integral Procedures	No	No
D3120	Pulp Cap Indirect	No	0%	Not Covered - Integral Procedures	No	No

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Root Canal (Endodontic) Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D3220	Therapeutic Pulpotomy	Yes	80%	--	Yes	Yes
D3221	Pulpal Debridement	Yes	80%	2 Per 12 Months ~ In Combination with Pulpal Debridement & Palliative Treatment	Yes	Yes
D3222	Partial Pulpotomy	Yes	80%	1 Per Tooth ~ Per Lifetime ~ Permanent Teeth	Yes	Yes
D3230	Pulpal Therapy, Anterior	Yes	80%	1 Per Primary Tooth ~ Per Lifetime ~ Only Absent Replacement By A Permanent Tooth	Yes	Yes
D3240	Pulpal Therapy, Posterior	Yes	80%	1 Per Primary Tooth ~ Per Lifetime ~ Only Absent Replacement By A Permanent Tooth	Yes	Yes
D3310	Root Canal Anterior	Yes	80%	1 Per Tooth ~ Per Lifetime	Yes	Yes
D3320	Root Canal Pre-molar	Yes	80%	1 Per Tooth ~ Per Lifetime	Yes	Yes
D3330	Root Canal Molar	Yes	80%	1 Per Tooth ~ Per Lifetime	Yes	Yes
D3331	Root Canal Obstruction	No	0%	Not Covered - Integral Procedures	No	No
D3332	Incomplete Endo Therapy	Not Covered				
D3333	Internal Root Repair	Yes	80%	By Report 1 Per Tooth ~ Per Lifetime	Yes	Yes
D3346	Retreatment Rct Anterior	Yes	80%	1 Per Tooth ~ Per Lifetime	Yes	Yes
D3347	Retreatment Rct Pre-molar	Yes	80%	1 Per Tooth ~ Per Lifetime	Yes	Yes
D3348	Retreatment Rct Molar	Yes	80%	1 Per Tooth ~ Per Lifetime	Yes	Yes
D3351	Apexification Initial	Yes	80%	--	Yes	Yes
D3352	Apexification Interim	Yes	80%	--	Yes	Yes
D3353	Apexification Final	Yes	80%	--	Yes	Yes
D3355	Pulpal Regen Intial	Yes	80%	--	Yes	Yes
D3356	Pulpal Regen Interim	Yes	80%	--	Yes	Yes
D3357	Pulpal Regen Final	Not Covered				
D3410	Apicoectomy Anterior	Yes	80%	--	Yes	Yes
D3421	Apicoectomy Pre-molar	Yes	80%	--	Yes	Yes

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Root Canal (Endodontic) Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D3425	Apicoectomy Molar	Yes	80%	--	Yes	Yes
D3426	Apicoectomy Add'l Root	Yes	80%	3 Per Molar ~ 1 Per Bicuspid ~ Posterior Teeth	Yes	Yes
D3428	Periradicular Bone Graft	Not Covered				
D3429	Periradicular Bone Graft	Not Covered				
D3430	Retrograde Filling	Yes	80%	3 Per Molar ~ 2 Per Bicuspid ~ 1 Per Anterior Teeth	Yes	Yes
D3431	Periradicular Bio Mats	Not Covered				
D3432	Periradicular Gtr	Not Covered				
D3450	Root Amputation	Yes	80%	--	Yes	Yes
D3460	Endodontic Implant	Not Covered				
D3470	Intentional Replantation	Not Covered				
D3471	Anterior Surgical Repair Of Root	Yes	80%	--	Yes	Yes
D3472	Premolar Surgical Repair Of Root	Yes	80%	--	Yes	Yes
D3473	Molar Surgical Repair Of Root	Yes	80%	--	Yes	Yes
D3501	Anterior Surgical Exposure	Yes	80%	--	Yes	Yes
D3502	Premolar Surgical Exposure	Yes	80%	--	Yes	Yes
D3503	Molar Surgical Exposure	Yes	80%	--	Yes	Yes
D3910	Isolation With Rubber Dam	Not Covered				
D3911	Intraorifice Barrier	Not Covered				
D3920	Hemisection	Yes	80%	--	Yes	Yes
D3921	Submergence Of An Erupted Tooth	Yes	80%	--	Yes	Yes
D3950	Canal Prep Fitting Post	Not Covered				
D3999	Unlisted Endodontic Proc	Not Covered				

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Surgical Gum (Periodontal) Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D4210	Gingivectomy 4 + Teeth	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4211	Gingivectomy 1 To 3 Teeth	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4212	Gingivectomy For Access	No	0%	Not Covered - Integral Procedures	No	No
D4230	Crwn Expsure Tooth Or Teeth	Not Covered				
D4231	Crwn Expsure One Or Teeth	Not Covered				
D4240	Gingival Flap 4 + Teeth	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4241	Gingival Flap 1-3 Teeth	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4245	Apically Positioned Flap	No	0%	Not Covered - Integral Procedures	No	No
D4249	Crown Lengthening	Yes	80%	1 Per Tooth ~ Per Lifetime	Yes	Yes
D4260	Osseous Surgery 4 + Teeth	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4261	Osseous Surg 1 To 3 Teeth	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4263	Bone Graft-first St Qd Ntrl Tth	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4264	Bone Graft-addl Site Qd Ntrl Tth	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4265	Bio Materials, Per Site	Not Covered				
D4266	Gtr-resorbable Barrier Ntrl Tth	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D4267	Gtr-non.resrb Barrier Ntrl Tth	Yes	80%	1 Per Tooth ~ Per 60 Months	Yes	Yes
D4268	Surgical Revision	No	0%	Not Covered - Integral Procedures	No	No
D4270	Pedicle Soft Tissue Graft	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4273	Autogenous Graft First Site	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4274	Distal Wedge Procedure	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes

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Surgical Gum (Periodontal) Services

Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D4275	Non-autogenous Graft First Site	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4276	Tissue And Pedicle Graft	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4277	Free Tissue Graft First Site	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4278	Free Tissue Graft Addl Site	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4283	Autogenous Graft First Site	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes
D4285	Non-autogenous Graft Addl Site	Yes	80%	1 Per 60 Months ~ Per Area of the Mouth	Yes	Yes

Non-Surgical Gum (Periodontal) Services

Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D4322	Splint - Intra-coronal	Not Covered				
D4323	Splint - Extra-coronal	Not Covered				
D4341	Scaling/planing 4 + Teeth	Yes	80%	1 Per 24 Months ~ Per Area of the Mouth	Yes	Yes
D4342	Scaling/planing 1-3 Teeth	Yes	80%	1 Per 24 Months ~ Per Area of the Mouth	Yes	Yes
D4346	Perio Scaling W/inflamm	Yes	80%	1 Per 36 Months ~ Age 16 And Older ~ In Combination with Cleanings	Yes	Yes
D4355	Full Mouth Debridement	Yes	80%	1 Per Lifetime	Yes	Yes
D4381	Antimicrobial Agents	Not Covered				
D4910	Periodontal Maintenance	Yes	80%	2 Per 12 Months	Yes	Yes
D4920	Unscheduled Dressing Chg	Not Covered				
D4921	Gingival Irrigation Quad	No	0%	Not Covered - Integral Procedures	No	No
D4999	Unlisted Periodontal Proc	Not Covered				

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Dentures, Denture Adjustments, Denture Repairs, Relining						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D5110	Complete Upper Denture	Yes	80%	1 Per 60 Months	Yes	Yes
D5120	Complete Lower Denture	Yes	80%	1 Per 60 Months	Yes	Yes
D5130	Immediate Upper Denture	Yes	80%	1 Per 60 Months	Yes	Yes
D5140	Immediate Lower Denture	Yes	80%	1 Per 60 Months	Yes	Yes
D5211	Upper Partial Resin Base	Yes	80%	1 Per 60 Months	Yes	Yes
D5212	Lower Partial Resin Base	Yes	80%	1 Per 60 Months	Yes	Yes
D5213	Upper Partial Metal Base	Yes	80%	1 Per 60 Months	Yes	Yes
D5214	Lower Partial Metal Base	Yes	80%	1 Per 60 Months	Yes	Yes
D5221	Immediate Upper Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5222	Immediate Lower Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5223	Immediate Upper Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5224	Immediate Lower Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5225	Flexible Upper Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5226	Flexible Lower Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5227	Immediate Maxillary Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5228	Immediate Mandibular Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5282	Unilateral Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5283	Unilateral Partial	Yes	80%	1 Per 60 Months	Yes	Yes
D5284	Unilateral Partial Dent	Yes	80%	1 Per 60 Months	Yes	Yes
D5286	Unilat Partial Dent Resin	Yes	80%	1 Per 60 Months	Yes	Yes
D5410	Adj Comp Upper Denture	Yes	80%	Integral Within 6 Months ~ By Same Dentist	Yes	Yes

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D5411	Adj Comp Lower Denture	Yes	80%	Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5421	Adj Partial Upper Denture	Yes	80%	Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5422	Adj Partial Lower Denture	Yes	80%	Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5511	Repair Denture Base	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5511	Repair Denture Base	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5512	Repair Denture Base	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5520	Repl Missing Teeth Comp Denture	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5611	Repair Resin Denture Base	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5612	Repair Resin Denture Base	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5621	Repair Cast Framework	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5622	Repair Cast Framework	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5630	Repr /replce Clsp Matrial	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5640	Repl Missing Teeth Part Denture	Yes	80%	4 Per 12 Months 4 Per 12 Months	Yes	Yes
D5650	Add Tooth To Partial	Yes	80%	4 Per 12 Months	Yes	Yes
D5650	Add Tooth To Partial	Yes	80%	4 Per 12 Months	Yes	Yes
D5660	Add Clasp/partial Denture	Yes	80%	4 Per 12 Months	Yes	Yes
D5660	Add Clasp/partial Denture	Yes	80%	4 Per 12 Months	Yes	Yes
D5670	Replace Teeth Max Denture	Yes	80%	1 Per 60 Months	Yes	Yes
D5671	Replace Teeth Mand Dent	Yes	80%	1 Per 60 Months	Yes	Yes

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D5710	Rebase Comp U Denture	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5711	Rebase Comp L Denture	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5720	Rebase U Partial Denture	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5721	Rebase L Partial Denture	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5725	Rebase Hybrid Prosthesis	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5730	Reline Comp Upper Direct	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5731	Reline Comp Lower Direct	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5740	Reline U Partial/direct	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5741	Reline L Partial/direct	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5750	Reline Upper Complete/indirect	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5751	Reline Lower Complete/indirect	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5760	Reline Upper Partial/indirect	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5761	Reline Lower Partial/indirect	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes
D5765	Sft Lnr Remv Denture - Indirect	Yes	80%	2 Per 12 Months Integral Within 6 Months ~ By Same Dentist	Yes	Yes

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D5810	Interim Complete Upper	Not Covered				
D5811	Interim Complete Lower	Not Covered				
D5820	Interim Partial Upper	Not Covered				
D5821	Interim Partial Lower	Not Covered				
D5850	Tissue Conditioning Upper	Yes	80%	2 Per Arch ~ Per 36 Months	Yes	Yes
D5851	Tissue Conditioning Lower	Yes	80%	2 Per Arch ~ Per 36 Months	Yes	Yes
D5862	Precision Attachment	Not Covered				
D5863	Overdenture Comp Max	Yes	80%	1 Per 60 Months	Yes	Yes
D5864	Overdenture Part Max	Yes	80%	1 Per 60 Months	Yes	Yes
D5865	Overdenture Comp Mand	Yes	80%	1 Per 60 Months	Yes	Yes
D5866	Overdenture Part Mand	Yes	80%	1 Per 60 Months	Yes	Yes
D5867	Replace Precision Attachment	Not Covered				
D5875	Modify Implant Prosthesis	Not Covered				
D5876	Add Metal Substructure	Not Covered				
D5899	Unlisted Rem Prosth Proc	Not Covered				
D5911	Facial Moulage, Sectional	Not Covered				
D5912	Facial Moulage, Complete	Not Covered				
D5913	Nasal Prosthesis	Not Covered				
D5914	Auricular Prosthesis	Not Covered				
D5915	Orbital Prosthesis	Not Covered				
D5916	Ocular Prosthesis	Not Covered				
D5919	Facial Prosthesis	Not Covered				
D5922	Nasal Septal Prosthesis	Not Covered				

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D5923	Ocular Prosthesis Interim	Not Covered				
D5924	Cranial Prosthesis	Not Covered				
D5925	Facial Implant Prosthesis	Not Covered				
D5926	Nasal Prosthesis Replmt	Not Covered				
D5927	Auricular Prost Replmt	Not Covered				
D5928	Orbital Prosthesis Replmt	Not Covered				
D5929	Facial Prosthesis Replmt	Not Covered				
D5931	Surgical Obturator	Not Covered				
D5932	Definitive Obturator	Not Covered				
D5933	Obturator Modification	Not Covered				
D5934	Mand Resect Prost/flange	Not Covered				
D5935	Mand Resect Prosthesis	Not Covered				
D5936	Obturator Interim	Not Covered				
D5937	Trismus Appliance	Not Covered				
D5951	Feeding Aid	Not Covered				
D5952	Pediatric Speech Aid	Not Covered				
D5953	Adult Speech Aid	Not Covered				
D5954	Palatal Augment Pros	Not Covered				
D5955	Palatal Lift Definitive	Not Covered				
D5958	Palatal Lift Interim	Not Covered				
D5959	Palatal Lift Modification	Not Covered				
D5960	Speech Aid Modification	Not Covered				
D5982	Surgical Stent	Not Covered				
D5983	Radiation Carrier	Not Covered				
D5984	Radiation Shield	Not Covered				
D5985	Radiation Cone Locator	Not Covered				



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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D5986	Fluoride Gel Carrier	Not Covered				
D5987	Commissure Splint	Not Covered				
D5988	Surgical Splint	Not Covered				
D5991	Topical Med Carrier	Not Covered				
D5992	Adjust Maxillofacial Pros	Not Covered				
D5993	Clean Maxillofacial Pros	Not Covered				
D5995	Medicament Carrier - Maxillary	Not Covered				
D5996	Medicament Carrier - Mandibular	Not Covered				
D5999	Maxillofacial Prosthesis	Not Covered				

Surgical Implant Procedures						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D6010	Endosteal Implant	Not Covered				
D6011	Second Stage Implant Surgery	Not Covered				
D6012	Place Interim Implant	Not Covered				
D6013	Mini Implant	Not Covered				
D6040	Epoosteal Implant	Not Covered				

Implant Supported Bridges & Dentures (Prosthetics)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D6050	Transosteal Implant	Not Covered				
D6051	Interim Implant Abutment	Not Covered				
D6055	Implant Connecting Bar	Not Covered				
D6056	Prefab Implant Abutment	Not Covered				
D6057	Custom Implant Abutment	Not Covered				

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Implant Supported Bridges & Dentures (Prosthetics)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D6058	Imp Abt Por/cer Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6059	Imp Abt Por/high Noble Cr	Yes	80%	1 Per 60 Months	Yes	Yes
D6060	Imp Abt Por/base Metal Cr	Yes	80%	1 Per 60 Months	Yes	Yes
D6061	Imp Abt Por/noble Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6062	Imp Abt Cast/high Noble	Yes	80%	1 Per 60 Months	Yes	Yes
D6063	Imp Abt Cast/base Metal	Yes	80%	1 Per 60 Months	Yes	Yes
D6064	Imp Abt Cast/noble Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6065	Implant Support Por/ce Cr	Yes	80%	1 Per 60 Months	Yes	Yes
D6066	Implant Support Por/me Cr	Yes	80%	1 Per 60 Months	Yes	Yes
D6067	Implant Support Metal Cr	Yes	80%	1 Per 60 Months	Yes	Yes
D6068	Imp Retainer Por/cer Fpd	Not Covered				
D6069	Imp Retainer Por/me Fpd	Not Covered				
D6070	Imp Retainer Por/me Fpd	Not Covered				
D6071	Imp Retainer Por/me Fpd	Not Covered				
D6072	Imp Retainer Cast Fpd	Not Covered				
D6073	Imp Retainer Cast Fpd	Not Covered				
D6074	Imp Retainer Cast Fpd	Not Covered				
D6075	Imp Support Retainer Fpd	Not Covered				
D6076	Imp Support Retainer Fpd	Not Covered				
D6077	Imp Support Retainer Fpd	Not Covered				
D6080	Implant Maintenance Proc	Not Covered				

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D6081	Implant Maintenance Proc	Not Covered				
D6082	Implant Sup Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6083	Implant Sup Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6084	Implant Sup Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6085	Interim Implant Abutment	Not Covered				
D6086	Implant Sup Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6087	Implant Sup Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6088	Implant Sup Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6089	Loose Implant Screw Per Screw	Yes	80%	1 Per Tooth ~ Integral Within 12 Months ~ By Same Dentist 1 Per Tooth ~ Per 3 Years 1 Per Tooth ~ Per 12 Months	Yes	Yes
D6090	Repr Implant/abutment Prosthesis	Not Covered				
D6091	Replace Implant Attachment	Not Covered				
D6092	Recement Implant Crown	Yes	80%	1 Per Tooth ~ Integral Within 12 Months ~ By Same Dentist 1 Per Tooth ~ Per 3 Years	Yes	Yes
D6093	Recement Implant Fpd	Yes	80%	1 Per Tooth ~ Integral Within 12 Months ~ By Same Dentist 1 Per Tooth ~ Per 3 Years	Yes	Yes
D6094	Imp Abut Titanium Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6096	Implant Maintenance Proc	Not Covered				
D6097	Abutment Sup Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6098	Implant Sup Retainer	Not Covered				
D6099	Implant Sup Retainer	Not Covered				
D6100	Implant Removal	Not Covered				
D6101	Debride Implant Defect	Not Covered				
D6102	Contour Implant Defect	Not Covered				

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Implant Supported Bridges & Dentures (Prosthetics)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D6103	Bone Graft Implant Defect	Not Covered				
D6104	Implant Bone Graft	Not Covered				
D6105	Implant Body Removal	Not Covered				
D6106	Gtr - Resorbable Barrier	Not Covered				
D6107	Gtr - Non-resorb Barrier	Not Covered				
D6110	Implant Complete Denture	Not Covered				
D6111	Implant Complete Denture	Not Covered				
D6112	Implant Partial Denture	Not Covered				
D6113	Implant Partial Denture	Not Covered				
D6114	Implant Fixed Comp Denture	Not Covered				
D6115	Implant Fixed Comp Denture	Not Covered				
D6116	Implant Fixed Part Denture	Not Covered				
D6117	Implant Fixed Part Denture	Not Covered				
D6118	Implant Complete Denture	Not Covered				
D6119	Implant Complete Denture	Not Covered				
D6120	Implant Sup Retainer	Not Covered				
D6121	Implant Sup Retainer	Not Covered				
D6122	Implant Sup Retainer	Not Covered				
D6123	Implant Sup Retainer	Not Covered				
D6180	Implant Maintenance Procedures	Not Covered				
D6190	Implant Index	Not Covered				
D6191	Semiprecision Abutment Plcmnt	Not Covered				
D6192	Semiprecision Attachment Plcmnt	Not Covered				

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Implant Supported Bridges & Dentures (Prosthetics)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D6193	Implant Screw Replacement	Yes	80%	1 Per Tooth ~ Per 3 Years ~ Integral Within 12 Months ~ By Same Dentist	Yes	Yes
D6194	Imp Titanium Crown Fpd	Not Covered				
D6195	Abutment Sup Retainer	Not Covered				
D6197	Repl Of Rest Material, Per Implt	Not Covered				
D6198	Remv Intrm Implant Component	Not Covered				
D6199	Unspecified Implant Proc	Not Covered				

Fixed Bridges & Dentures (Prosthetics)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D6205	Indirect Resin Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6210	Cast High Noble Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6211	Cast Base Metal Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6212	Cast Noble Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6214	Titanium Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6240	Porc High Noble Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6241	Porc Base Metal Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6242	Porc Noble Metal Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6243	Porc Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6245	Pontic Porcelain/ceramic	Yes	80%	1 Per 60 Months	Yes	Yes
D6250	Resin High Noble Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6251	Resin Base Metal Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6252	Resin Noble Metal Pontic	Yes	80%	1 Per 60 Months	Yes	Yes
D6253	Interim Pontic	Not Covered				

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Fixed Bridges & Dentures (Prosthetics)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D6545	Cast Bonded Retainer	Yes	80%	1 Per 60 Months	Yes	Yes
D6548	Retainer Porc/ceramic	Yes	80%	1 Per 60 Months	Yes	Yes
D6549	Resin Retainer	Yes	80%	1 Per 60 Months	Yes	Yes
D6600	Inlay Por/ceramic 2 Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6601	Inlay Por/ceramic 3+surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6602	Inlay High Metal 2 Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6603	Inlay High Metal 3+surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6604	Inlay Base Metal 2 Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6605	Inlay Base Metal 3+ Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6606	Inlay Noble Metal 2 Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6607	Inlay Noble Metal 3+ Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6608	Onlay Por/ceramic 2 Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6609	Onlay Por/ceramic 3+ Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6610	Onlay High Metal 2 Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6611	Onlay High Metal 3+ Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6612	Onlay Base Metal 2 Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6613	Onlay Base Metal 3+ Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6614	Onlay Noble Metal 2 Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6615	Onlay Noble Metal 3+ Surf	Yes	80%	1 Per 60 Months	Yes	Yes
D6624	Titanium Inlay	Yes	80%	1 Per 60 Months	Yes	Yes
D6634	Titanium Onlay	Yes	80%	1 Per 60 Months	Yes	Yes

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Fixed Partial Denture Retainers						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D6710	Indrct Retainer Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6720	Resn High Nobl Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6721	Rsn Bse Metl Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6722	Resn Nble Metal Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6740	Por/cer Rtrn Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6750	Porc High Nble Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6751	Por Bse Metl Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6752	Por Nobl Metl Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6753	Por Retainer Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6780	3/4 Hgh Nble Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6781	3/4 Bse Metl Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6782	3/4 Cst Nble Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6783	3/4 Por/cer Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6784	3/4 Retainer Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6790	Cst Hgh Nble Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6791	Cst Bse Metl Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6792	Cst Nble Rtrn Crwn	Yes	80%	1 Per 60 Months	Yes	Yes
D6793	Interim Retainer Crown	Not Covered				
D6794	Titanium Retainer Crown	Yes	80%	1 Per 60 Months	Yes	Yes
D6920	Connector Bar	Not Covered				
D6930	Recement Fixed Denture	Yes	80%	1 Per Tooth ~ Integral Within 12 Months ~ By Same Dentist 1 Per Tooth ~ Per 3 Years	Yes	Yes
D6930	Recement Fixed Denture	Yes	80%	1 Per Tooth ~ Integral Within 12 Months ~ By Same Dentist 1 Per Tooth ~ Per 3 Years	Yes	Yes

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Fixed Partial Denture Retainers								
Procedure	Description	Covered	In-Network Coverage % or Copay \$		Limitation	Applies to Deductible	Applies to Maximum	
D6940	Stress Breaker	Not Covered						
D6950	Precision Attachment	Not Covered						
D6980	Fixed Partial Dent Repair	Yes	80%	--		Yes	Yes	
D6985	Pediatric Partial	Not Covered						
D6999	Unspec Fixed Prosthetic	Not Covered						

Oral Surgery								
Procedure	Description	Covered	In-Network Coverage % or Copay \$		Limitation	Applies to Deductible	Applies to Maximum	
D7111	Ext Coronal Remnant Prim	Yes	80%	--		Yes	Yes	
D7140	Extraction	Yes	80%	--		Yes	Yes	
D7210	Extraction, Erupted Tooth	Yes	80%	--		Yes	Yes	
D7220	Soft Tissue Impaction	Yes	80%	--		Yes	Yes	
D7230	Partial Bony Impaction	Yes	80%	--		Yes	Yes	
D7240	Complete Bony Impaction	Yes	80%	--		Yes	Yes	
D7241	Cbi-unusual Surgical Comp	Yes	80%	--		Yes	Yes	
D7250	Removal Of Tooth Roots	Yes	80%	--		Yes	Yes	
D7251	Coronectomy	Yes	80%	--		Yes	Yes	
D7252	Partial Extraction Of A Tooth	Not Covered						
D7259	Nerve Dissection	Yes	80%		1 Per Tooth ~ Per Lifetime ~ Permanent Teeth	Yes	Yes	
D7260	Oroantral Fistula Closure	Not Covered						
D7261	Close Sinus Perforation	Not Covered						
D7270	Tooth Reimplantation	Yes	80%	--		Yes	Yes	
D7272	Tooth Transplantation	Not Covered						
D7280	Exposure Unerupted Tooth	Yes	80%		1 Per Tooth ~ Per Lifetime	Yes	Yes	

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Oral Surgery						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D7282	Mobilization Of Tooth	Not Covered				
D7283	Device To Aid Eruption	Yes	80%	1 Per Tooth ~ Per Lifetime	Yes	Yes
D7284	Biopsy Of Minor Salivary Glands	Yes	80%	--	Yes	Yes
D7285	Biopsy Hard Oral Tissue	Not Covered				
D7286	Biopsy Soft Oral Tissue	Not Covered				
D7287	Cytology Sample	Not Covered				
D7288	Brush Biopsy	Not Covered				
D7290	Reposition Teeth-surgical	Not Covered				
D7291	Fiberotomy	Yes	80%	1 Per Tooth ~ Per Lifetime ~ Tooth Nbrs 5 Thru 12 ~ Tooth Nbrs 21 Thru 28	Yes	Yes
D7292	Temp Anchor/w/plate/flap	Not Covered				
D7293	Temp Anchor With Flap	Not Covered				
D7294	Temp Anchor Without Flap	Not Covered				
D7295	Harvest Bone For Graft	Not Covered				
D7296	Corticotomy 1-3 Teeth	Not Covered				
D7297	Corticotomy 4 Or More Teeth	Not Covered				
D7298	Remv Of Scrw Ret Plate, Req Flap	Not Covered				
D7299	Remv Of Temp Anc Dvce, Req Flap	Not Covered				
D7300	Remv Of Temp Anc Dvc, W/o Flap	Not Covered				
D7310	Alveo With Ext 4+ Teeth	Yes	80%	--	Yes	Yes
D7311	Alveo With Ext 1-3 Teeth	No	0%	Not Covered - Integral Procedures	No	No
D7320	Alveo No Ext 4+ Teeth	Yes	80%	--	Yes	Yes
D7321	Alveo No Ext 1-3 Teeth	Yes	80%	--	Yes	Yes
D7340	Vestibuloplasty	Yes	80%	--	Yes	Yes

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D7350	Vestibuloplasty, Complex	Yes	80%	--	Yes	Yes
D7410	Benign Lesion, 1.25 Cm	Not Covered				
D7411	Benign Lesion Over 1.25cm	Not Covered				
D7412	Benign Lesion Complicated	Not Covered				
D7413	Malignant Lesion 1.25cm	Not Covered				
D7414	Malig Lesion Over 1.25cm	Not Covered				
D7415	Malig Lesion Complicated	Not Covered				
D7440	Malignant Tumor, 1.25 Cm	Not Covered				
D7441	Mal Tumor Over 1.25 Cm	Not Covered				
D7450	Odontogenic Cyst 1.25 Cm	Yes	80%	--	Yes	Yes
D7451	Odont Cyst Over 1.25 Cm	Yes	80%	--	Yes	Yes
D7460	Nonodont Cyst 1.25 Cm	Not Covered				
D7461	Nonodont Cyst Over 1.25cm	Not Covered				
D7465	Destruction Of Lesion	Not Covered				
D7471	Removal Lateral Exostosis	Yes	80%	--	Yes	Yes
D7472	Removal Torus Palatinus	Yes	80%	--	Yes	Yes
D7473	Remove Torus Mandibularis	Yes	80%	--	Yes	Yes
D7485	Reduce Osseous Tuberosity	Yes	80%	--	Yes	Yes
D7490	Radical Resect Max/mand	Not Covered				

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Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D7509	Marsupialization Of Odont Cyst	Yes	80%	--	Yes	Yes
D7510	I And D Abscess Intraoral	Yes	80%	By Report	Yes	Yes
D7511	I And D Intraoral Complicated	Yes	80%	By Report	Yes	Yes
D7520	I And D Abscess, Extraoral	Not Covered				
D7521	I And D Extraoral Complicated	Not Covered				
D7530	Foreign Body, Skin/subcu	Not Covered				
D7540	Foreign Body, Muscle/bone	Not Covered				
D7550	Sequestrectomy	Not Covered				
D7560	Maxillary Sinusotomy	Not Covered				
D7610	Open Reduction Maxilla	Not Covered				
D7620	Closed Reduction Maxilla	Not Covered				
D7630	Open Reduction Mandible	Not Covered				
D7640	Closed Reduction Mandible	Not Covered				
D7650	Open Reduction Malar	Not Covered				
D7660	Closed Reduction Malar	Not Covered				
D7670	Alveolar Fx Simple/closed	Yes	80%	--	Yes	Yes
D7671	Alveolar Fx Simple/open	Yes	80%	--	Yes	Yes
D7680	Reduction Facial Bones	Not Covered				
D7710	Open Red. Comp. Maxilla	Not Covered				
D7720	Closed Red. Comp. Maxilla	Not Covered				
D7730	Open Red. Comp. Mandible	Not Covered				

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			Coverage % or	Copay \$				
D7740	Closed Red. Comp. Mand.	Not Covered						
D7750	Open Red Comp. Malar	Not Covered						
D7760	Closed Red. Comp. Malar	Not Covered						
D7770	Alveolar Fx Compound/open	Yes	80%	--		Yes	Yes	
D7771	Alveolar Fx Comp/closed	Yes	80%	--		Yes	Yes	
D7780	Comp Red. Facial Bones	Not Covered						
D7810	Open Reduction Tmj	Not Covered						
D7820	Closed Reduction Tmj	Not Covered						
D7830	Manipulation Tmj	Not Covered						
D7840	Condylectomy Tmj	Not Covered						
D7850	Surgical Discectomy Tmj	Not Covered						
D7852	Disc Repair Tmj	Not Covered						
D7854	Synovectomy Tmj	Not Covered						
D7856	Myotomy Tmj	Not Covered						
D7858	Joint Reconstruction Tmj	Not Covered						
D7860	Arthrotomy Tmj	Not Covered						
D7865	Arthroplasty Tmj	Not Covered						
D7870	Arthrocentesis Tmj	Not Covered						
D7871	Lysis/lavage Tmj	Not Covered						
D7872	Arthroscopy Tmj, Diag.	Not Covered						
D7873	Arthroscopy	Not Covered						
D7874	Arthroscopy	Not Covered						
D7875	Arthroscopy: Synovectomy	Not Covered						
D7876	Arthroscopy: Discectomy	Not Covered						
D7877	Arthroscopy: Debridement	Not Covered						

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Oral Surgery						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D7880	Occlusal Orthotic Device	Not Covered				
D7881	Orthotic Adjustment	Not Covered				
D7899	Unspecified Tmd Therapy	Not Covered				

Other Repair Procedures						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D7910	Suture Up To 5 Cm	Not Covered				
D7911	Complex Suture To 5 Cm	Not Covered				
D7912	Complex Suture Over 5 Cm	Not Covered				
D7920	Skin Graft	Not Covered				
D7921	Concentrate Product	Not Covered				
D7922	Biological Dressing	No	0%	Not Covered - Integral Procedures	No	No
D7939	Indexing Of Osteotomy	Not Covered				
D7940	Osteoplasty	Not Covered				
D7941	Osteotomy Mand Rami	Not Covered				
D7943	Osteotomy Mand Rami/graft	Not Covered				
D7944	Osteotomy, Segmental	Not Covered				
D7945	Osteotomy, Body Mandible	Not Covered				
D7946	Lefort I, Total	Not Covered				
D7947	Lefort I Segmented	Not Covered				
D7948	Lefort Ii Or Iii	Not Covered				
D7949	Lefort Ii Or Iii, Graft	Not Covered				
D7950	Graft Mand/maxilla	Not Covered				
D7951	Sinus Augmentation	Not Covered				
D7952	Sinus Augmentation	Not Covered				
D7953	Bone Graft Preserve Ridge	Not Covered				

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Other Repair Procedures								
Procedure	Description	Covered	In-Network		Limitation	Applies to Deductible	Applies to Maximum	
			Coverage % or Coplay \$					
D7955	Repair Tissue Defect Head	Not Covered						
D7956	Gtr Resorbable Per Site	Not Covered						
D7957	Gtr - Non-resrbable Per Site	Not Covered						
D7961	Buccal Frenectomy	Yes	80%	--		Yes	Yes	
D7962	Lingual Frenectomy	Yes	80%	--		Yes	Yes	
D7963	Frenuloplasty	Yes	80%	--		Yes	Yes	
D7970	Excision Tissue/arch	Not Covered						
D7971	Exc Pericoronal Gingiva	Yes	80%	--		Yes	Yes	
D7972	Reduce Fibrous Tuberosity	Yes	80%	--		Yes	Yes	
D7979	Sialolithotomy	Not Covered						
D7980	Surg Sialolithotomy	Not Covered						
D7981	Excise Salivary Gland	Not Covered						
D7982	Sialodochoplasty	Not Covered						
D7983	Closure Salivary Fistula	Not Covered						
D7990	Emergency Tracheotomy	Not Covered						
D7991	Coronoidectomy, Mandible	Not Covered						
D7993	Surg Plcmnt Craniofacial Imp	Not Covered						
D7994	Surg Plcmnt Zygomatic Imp	Not Covered						
D7995	Synthetic Bone Graft	Yes	80%	--		Yes	Yes	
D7996	Implant - Mandible	Not Covered						
D7997	Appliance Removal	Not Covered						
D7998	Fixation Device No Fx	Not Covered						
D7999	Unlisted Oral Surg Proc	Not Covered						



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Braces (Orthodontics)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D8010	Limited Ortho Primary	Not Covered				
D8020	Limited Ortho Transition	Not Covered				
D8030	Limited Ortho Adolescent	Not Covered				
D8040	Limited Ortho Adult	Not Covered				
D8070	Comp Ortho Trtmnt Trans	Not Covered				
D8080	Comp Ortho Trtmnt Adoles	Not Covered				
D8090	Comp Ortho Trtmnt Adult	Not Covered				
D8091	Ort Tx For Orthognathic Surg	Not Covered				
D8210	Habit Appliance Removable	Not Covered				
D8220	Habit Appliance Fixed	Not Covered				
D8660	Pre-ortho Examination	Not Covered				
D8670	Periodic Ortho Visit	Not Covered				
D8671	Ort Visit For Orthognathic Surg	Not Covered				
D8680	Orthodontic Retention	Not Covered				
D8681	Ortho Retainer Adjustment	Not Covered				
D8695	Removal Of Ortho Appliance	Not Covered				
D8696	Repair Ortho Appl Max	Not Covered				
D8697	Repair Ortho Appl Mand	Not Covered				
D8698	Recement Rtnr Max	Not Covered				
D8699	Recement Rtnr Mand	Not Covered				
D8701	Repair Fix Rtnr Max	Not Covered				
D8702	Repair Fix Rtnr Mand	Not Covered				
D8703	Replace Retainer	Not Covered				
D8704	Replace Retainer	Not Covered				

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Braces (Orthodontics)						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D8999	Unlisted Ortho Treatment	Not Covered				

Emergency (Palliative) Treatment						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D9110	Palliative Treatment	Yes	100%	2 Per 12 Months ~ In Combination with Pulpal Debridement & Palliative Treatment	No	Yes
D9120	Fixed Partial Sectioning	Not Covered				
D9130	Unspecified Tmd Therapy	Not Covered				
D9210	Local Anes/no Operative	No	0%	Not Covered - Integral Procedures	No	No
D9211	Regional Block Anesthesia	No	0%	Not Covered - Integral Procedures	No	No
D9212	Trigeminal Div Block Anes	No	0%	Not Covered - Integral Procedures	No	No
D9215	Local Anesthesia	No	0%	Not Covered - Integral Procedures	No	No

Adjunctive Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D9219	Anesthesia Evaluation	No	0%	Not Covered - Integral Procedures	No	No
D9222	General Anesthesia	Yes	80%	60 Minutes Per Visit	Yes	Yes
D9223	General Anesthesia	Yes	80%	60 Minutes Per Visit	Yes	Yes
D9230	Analgesia, Nitrous Oxide	Yes	80%	--	Yes	Yes
D9239	Intravenous Sedation	Yes	80%	60 Minutes Per Visit	Yes	Yes
D9243	Intravenous Sedation	Yes	80%	60 Minutes Per Visit	Yes	Yes
D9248	Non Iv Conscious Sedation	Yes	80%	--	Yes	Yes
D9310	Consultation	Yes	100%	3 Per 12 Months	No	Yes
D9311	Consultation	Not Covered				

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Adjunctive Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D9410	House Call/ext Facility	Not Covered				
D9420	Hospital Call	Not Covered				
D9430	Office Visit-observation	Not Covered				
D9440	Office Visit After Hours	Not Covered				
D9450	Case Presentation	Not Covered				
D9610	Therapeutic Drug	Not Covered				
D9612	Therapeutic Drugs Two+	Not Covered				
D9613	Therapeutic Drugs, Per Quad	Not Covered				
D9630	Drugs Or Medicaments	Not Covered				

Other Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D9910	Desensitizing Medicaments	Not Covered				
D9911	Desensitizing Resin	Not Covered				
D9912	Previsit Patient Screening	Not Covered				
D9913	Neuromodulators	Not Covered				
D9914	Dermal Fillers	Not Covered				
D9920	Behavior Management	Not Covered				
D9930	Complications Postsurg	Not Covered				
D9932	Clean And Inspect Denture	No	0%	Not Covered - Integral Procedures	No	No
D9933	Clean And Inspect Denture	No	0%	Not Covered - Integral Procedures	No	No
D9934	Clean And Inspect Denture	No	0%	Not Covered - Integral Procedures	No	No
D9935	Clean And Inspect Denture	No	0%	Not Covered - Integral Procedures	No	No
D9938	Fabrication Aesthetic Appliance	Not Covered				



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Other Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D9939	Placement Of Aesthetic Appliance	Not Covered				
D9941	Athletic Mouthguard	Not Covered				
D9942	Repair Occlusal Guard	Not Covered				
D9943	Occlusal Guard Adjustment	Not Covered				
D9944	Occlusal Guard (Night Guard)	Not Covered				
D9945	Occlusal Guard (Night Guard)	Not Covered				
D9946	Occlusal Guard (Night Guard)	Not Covered				
D9947	Sleep Apnea Appliance	Not Covered				
D9948	Sleep Apnea Appl Adjustment	Not Covered				
D9949	Sleep Apnea Appl Repair	Not Covered				
D9950	Occlusion Analysis	Not Covered				
D9951	Occlusal Adjust Limited	Not Covered				
D9952	Occlusal Adjust Complete	Not Covered				
D9953	Reline Sleep Apnea Appliance	Not Covered				
D9954	Oat Morning Repositioning Device	Not Covered				
D9955	Oat Titration Visit	Not Covered				
D9956	Admn Of Home Sleep Apnea Test	Not Covered				
D9957	Screen For Breathing Disorder	Not Covered				
D9959	Sleep Apnea Procedure	Not Covered				
D9961	Case Management	Not Covered				
D9970	Enamel Microabrasion	Not Covered				
D9971	Odontoplasty	Not Covered				
D9972	Office Bleaching/arch	Not Covered				

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Other Services						
Procedure	Description	Covered	In-Network Coverage % or Copay \$	Limitation	Applies to Deductible	Applies to Maximum
D9973	External Bleaching/tooth	Not Covered				
D9974	Internal Bleaching/tooth	Not Covered				
D9975	Home Bleaching/arch	Not Covered				
D9985	Sales Tax	Not Covered				
D9986	Missed Appointment	Not Covered				
D9987	Cancelled Appointment	Not Covered				
D9990	Unlisted Adjunctive Svc	Not Covered				
D9991	Case Management	Not Covered				
D9992	Case Management	Not Covered				
D9993	Case Management	Not Covered				
D9994	Case Management	Not Covered				
D9995	Teledentistry	Not Covered				
D9996	Teledentistry	Not Covered				
D9997	Dental Case Mgt	Not Covered				
D9999	Unlisted Adjunctive Svc	Not Covered				