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EssentialSmile Georgia - Total Care

Members can search for a Network Provider at
www. Solsticecare.com/provider-search.aspx
Member Services: 1.855.574.1284

The Copayments listed on this Schedule of Benefits apply when a Participating Provider who is a General Dentists performs the Covered Services. **You are responsible for requesting Preauthorization for treatment of malignancies, cysts or neoplasms, general** anesthesia, IV sedation, crowns, bridges, prosthetics, and Network Specialist Dentists.

Symbol Legend	† Procedures that are not eligible at a Specialist ^ Adult Copayments that do not include the cost of material and laboratory fees.	
Cost-Sharing	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Deductible Child under Age 19 (Applies to all services)	**$30**	
Adult (Applies to all services)	**$0**	
Out-of-Pocket Limit One (1) per Child under Age 19	$450	In circumstances where a Member receives emergency care in non-network facility, We will fully reimburse a non-network physician or provider for emergency care servcices at the usual and customary rate or at an agreed rate until the Member can reasonably be expected to transfer to a network physician or provider.
More than One (1) Child under Age 19	$900	

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
	APPOINTMENTS			
D0120	Periodic oral evaluation - established patient	1 Every 6 Months	$0	$0
D0140	Limited oral evaluation - problem focused	1 Every 6 Months	$0	$0
D0150	Comprehensive oral evaluation - new or established patient	1 Every 36 Months	$0	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report		$0	$0

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D0180	Comprehensive periodontal evaluation - new or established patient	1 Every 36 Months	$0	$0
	RADIOGRAPHY / DIAGNOSTIC DENTISTRY			
D0210	Intraoral – comprehensive series of radiographic images	1 Every 60 Months	$0	$16
D0220	Intraoral - periapical first radiographic image		$0	$12
D0230	Intraoral - periapical each additional radiographic image		$0	$10
D0240	Intraoral - occlusal radiographic image		$0	$10
D0270	Bitewing - single radiographic image	1 Set Every 6 Months	$0	$7
D0272	Bitewings - two radiographic images	1 Set Every 6 Months	$0	$10
D0273	Bitewings - three radiographic images	1 Set Every 6 Months	$0	$10
D0274	Bitewings - four radiographic images	1 Set Every 6 Months	$0	$12
D0277	Vertical bitewings - 7 to 8 radiographic images	1 Set Every 6 Months	$0	$16
D0330	Panoramic radiographic image	1 Every 60 Months	$0	$16
D0340	2d cephalometric radiographic image – acquisition, measurement and analysis		$125	$150
D0350	2d oral/facial photographic image obtained intra-orally or extra-orally		$31	$30
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw		Not Covered	$175
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible		Not Covered	$175
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium		Not Covered	$175
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium		Not Covered	$175
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures		Not Covered	$175
D0369	Maxillofacial MRI capture and interpretation		Not Covered	$175
D0370	Maxillofacial ultrasound capture and interpretation		Not Covered	$175
D0371	Sialoendoscopy capture and interpretation		Not Covered	$175
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw		Not Covered	$175
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible		Not Covered	$175
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium		Not Covered	$175
D0383	Cone beam CT image capture with field of view of both jaws; with or without cranium		Not Covered	$175
D0384	Cone beam CT image capture for TMJ series including two or more exposures		Not Covered	$175
D0385	Maxillofacial MRI image capture		Not Covered	$175

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D0386	Maxillofacial ultrasound image capture		Not Covered	$175
D0393	Virtual treatment simulation using 3d image volume or surface scan		Not Covered	$125
D0394	Digital subtraction of two or more images or image volumes of the same modality		Not Covered	$12
D0395	Fusion of two or more 3d image volumes of one or more modalities		Not Covered	$12
D0415	Collection of microorganisms for culture and sensitivity		Not Covered	$0
D0425	Caries susceptibility tests		Not Covered	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures		Not Covered	$56
D0460	Pulp vitality tests		Not Covered	$25
D0470	Diagnostic casts		$55	$50
	PREVENTIVE DENTISTRY			
D1110	Prophylaxis - adult	Dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive (6) months	$0	$0
D1120	Prophylaxis - child	Dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive (6) months	$0	$0
D1206	Topical application of fluoride varnish	Limited To 2 Every 12 Months	$15	$12
D1208	Topical application of fluoride – excluding varnish	Limited To 2 Every 12 Months	$15	$12
D1351	Sealant - per tooth	1 Sealant Per Unrestored Permanent Tooth Every 36 Months	$25	$20
D1510	Space maintainer - fixed, unilateral - per quadrant		$0	$0
D1516	Space maintainer – fixed – bilateral, maxillary		$0	$0
D1517	Space maintainer – fixed – bilateral, mandibular		$0	$0
D1520	Space maintainer - removable, unilateral - per quadrant		$0	$0
D1526	Space maintainer – removable – bilateral, maxillary		$0	$0

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D1527	Space maintainer – removable – bilateral, mandibular		$0	$0
D1551	Re-cement or re-bond bilateral space maintainer - maxillary		$30	$30
D1552	Re-cement or re-bond bilateral space maintainer - mandibular		$30	$30
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant		$30	$30
	RESTORATIVE DENTISTRY			
D2140	Amalgam - one surface, primary or permanent		$56	$60
D2150	Amalgam - two surfaces, primary or permanent		$65	$65
D2160	Amalgam - three surfaces, primary or permanent		$85	$85
D2161	Amalgam - four or more surfaces, primary or permanent		$109	$110
D2330	Resin-based composite - one surface, anterior		$65	$65
D2331	Resin-based composite - two surfaces, anterior		$84	$85
D2332	Resin-based composite - three surfaces, anterior		$102	$110
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)		$124	$135
D2391	Resin-based composite - one surface, posterior		Not Covered	$105
D2392	Resin-based composite - two surfaces, posterior		Not Covered	$120
D2393	Resin-based composite - three surfaces, posterior		Not Covered	$130
D2394	Resin-based composite - four or more surfaces, posterior		Not Covered	$150
D2510	Inlay - metallic - one surface		$350	$380
D2520	Inlay - metallic - two surfaces		$350	$420
D2530	Inlay - metallic - three or more surfaces		$350	$465
D2542	Onlay - metallic - two surfaces		$350	$505
D2543	Onlay - metallic - three surfaces		$350	$545
D2544	Onlay - metallic - four or more surfaces		$350	$560
D2642	Onlay - porcelain/ceramic - two surfaces		$350	$435^
D2643	Onlay - porcelain/ceramic - three surfaces		$350	$535^
D2740	Crown - porcelain/ceramic	Limited To 1 Per Tooth Every 60 Months	$350	$330^
D2750	Crown - porcelain fused to high noble metal	Limited To 1 Per Tooth Every 60 Months	$350	$350^
D2751	Crown - porcelain fused to predominantly base metal	Limited To 1 Per Tooth Every 60 Months	$350	$350^
D2752	Crown - porcelain fused to noble metal	Limited To 1 Per Tooth Every 60 Months	$350	$350^
D2780	Crown - 3/4 cast high noble metal	Limited To 1 Per Tooth Every 60 Months	$350	$350^
D2781	Crown - 3/4 cast predominantly base metal	Limited To 1 Per Tooth Every 60 Months	$350	$350^

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D2783	Crown - 3/4 porcelain/ceramic	Limited To 1 Per Tooth Every 60 Months	$350	$350^
D2790	Crown - full cast high noble metal	Limited To 1 Per Tooth Every 60 Months	$350	$350^
D2791	Crown - full cast predominantly base metal	Limited To 1 Per Tooth Every 60 Months	$350	$350^
D2792	Crown - full cast noble metal		$350	$350^
D2794	Crown - titanium and titanium alloys	Limited To 1 Per Tooth Every 60 Months	$350	$350^
D2799	Interim crown– further treatment or completion of diagnosis necessary prior to final impression		$350	Not Covered
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		$36	$40
D2920	Re-cement or re-bond crown		$36	$40
D2930	Prefabricated stainless steel crown - primary tooth	Limited To 1 Per Tooth Every 60 Months	$110	$100
D2931	Prefabricated stainless steel crown - permanent tooth	Limited To 1 Per Tooth Every 60 Months	$110	$100
D2940	Protective restoration		$32	$35
D2950	Core buildup, including any pins when required	Limited To 1 Per Tooth Every 60 Months	$90	$75
D2951	Pin retention - per tooth, in addition to restoration		$24	$25
D2954	Prefabricated post and core in addition to crown	Limited To 1 Per Tooth Every 60 Months	$140	$90
D2960	Labial veneer (resin laminate) - chairside		$300	Not Covered
D2961	Labial veneer (resin laminate) - laboratory		$350	Not Covered
D2962	Labial veneer (porcelain laminate) - laboratory		$350	Not Covered
D2980	Crown repair necessitated by restorative material failure		$95	$45
	ENDODONTICS SERVICES			
D3110	Pulp cap - direct (excluding final restoration		$95	Not Covered
D3120	Pulp cap - indirect (excluding final restoration)		$95	Not Covered
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service	$65	$85
D3221	Pulpal debridement, primary and permanent teeth		$65	Not Covered
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service	$75	$75
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	Limited to once per tooth per lifetime	$157	$157

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	Limited to once per tooth per lifetime	$200	$200
D3310	Endodontic therapy, anterior tooth (excluding final restoration)		$350	$395
D3320	Endodontic therapy, premolar tooth (excluding final restoration)		$350	$485
D3330	Endodontic therapy, molar tooth (excluding final restoration)		$350	$700
D3346	Retreatment of previous root canal therapy - anterior		$350	$550
D3347	Retreatment of previous root canal therapy - premolar		$350	$700
D3348	Retreatment of previous root canal therapy - molar		$350	$850
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)		$160	$160
D3352	Apexification/recalcification – interim medication replacement		$90	$90
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)		$235	$235
D3410	Apicoectomy - anterior		$350	$385
D3421	Apicoectomy - premolar (first root)		$350	$413
D3425	Apicoectomy - molar (first root)		$350	$495
D3426	Apicoectomy (each additional root)		$176	$176
D3430	Retrograde filling - per root		$95	$95
D3450	Root amputation - per root		$235	$235
D3920	Hemisection (including any root removal), not including root canal therapy		$205	$205
	PERIODONTIC SERVICES			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited To 1 Every 36 Months	$350	$450
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Limited To 1 Every 36 Months	$149	$150
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited To 1 Every 36 Months	$325	$325
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Limited To 1 Every 36 Months	$325	$325
D4249	Clinical crown lengthening – hard tissue		$350	$500

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	Limited To 1 Every 36 Months	$350	$786
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	Limited To 1 Every 36 Months	$350	$786
D4263	Bone replacement graft – retained natural tooth – first site in quadrant		$350	Not Covered
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant		$350	Not Covered
D4270	Pedicle soft tissue graft procedure		$350	$447
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft		$350	$550
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft		$350	Not Covered
D4276	Combined connective tissue and pedicle graft, per tooth		$350	Not Covered
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft		$350	$375
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		$150	$150
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		$350	Not Covered
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		$300	Not Covered
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns		$350	Not Covered
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns		$350	Not Covered
D4341	Periodontal scaling and root planing - four or more teeth per quadrant		$150	150†
D4342	Periodontal scaling and root planing - one to three teeth per quadrant		$80	95†

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	Limited To 1 Per Lifetime	$90	$90†
D4910	Periodontal maintenance	Dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive (6) months	$100	$101
	PROSTHODONTICS- REMOVABLE			
D5110	Complete denture - maxillary	Limited To 1 Every 60 Months	$350	$455^
D5120	Complete denture - mandibular	Limited To 1 Every 60 Months	$350	$455^
D5130	Immediate denture - maxillary	Limited To 1 Every 60 Months	$350	$525^
D5140	Immediate denture - mandibular	Limited To 1 Every 60 Months	$350	$525^
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	Limited To 1 Every 60 Months	$350	$350^
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	Limited To 1 Every 60 Months	$350	$350^
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Limited To 1 Every 60 Months	$350	$575^
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Limited To 1 Every 60 Months	$350	$575^
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Limited To 1 Every 60 Months	$350	$195^
D5283	Removable unilateral partial denture – one piece cast metal (including rententive/clasping materias, rests, and teeth), mandibular	Limited To 1 Every 60 Months	$350	$195^
D5410	Adjust complete denture - maxillary		$30	$30^
D5411	Adjust complete denture - mandibular		$30	$30^
D5421	Adjust partial denture - maxillary		$30	$30^
D5422	Adjust partial denture - mandibular		$30	$30^
D5511	Repair broken complete denture base, mandibular		$110	$60^
D5512	Repair broken complete denture base, maxillary		$110	$60^
D5520	Replace missing or broken teeth - complete denture (each tooth)		$90	$40^
D5611	Repair resin partial denture base, mandibular		$85	$35^
D5612	Repair resin partial denture base, maxillary		$85	$35^

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D5621	Repair cast partial framework, mandibular		$90	$40^
D5622	Repair cast partial framework, maxillary		$90	$40^
D5630	Repair or replace broken retentive clasping materials – per tooth		$110	$60^
D5640	Replace broken teeth - per tooth		$90	$40^
D5650	Add tooth to existing partial denture		$100	$50^
D5660	Add clasp to existing partial denture - per tooth		$125	$75^
D5710	Rebase complete maxillary denture	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$280	$231^
D5720	Rebase maxillary partial denture	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$250	$200^
D5721	Rebase mandibular partial denture	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$250	$200^
D5730	Reline complete maxillary denture (direct)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$155	$105^
D5731	Reline complete mandibular denture (direct)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$155	$105^
D5740	Reline maxillary partial denture (direct)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$130	$80^
D5741	Reline mandibular partial denture (direct)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$130	$80^
D5750	Reline complete maxillary denture (indirect)		$235	$185^
D5751	Reline complete mandibular denture (indirect)		$235	$185^
D5760	Reline maxillary partial denture (indirect)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$200	$150^
D5761	Reline mandibular partial denture (indirect)	Limited To 1 In A 36-Month Period 6 Months After The Initial Installation	$200	$150^

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D5850	Tissue conditioning, maxillary		$75	$75
D5851	Tissue conditioning, mandibular		$75	$75
	IMPLANT SERVICES			
D6010	Surgical placement of implant body: endosteal implant	Limited To 1 Per Tooth Every 60 Months	$350	$1400
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	Limited To 1 Per Tooth Every 60 Months	$350	$1400
D6040	Surgical placement: eposteal implant	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
D6050	Surgical placement: transosteal implant	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
D6056	Prefabricated abutment – includes modification and placement	Limited To 1 Per Tooth Every 60 Months	$350	$476
D6058	Abutment supported porcelain/ceramic crown	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6062	Abutment supported cast metal crown (high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6063	Abutment supported cast metal crown (predominantly base metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6064	Abutment supported cast metal crown (noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6065	Implant supported porcelain/ceramic crown	Limited To 1 Per Tooth Every 60 Months	$350	Not Covered
D6066	Implant supported crown - porcelain fused to high noble alloys	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6067	Implant supported crown - high noble alloys	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6068	Abutment supported retainer for porcelain/ceramic fpd	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6069	Abutment supported retainer for porcelain fused to metal fpd (high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6070	Abutment supported retainer for porcelain fused to metal fpd (predominantly base metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6071	Abutment supported retainer for porcelain fused to metal fpd (noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6072	Abutment supported retainer for cast metal fpd (high noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6073	Abutment supported retainer for cast metal fpd (predominantly base metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D6074	Abutment supported retainer for cast metal fpd (noble metal)	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6075	Implant supported retainer for ceramic fpd	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6077	Implant supported retainer for metal FPD - high noble alloys	Limited To 1 Per Tooth Every 60 Months	$350	$750
D6100	Surgical removal of implant body	Limited To 1 Per Tooth Every 60 Months	$352	$650
	PROSTHODONTICS- FIXED			
D6210	Pontic - cast high noble metal	1 Every 60 Months	$350	$350^
D6211	Pontic - cast predominantly base metal	1 Every 60 Months	$350	$350^
D6212	Pontic - cast noble metal	1 Every 60 Months	$350	$350^
D6214	Pontic - titanium and titanium alloys	1 Every 60 Months	$350	$350^
D6240	Pontic - porcelain fused to high noble metal	1 Every 60 Months	$350	$350^
D6241	Pontic - porcelain fused to predominantly base metal	1 Every 60 Months	$350	$350^
D6242	Pontic - porcelain fused to noble metal	1 Every 60 Months	$350	$350^
D6245	Pontic - porcelain/ceramic	1 Every 60 Months	$350	$350^
D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 Every 60 Months	$235	$250^
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	1 Every 60 Months	$350	$190^
D6602	Retainer inlay - cast high noble metal, two surfaces	1 Every 60 Months	$350	$205^
D6603	Retainer inlay - cast high noble metal, three or more surfaces	1 Every 60 Months	$350	$305^
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	1 Every 60 Months	$350	$485^
D6611	Retainer onlay - cast high noble metal, three or more surfaces	1 Every 60 Months	$350	$500
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	1 Every 60 Months	$350	$460
D6740	Retainer crown - porcelain/ceramic	1 Every 60 Months	$350	$350^
D6750	Retainer crown - porcelain fused to high noble metal	1 Every 60 Months	$350	$350^
D6751	Retainer crown - porcelain fused to predominantly base metal	1 Every 60 Months	$350	$350^
D6752	Retainer crown - porcelain fused to noble metal		$350	$350^
D6780	Retainer crown - 3/4 cast high noble metal		$350	$350^
D6781	Retainer crown - 3/4 cast predominantly base metal	1 Every 60 Months	$350	$350^
D6782	Retainer crown - 3/4 cast noble metal	1 Every 60 Months	$350	$350^
D6783	Retainer crown - 3/4 porcelain/ceramic	1 Every 60 Months	$350	$350^
D6790	Retainer crown - full cast high noble metal	1 Every 60 Months	$350	$350^
D6791	Retainer crown - full cast predominantly base metal	1 Every 60 Months	$350	$350^

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D6792	Retainer crown - full cast noble metal	1 Every 60 Months	$350	$350^
D6980	Fixed partial denture repair necessitated by restorative material failure		$65	$70
	ORAL SURGERY			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)		$83	$85
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		$156	$160
D7220	Removal of impacted tooth - soft tissue		$200	$200
D7230	Removal of impacted tooth - partially bony		$262	$265
D7240	Removal of impacted tooth - completely bony		$312	$315
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications		$350	$375
D7250	Removal of residual tooth roots (cutting procedure)		$156	$160
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only		$270	$270
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth		$350	$357
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)		$215	$215
D7280	Exposure of an unerupted tooth		$350	$370
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)		$350	Not Covered
D7286	Incisional biopsy of oral tissue-soft		$300	Not Covered
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant		$131	$131
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		$54	$54
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant		$207	$207
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		$93	$93
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm		$350	Not Covered
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm		$350	Not Covered
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm		$350	Not Covered
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm		$350	Not Covered
D7471	Removal of lateral exostosis (maxilla or mandible)		$265	$365
D7510	Incision and drainage of abscess - intraoral soft tissue		$124	$125
D7910	Suture of recent small wounds up to 5 cm		$35	$35

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D7971	Excision of pericoronal gingiva		$150	$150
	ORTHODONTIA			
D8010	Limited orthodontic treatment of the primary dentition	Medically Necessary Child Only	$350	Not Covered
D8020	Limited orthodontic treatment of the transitional dentition	Medically Necessary Child Only	$350	Not Covered
D8030	Limited orthodontic treatment of the adolescent dentition	Medically Necessary Child Only	$350	Not Covered
D8040	Limited orthodontic treatment of the adult dentition	Adults Only	Not Covered	$1800
D8070	Comprehensive orthodontic treatment of the transitional dentition	Medically Necessary Child Only	$350	Not Covered
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Medically Necessary Child Only	$350	Not Covered
D8090	Comprehensive orthodontic treatment of the adult dentition	Adults Only	Not Covered	$4650
D8210	Removable appliance therapy	Medically Necessary Child Only	$350	$350
D8220	Fixed appliance therapy	Medically Necessary Child Only	$236	$295
D8660	Pre-orthodontic treatment examination to monitor growth and development	Medically Necessary Child Only	$63	$70
D8670	Periodic orthodontic treatment visit	Medically Necessary Child Only	$35	$35
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Medically Necessary Child Only	$15	$300
D8703	Replacement of lost or broken retainer – maxillary		$350	Not Covered
D8704	Replacement of lost or broken retainer – mandibular		$350	Not Covered
	MISCELLANEOUS SERVICES			
D9110	Palliative treatment of dental pain - per visit		$40	$40
D9210	Local anesthesia not in conjunction with operative or surgical procedures		$40	Not Covered
D9215	Local anesthesia in conjunction with operative or surgical procedures		$40	Not Covered
D9222	Deep sedation/general anesthesia – first 15 minutes		$65	$170
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment		$65	$170
D9239	Intravenous moderate (conscious) sedation/analgesia-first 15 minutes		$55	$150
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment		$55	$150
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician		$25	$25

CODE	DESCRIPTION	LIMITATIONS	MEMBER COST-SHARING CHILD	MEMBER COST-SHARING ADULT
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed		$5	$35
D9440	Office visit - after regularly scheduled hours		$35	$35
D9610	Therapeutic parenteral drug, single administration		$25	$35
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report		$39	$40
D9941	Fabrication of athletic mouthguard		Not Covered	$255
D9942	Repair and/or reline of occlusal guard		Not Covered	$45
D9944	Occlusal guard – hard appliance, full arch		$350	$375
D9945	Occlusal guard – soft appliance, full arch		$350	$375
D9946	Occlusal guard – hard appliance, partial arch		$350	$375
D9972	External bleaching - per arch - performed in office		Not Covered	$150
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays		Not Covered	$240