

Welcome to Advantage Dental Plan®

CERTIFICATE OF COVERAGE TABLE OF CONTENTS

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Advantage hopes the following information will help you get the most out of your dental benefits.

This handbook is provided to give you an overview of how the plan works and the extent of your benefits. Please refer to your Master Contract for more detailed information, call Advantage's **Member Services Department at 1-866-268-9615**, or electronically at customerservice@advantagdental.com.

I. How the Plan Works

The next time you visit your Licensed Dentist, tell the receptionist that you have dental benefits through Advantage Dental Plan Inc. The details of your plan are noted on your Advantage membership card, so be sure to have it available for the office staff to photocopy. The claims paperwork and billing are usually handled by your dentist, and all payments on the covered portion of your care are usually paid directly to your Licensed Dentist by Advantage. If your dentist is not an Advantage participating Licensed Dentist, check to make sure they will handle your claims paperwork.

COST ESTIMATES – Dental Benefits under this plan are designed to help you have a healthy mouth, free of discomfort and able to chew your food. It is not designed to give you perfect dentistry or teeth that look like an “Extreme Makeover.” As a result, your dentist may suggest treatment that is not covered by Advantage. This does not mean what is recommended is not good dentistry or necessary treatment, it just means it is not covered by Advantage. Dental benefits are also designed to assist you in getting your needed dentistry done, not to pay for everything you or your dentist may want to do. Dentist’s do not all charge the same fee for the same services. Some charge more than others. What is charged may not have any relationship to the quality of the dentistry done. This may make it difficult to know what Advantage pays and what your portion will be. Sometimes it is difficult for your dentist to determine what your benefit is until after the treatment is done, so they may give you a range of prices. As a result of all of this, you may want to have your dentist determine how much Advantage is going to cover prior to agreeing with any suggested dental care. If you want a more specific cost estimate other than a range, please ask your dentist to send a pre-estimate to Advantage. This should be sent on a standard current American Dental Association claim form, addressed to:

Advantage Dental Plan Inc.
PO Box 1200
Redmond, OR 97756

Or ask your dentist to submit the pre-estimate electronically.

BILLING REQUIREMENTS FOR DENTISTRY DONE IN FOREIGN COUNTRIES –

Dentistry done in Countries other than USA require proof of licensure by the dentist or denturist as well as an exact description of the procedure done, date of service and charges paid. In the case of crowns, bridges, partials, and dentures being redone the date of previous placement and reasons for being redone are required.

EMERGENCY CARE – If you have an urgent or emergency situation that cannot wait until standard business hours and you do not have a Licensed Dentist, or your regular contracted Licensed Dentist is unavailable, **call 1-866-268-9615**. Advantage may put you in touch with a Licensed Dentist within the service area. It is possible that you may be referred to a non-

contracted Licensed Dentist when a contracted dentist is not available. Please refer to the section explaining Amount of Payment.

If you are away from home and you visit a Licensed Dentist for emergency care, have the Licensed Dentist submit the claim to:

Advantage Dental Plan, Inc.

PO Box 1200

Redmond, OR 97756

Or have them submit the claim electronically.

When calling Advantage for any reason always note who at Advantage you talked to, the information received, and the date and time of the contact.

II. DENTAL SERVICES COVERED

Advantage is designed to foster and support long term dental health. All of the Advantage contracted Dentists support this philosophy. All claims will be evaluated based on this concept. Without first treating the active dental disease (active decay, gingivitis and periodontitis), contracted dentists may not chose to perform definitive dentistry (crowns, permanent fillings, periodontal therapy).

Your dental care program covers the following services when performed by a Dentist and when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function. Such standards shall be determined by the Advantage Quality Improvement Committee and approved by the Advantage Executive Committee.

Dentistry is generally divided into three "classes." Advantage usually follows the guidelines for classes I, II and III, but at times may switch the covered service to a different class. **Please see your Summary Sheet to verify the level of coverage.** The categories listed below are what will be under the different classes shown on our summary sheet.

DIAGNOSTIC – Comprehensive, Periodic, and problem focused examinations. (See Limitations and Exclusions).

PREVENTATIVE – Prophylaxis (cleaning), topical fluoride applications, certain space maintainers, and sealants. (See Limitations and Exclusions).

RESTORATIVE – Treatment of tooth decay, broken restoratives, and broken teeth can be treated by the following methods: filling materials such as amalgam, and/or composite resin, metal, porcelain, plastic or a combination of crowns, inlays, or onlays (See Limitations and Exclusions).

ENDODONTIC – Procedures for pulpal therapy and root canal fillings. (See Limitations and Exclusions).

PERIODONTAL THERAPY – Treatment of tissues supporting the teeth. (See Limitations and Exclusions).

PROSTHODONTIC – Procedures for construction or repair of fixed bridges, removable partials, and complete and immediate dentures. These include fixed and removable appliances (See Limitations and Exclusions).

ORAL SURGERY – Non complicated oral surgery procedures such as simple single tooth extractions. Complicated oral surgery procedures such as impacted teeth. (See Limitations & Exclusions).

ADJUNCTIVE GENERAL SERVICES – These are usually split among other service categories and/or classes (See Limitations and Exclusions).

RIDERS– Riders include Orthodontic, Implant Services, TMJ Services, Cosmetic and Composite Services. (See Limitations and Exclusions).

III. LIMITATIONS

Services deemed outside the scope of routine dental practices as determined by the Advantage Quality Improvement Committee and approved by the Advantage Executive Committee.

DIAGNOSTIC – Comprehensive and Periodic Examinations are limited to twice a Policy Year. Full mouth x-rays are limited to once every five years. Bitewing x-rays are limited to once a Policy Year. Pulp vitality tests, video screenings, diagnostic casts, etc. are included as part of the examination. Panoramic x-rays are limited to once every 5 years unless pathology is involved. Periapical x-rays are limited to six per tooth per date of service. Problem focused examinations are limited to four per contract year. Comprehensive periodontal examinations are limited to one per contract year.

PREVENTATIVE – Prophylaxis (cleaning) and fluoride applications are limited to twice a Policy Year. Plaque control, oral hygiene instructions and dietary instructions are not covered. The plan covers sealants on molars for those 16 years old and under once every five years. Athletic mouth guards are covered by the plan for one per lifetime up to 18 years if still in secondary school. Fluoride varnish applications for Children 3 years and under are covered up to 12 applications per year if child is deemed at risk for dental infection. Fluoride treatments done on the same date of service as prophylaxis will be paid with the combined prophylaxis & fluoride treatment code.

RESTORATIVE AND PROSTHETIC– A separate charge for anesthesia is not covered when used for restorative and prosthetic procedures. Replacement of an existing crown, onlay, or prosthetic device is covered only if it cannot be made satisfactory.

Replacement of necessary crowns, jackets, and gold or cast metal restorations (including all plastic and ceramic restorations) as well as fixed bridges, implants, crowns, abutments, retainers, permanent partials, and complete or immediate dentures are limited to one per various time period. This usually is only 5 years, but may be up to 10 years. Please refer to your specific summary of benefits sheet for benefit time period limitations.

Replacement of 3 or more surface fillings on molar teeth of any type may have a limit of one per a specific time period such as 0 to 60 months. Please refer to your specific summary of benefits sheet for benefit time period limitations.

ALTERNATE METHODS OF TREATMENT – If an alternate method of treatment:

1. Could have been performed and resulted in a lower charge, and
2. Would not have had an adverse affect on the dental health of the person then covered dental charges will be based on the charges of the least expensive acceptable method.

EXAMPLES OF ALTERNATE PROCEDURES:

1. Tooth-colored fillings rather than amalgam silver fillings on back (posterior) teeth. See summary sheet for specifics
2. Tooth-colored caps (crowns) rather than metal caps (crowns) on second or third molar teeth.
3. High Noble Metal caps (crowns) rather than noble metal caps (crowns) on back (posterior) teeth.
4. All porcelain and high noble caps (crowns) on back teeth rather than porcelain noble metal caps (crowns) on back (posterior) teeth.
5. Three surface porcelain and gold onlays on back (posterior) teeth rather than 3 surface amalgam (silver) fillings on back (posterior) teeth.

If an eligible person elected to go ahead with the procedure, Advantage will pay the eligible person's benefit for the alternate procedure based upon the plan's maximum allowable fee. The eligible person will then be responsible for the remainder of the dentist's fee.

If you are unsure if the procedures being done are covered by this alternate method of payment, please ask your Dentist.

IMPLANTS – Limited to use of American Dental Association CDT codes only. Implant coverage is limited to single implant to replace an extracted tooth that normally would be replaced with a brige. Implant crown retainers and abutments are treated the same as regular crowns and bridges.

TEMPORARY (PROVISIONAL) CROWNS – If crowns are done within twelve months of temporary (provisional) crown being placed on a tooth, the payment on the temporary (provisional) crown will be deducted from payment on the billed crown.

FILLINGS – The cost of fillings done within 90 days of a crown or bridge request will be deducted from any eligible payment towards a crown payment.

UPPER & LOWER INTERIM COMPLETE & INTERIM PARTIAL DENTURES – Advantage will pay for one Interim partial denture per arch, if needed, by report, and one upper and lower complete denture once every five to ten years. Please refer to your specific summary of benefit sheet for benefit time period limitation.

COMPLETE, IMMEDIATE AND PARTIAL DENTURES – Extra charges for fitting crowns to partial dentures will be limited to and included in the cost of the crown.

Specialized or personalized prosthetics devices are limited to the cost of standard devices. Relines and re-bases are covered every 30 months, except in the case of immediate denture where permanent relines will be paid after six months of insertion of immediate denture. Adjustments for new dentures are included in the price of the new full or partial dentures for 12 months. Complete and Immediate dentures are limited to one upper and lower every five or ten years or once a life time. Please refer to your specific summary of benefits sheet for benefit time period limitation. Tissue conditions are limited to four per contract year.

FULL MOUTH DEBRIDEMENT – This procedure is only covered if an evaluation cannot be performed due to the obstruction of plaque and calculus on the teeth. This procedure is not covered if performed on the same date as the prophylaxis. This procedure is only covered once every 36 months.

CORE BUILD-UPS – Are not a covered benefit unless used to restore a tooth that has been treated endodontically (root canal).

TOOTH DESENSITIZATION – This procedure is covered as a separate procedure from other dental treatment.

TRANSSEPTAL FIBER SURGERY – Claims must be accompanied by a referral from an orthodontist or a Dentist if orthodontic treatment is done other than by an orthodontist.

ROOT PLANING AND CURETTAGE – Limited to four quadrants every 24 months.

CROWN LENGTHENING – Covered only if done by a periodontist or by report only and not on the same day as any restorative treatment.

ENDODONTICS – Root canal therapy limited to one root canal per tooth every five years.

ROOT CANAL RE TREATMENT – Not covered if done by original treating Dentists within five years. Limited to one retreatment every five years on services performed by dentist other than Dentists who originally performed the root canal.

APICOECTOMIES & RETROFILL AMALAGAMS – Limited to one per root per lifetime of tooth.

FRENECTOMIES –

Limited to children 12 years old or older on referral from the Orthodontist or Dentist who did the Orthodontic treatment. Requires the referral to be sent with the claim for these services.

DIRECT PULP CAPS -

Limited to teeth treated using portland cement type of materials, one per tooth per contract year.

THIRD MOLAR SURGERY- is limited to removal for those teeth that include pathology and/or infection. Pain alone is not considered a reason for third molar surgery.

ANESTHESIA SERVICES -

Limited to children 6 and younger and patients with mental disabilities that render them incapable of treatment in the dental office under local anesthesia. This is limited to conscious sedation and single oral sedatives.

PRE-EXISTING TOOTH –

Replacement of a tooth is limited to those teeth removed while the current plan is in affect. This limitation includes teeth replaced with implants, implant crowns, abutments and retainers, retainers, pontics, fixed bridges, and permanent partial dentures. If the tooth or teeth were removed before the plan was in affect, replacement is not covered.
(see summary sheet)

IV. EXCLUSIONS

1. Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency (except for Medicaid Coverage).
2. Services covered by enrollee's medical plan.
3. Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
4. Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
5. Separate charges for anesthesia, other than general anesthesia administered by a Dentist in connection with covered oral surgical services performed in a dental office. (See anesthesia services under limitations).
6. Experimental procedures and/or any other procedure or appliance (crowns, bridges, partials) that is unlikely to have a good long term prognosis.
7. Broken appointments.
8. Claims submitted more than 12 months after date of rendition of the service.
9. Porcelain crowns, porcelain to metal crowns or porcelain onlays on second or third molars.
10. Space maintainers for enrollees who will need orthodontics in the future.
11. Orthodontics on enrollees who have active dental disease (decay, gingivitis, or periodontitis). This is an exclusion to the Orthodontic Rider if selected by your group.
12. Services performed after the insured person's coverage has ceased.
13. Charges for sterilization of dental supplies and/or instruments.
14. All other services or supplies not specifically covered.
15. War-related conditions. The treatment of any condition caused by or arising out of an act of war, armed invasion or aggression.
16. Gnathologic recordings. Recordings of jaw movement and positions.
17. Educational programs. Services and supplies to teach nutritional and oral hygiene techniques beyond those normally provided with preventive dental visits.
18. Loss, theft or breakage. Denture replacement made necessary by loss, theft or breakage.
19. Indirect pulp caps are to be included in the restoration process and are not a separate covered benefit.
20. Gingivectomy, gingivoplasty or crown lengthening in conjunction with crown prep or bridge services done on the same date of service.
21. Devices and procedures for Intra and extra coronal splinting to stabilize mobile teeth.
22. Antimicrobial agents delivered via a controlled release vehicle into diseased crevicular tissue.
23. Bone replacement grafts to prepare sockets for implants after tooth extraction.
24. Sinus lift grafts to prepare sinus sites for implants.

25. Removal of third molars (wisdom) teeth for orthodontic purposes is not a covered service
26. Services performed for cosmetic reasons are not a covered service.
27. Orthodontic Services except as provided by Orthodontic benefit rider.
28. Temporomandibular joint services except as provided by a TMJ rider.
29. Surgical placement or removal of implants unless covered by Implant rider.
(please see Implants under limitations)

V. CLAIMS QUESTIONS AND APPEAL PROCEDURE

Advantage recommends that you first contact your Licensed Dentist if you have questions concerning the payment. He or she can usually explain to you any services which may be limited or excluded.

If you still have questions or disagree with payment, you have a right to request a review. Such a review must be requested, in writing, within 90 days following receipt of our notice of payment or denial.

You may request a review by writing a letter to:

**Advantage Dental Plan, Inc.
442 SW Umatilla Ave, Suite 200
Redmond, OR 97756**

Or file it electronically to customerservice@advantagedental.com

Your letter must state the reason you are requesting a claim review. Please include your Group number and Advantage patient identification number. Advantage will fully review your appeal and may request additional documents from you during this process. You will receive a decision within 60 days from the date your request is received by Advantage.

If the dispute involves dental questions, a panel of Licensed Dentist will review the matter and make a final decision. That decision is final and binding on all parties. Other kinds of questions may be subject to arbitration statutes of the State of Oregon.

VI. NOTICE OF PRIVACY PRACTICES SUMMARY

APPROVAL TO RELEASE INFORMATION

When you accept the Plan's benefits, you authorize your personal financial and health records to be used by the Plan for certain reasons, such as to pay your claims. Your records may be used for the purpose of utilization review, quality assurance, and peer review by the Plan or our associates. Advantage may use your records such as claims data for quality improvement.

PRIVACY OF MEMBER INFORMATION

Health care is a deeply personal issue for people. All of us need to know that our financial and health care information is kept private. Advantage respects the privacy of our members.

To keep your information private, Advantage has these procedures in place:

- Advantage restricts the access of your records held by the Plan to employees who need it and to you. Entries into member records are tracked for security. Advantage employees must report all security abuses.
- Unique and secured login names and passwords are required to access Advantage's computer system. Firewalls, encryption, and data backup are used. These tools are also used to secure private information on our website.
- Advantage employees are trained on privacy issues and must sign a statement of nondisclosure at the time they are hired. They must review the training and sign again each year.
- Each Advantage department adopts its own policies to monitor the handling and use of your information.
- You must sign an authorization in order for Advantage to release your identifiable information to those outside of the Plan and Advantage associates, except in cases where the law requires or permits such a release.
- When member records are used in health studies, Advantage does not release identifiable information. Aggregate data is used as soon in the process as possible. Advantage does this to fully protect the privacy of our Plan members.
- Advantage contracted providers must sign a statement of nondisclosure as a part of their contract with Advantage.
- You have the right to submit a complaint if you feel your privacy is compromised in any way.
- You have the right to see your health records. Call your Member Services Team to ask how to set up a time for this.

If you have questions about your personal information or that of a member of your home, please call your Member Services Team at **1-866-268-9615**. You can view the full Notice of Privacy Practices at ww.advantagedental.com. You may also call your Member Services Team to ask for a copy to be mailed to you.

VII. AMOUNT OF PAYMENT

TABLE OF ALLOWANCE:

This is not the maximum fee that the dentist can charge. This is the fee that Advantage pays towards your dentist's charge. If your Dentist's fee is higher than the maximum fee listed here, you will owe your Dentist the difference. Some of these services also have limitations and exclusions (see the Limitation and Exclusion section of this Certificate of Coverage).

MAXIMUM PAYMENT:

The maximum amount payable by the covered services received each Policy Year or portion thereof for each eligible patient is limited to the amount listed on the Schedule of Fee's and the annual max stated on your summary of benefits. Orthodontics, implant, and/or Temporal Mandibular Joint (TMJ), if covered under this plan, are subject to the lifetime maximum listed on the Summary Sheet.

Individual Product Schedule of Fees

00120	PERIODIC ORAL EVALUATION	\$50
00140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	\$70
00145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	\$25
00150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	\$75
00160	DETAILED AND EXTENSIVE ORAL EVALUATION-PROBLEM FOCUSED, BY REPORT	\$65
00170	RE-EVALUATION-limited, problem focused(established patient, not post operative visit)	\$55
00180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT	\$65
00210	INTRAORAL-COMPLETE SERIES	\$110
00220	INTRAORAL-PERIAPICAL-FIRST FILM	\$25
00230	INTRAORAL-PERIAPICAL EACH ADDL FILM	\$18
00270	BITEWINGS-SINGLE FILM	\$20
00272	BITEWINGS-TWO FILMS	\$38
00273	BITEWINGS, THREE FILMS	\$45
00274	BITEWINGS-FOUR FILMS	\$60
00277	Vertical Bitewings-7 to 8 films	\$100
00330	PANORAMIC FILM	\$95
00363	CONE BEAM – THREE DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES	\$50
00415	BACTERIOLOGIC STUDIES	\$85
00486	ACCESSION OF BRUSH BIOPSY SAMPLE, MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT	\$50
00999	UNSPEC DIAGNOSTIC PROCEDURE	\$0
01110	*PROPHYLAXIS - ADULT	\$85
01120	*PROPHYLAXIS -CHILD	\$65
01201	*TOPICAL APPL. FLUORIDE-CHILD INC PROPHY	\$95
01203	*TOPICAL APPL OF FLUORIDE-CHILD(PROPHYLAXIS NOT INCLUDED	\$35
01204	TOPICAL APPL OF FLUORIDE-ADULT PROPHY LAXIS NOT INCLUDED	\$35
01205	TOPICAL APPL FLUORIDE-ADULT INC PROPHY	\$105
01206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS	\$25
01320	TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE	\$0
01351	*SEALANT-PER TOOTH	\$45
01510	SPACE MAINTAINER-FIXED-UNILATERAL	\$275
01515	SPACE MAINTAINER- FIXED-BILATERAL	\$395
01525	SPACE MAINTAINER-REMOVABLE-BILATERAL	\$340
01550	RECEMENTATION OF SPACE MAINTAINER	\$60
01555	REMOVAL OF FIXED SPACE MAINTAINER	\$70
02140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT	\$80
02150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT	\$100
02160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	\$125
02161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	\$150
02330	RESIN-ONE SURFACE, ANTERIOR	\$100
02331	RESIN-TWO SURFACES, ANTERIOR	\$130
02332	RESIN-THREE SURFACES, ANTERIOR	\$180
02335	RESIN-FOUR/MORE SURF W/INCISAL ANGLE	\$200
02391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	\$80
02392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	\$100
02393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	\$125

Individual Product Schedule of Fees

02394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	\$150
02544	ONLAY-METALLIC-FOUR OR MORE SURFACES	\$375
02644	ONLAY-PORCELAIN/CERAMIC-FOUR SURFACES	\$375
02664	ONLAY-COMPOSITE/RESIN-FOUR SURFACES LAB	\$375
02710	CROWN - RESIN (INDIRECT)	\$375
02712	CROWN - RESIN BASED COMPOSITE (INDIRECT)	\$375
02720	CROWN-RESIN WITH HIGH NOBLE METAL	\$375
02721	*CROWN-RESIN WITH BASE METAL	\$375
02722	*CROWN-RESIN WITH NOBLE METAL	\$375
02740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	\$375
02750	CROWN-PORCELAIN FUSED TO HIGH NOBLE	\$375
02751	*CROWN-PORCELAIN FUSED TO BASE METAL	\$375
02752	*CROWN-PORCELAIN FUSED TO NOBLE METAL	\$375
02780	CROWN-3/4 cast high noble metal	\$375
02781	CROWN-3/4 cast predominantly base metal	\$375
02782	CROWN-3/4 cast noble metal	\$375
02783	CROWN-3/4 cast porcelain/ceramic	\$375
02790	CROWN-FULL CAST HIGH NOBLE METAL	\$375
02791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	\$375
02792	CROWN-FULL CAST NOBLE METAL	\$375
02794	CROWN TITANIUM	\$375
02799	Provisional Crown	\$180
02810	CROWN-3/4 CAST METALLIC	\$375
02910	RECEMENT INLAY	\$65
02915	RECEMENT CASE OR PREFABRICATED POST AND CORE	\$65
02920	RECEMENT CROWN	\$65
02930	PREFABRICATED STAINLESS STEEL CRWN - PRIMARY	\$180
02931	PREFABRICATED STAINLESS STEEL CRWN - PERMANENT	\$220
02932	PREFABRICATED RESIN TOOTH	\$220
02933	PREFAB STAINLESS STEEL CRWN W/ RESIN WINDOW	\$180
02934	PREFABRICATED ESTHETIC COASTED STAINLESS STEEL CROWN - PRIMARY TOOTH	\$180
02940	SEDATIVE FILLING	\$65
02950	*CORE BUILDUP, INCLUDING ANY PINS	\$105
02951	PIN RETENTION-PER TH, IN ADD TO RESTORATION	\$65
02952	CAST POST & CORE IN ADDITION TO CROWN	\$125
02952	CAST POST & CORE IN ADDITION TO CROWN	\$175
02953	Each additional cast post-same tooth	\$175
02954	PREFAB POST & CORE IN ADD TO CROWN	\$175
02955	POST REMOVAL-NOT IN CONJUNCTION W/ENDODONTIC THERAPY	\$0
02960	LABIAL VENEER (LAMINATE)-CHAIRSIDE	\$300
02961	LABIAL VENEER (RESIN LAMINATE) - LAB	\$300
02962	LABIAL VENEER (PORCELAIN LAMINATE) -LAB	\$375
02970	TEMP CROWN (FRACTURED TOOTH)	\$125
03110	PULP CAP-DIRECT (EXCLUDING FINAL RESTOR)	\$60
03220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL REST)	\$175
03221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH	\$110
03230	PULPAL THERAPY(RESORBABLE FILLING) ANTERIOR, PRIMARY TOOTH-EXCLUDING FINAL RESTORATION)	\$150

Individual Product Schedule of Fees

03240	PULPAL THERAPY(RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH(EXCLUDING FINAL RESTORATION)	\$210
03310	ANTERIOR (EXCLUDING FINAL RESTORATION)	\$300
03320	BICUSPID (EXCLUDING FINAL RESTORATION)	\$350
03330	MOLAR (EXCLUDING FINAL RESTORATION)	\$425
03331	Treatment of Root Canal Obstruction; non-surgical access	\$200
03332	Incomplete Endodontic Therapy; inoperable or fractured tooth	\$200
03333	Internal Root Repair of Perforation Defects	\$200
03346	RETREATMENT PREVIOUS ROOT CANAL - ANTERIOR	\$300
03347	RETREATMENT PREVIOUS ROOT CANAL - BICUSPID	\$350
03348	RETREATMENT PREVIOUS ROOT CANAL - MOLAR	\$425
03351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT	\$240
03352	APEXIFICATION/RECALCIFICATION-INTERIM MED REPLACEMENT	\$240
03353	APEXIFICATION/RECALCIFICATION-FINAL FISIT	\$240
03410	APICOECTOMY/PERIRADICULAR SURG-ANTERIOR	\$360
03421	APICOECTOMY/PERIRADICULAR SURG-BICUSPID (FIRST ROOT)	\$360
03425	APICOECTOMY/PERIRADICULAR SURG-MOLAR	\$360
03426	APICOECTOMY/PERIRADUCULAR SURG (EA. ADD. ROOT)	\$125
03430	RETROGRADE FILLING-PER ROOT	\$100
03450	ROOT AMPUTATION-PER ROOT	\$150
03999	UNSPEC ENDODONTIC PROC . BY REPORT	\$0
04210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	\$335
04211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE TEETH, PER QUADRANT	\$150
04240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	\$315
04241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	\$300
04245	Apically Positioned Flap	\$0
04250	MUCOGINGIVAL SURG -PER QUAD	\$275
04260	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	\$465
04261	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - ONE TO THREE TEETH, PER QUADRANT	\$420
04274	DISTAL OR PROXIMAL WEDGE PROCEDURE(WHEN NOT PERFORMED IN CONJUNCTION /SURGICAL PROC/SAME ANATOMICAL	\$150
04341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	\$150
04342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	\$125
04355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS	\$135
04910	PERIODONTAL MAINTENANCE	\$100
04999	PERIO RE-EVALUATION	\$90
05110	COMPLETE UPPER	\$600
05120	COMPLETE LOWER	\$600
05130	IMMEDIATE UPPER	\$600
05140	IMMEDIATE LOWER	\$600
05211	*UPPER PARTIAL-RESIN BASE INCLUDING CLASPS, RESTS, & TEETH	\$600
05212	*MANDIBULAR PARTIAL DENTURE- RESIN(INCLUDING ANY CONVENTIONAL CLASPS, RESTS & TEETH	\$600
05213	*UPPER PARTIAL-CAST METAL/RESIN INCLUDING CLASPS, RESTS, & TEETH.	\$600
05214	*LOWER PARTIAL-CAST METAL/RESIN SADDLES (INCLUDING CLASPS, RESTS & TEETH)	\$600

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05225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)	\$600
05226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS AND TEETH)	\$600
05281	REMOVABLE UNILATERAL PARTIAL DENTURE- ONE PIECE CAST METAL W/CLASPS & TEETH	\$250
05410	ADJUST COMPLETE DENTURE - UPPER	\$50
05411	ADJUST COMPLETE DENTURE - LOWER	\$50
05421	ADJUST PARTIAL DENTURE - UPPER	\$50
05422	ADJUST PARTIAL DENTURE - LOWER	\$50
05510	REPAIR BROKEN COMPLETE DENTURE BASE	\$120
05520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE	\$100
05610	REPAIR RESIN DENTURE BASE	\$100
05620	REPAIR CAST FRAMEWORK	\$180
05630	REPAIR OR REPLACE BROKEN CLASP	\$150
05640	REPLACE BROKEN TEETH-PER TOOTH	\$80
05650	ADD TOOTH TO EXISTING PARTIAL DENTURE	\$80
05660	ADD CLASP TO EXISTING PARTIAL DENTURE	\$80
05670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	\$250
05671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	\$250
05710	REBASE COMPLETE UPPER DENTURE	\$200
05711	REBASE COMPLETE LOWER DENTURE	\$200
05720	REBASE UPPER PARTIAL DENTURE	\$200
05721	REBASE LOWER PARTIAL DENTURE	\$200
05730	*RELINE COMPLETE UPPER DENTURE (CHAIRSIDE)	\$125
05731	*RELINE COMPLETE LOWER DENTURE (CHAIRSIDE)	\$125
05740	*RELINE UPPER PARTIAL DENTURE (CHAIRSIDE)	\$125
05741	*RELINE LOWER PARTIAL DENTURE (CHAIRSIDE)	\$125
05750	*RELINE COMPLETE UPPER DENTURE (LABORATORY)	\$175
05751	*RELINE COMPLETE LOWER DENTURE (LABORATORY)	\$175
05760	*RELINE UPPER PARTIAL DENTURE (LABORATORY)	\$175
05761	*RELINE LOWER PARTIAL DENTURE (LABORATORY)	\$175
05810	INTERIM COMPLETE DENTURE (UPPER)	\$300
05811	INTERIM COMPLETE DENTURE (LOWER)	\$300
05820	INTERIM PARTIAL DENTURE (UPPER)	\$300
05821	INTERIM PARTIAL DENTURE (LOWER)	\$300
05850	*TISSUE CONDITIONING, MAXILLARY	\$100
05851	*TISSUE CONDITIONING, MANDIBULAR	\$100
06058	Abutment supported porcelain/ceramic crown	\$375
06059	Abutment supported porcelain fused to metal crown (high noble metal)	\$375
06060	Abutment supported porcelain fused to metal crown (predominantly base metal)	\$375
06061	Abutment supported porcelain fused to metal crown (noble metal)	\$375
06062	Abutment supported cast metal crown (high noble metal)	\$375
06063	Abutment supported cast metal crown (predominantly base metal)	\$375
06064	Abutment supported cast metal crown (noble metal)	\$375
06065	Implant supported porcelain/ceramic crown	\$375
06066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	\$375
06067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	\$375

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06068	Abutment supported retainer for porcelain/ceramic FPD	\$375
06069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	\$375
06070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	\$375
06071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	\$375
06072	Abutment supported retainer for cast metal FPD (high noble metal)	\$375
06073	Abutment supported retainer for cast metal FPD (predominantly base metal)	\$375
06074	Abutment supported retainer for cast metal FPD (noble metal)	\$375
06075	Implant supported retainer for ceramic FPD	\$375
06076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	\$375
06077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	\$375
06078	Implant/Abutment supported fixed denture for completely edentulous arch	\$375
06079	Implant/Abutment supported fixed denture for partially edentulous arch	\$375
06092	RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN	\$60
06093	RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	\$60
06094	ABUTMENT SUPPORTED CROWN (TITANIUM)	\$375
06095	REPAIR IMPLANT ABUTMENT, BY REPORT	\$375
06210	PONTIC-CAST HIGH NOBLE METAL	\$375
06211	PONTIC-CAST PREDOMINANTLY BASE METAL	\$375
06212	PONTIC-CAST NOBLE METAL	\$375
06214	PONTIC - TITANIUM	\$375
06240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	\$375
06241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$375
06242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	\$375
06245	PONTIC -porcelain/ceramic	\$375
06250	PONTIC-RESIN WITH HIGH NOBLE METAL	\$375
06251	PONTIC-RESIN WITH PREDOMINANTLY BASE METAL	\$375
06252	PONTIC-RESIN WITH NOBLE METAL	\$375
06253	PROVISIONAL PONTIC	\$180
06545	RETAINER- CAST, METAL, RESIN BONDED	\$175
06548	Retainer-porcelain/ceramic for resin bonded fixed prosthesis	\$175
06634	ONLAY - TITANIUM	\$375
06710	CROWN - INDIRECT RESIN BASED COMPOSITE	\$375
06720	CROWN-RESIN WITH HIGH NOBLE METAL	\$375
06721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	\$375
06722	CROWN-RESIN WITH NOBLE METAL	\$375
06740	CROWN-porcelain/ceramic	\$375
06750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	\$375
06751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$375
06752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$375
06780	CROWN-3/4 CAST HIGH NOBLE METAL	\$375
06781	CROWN-3/4 cast predominantly based metal	\$375
06782	CROWN-3/4 cast noble metal	\$375
06783	CROWN-3/4 porcelain/ceramic	\$375
06790	CROWN-FULL CAST HIGH NOBLE METAL	\$375
06791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	\$375
06792	CROWN-FULL CAST NOBLE METAL	\$375
06793	PROVISIONAL RETAINER CROWN	\$100

Individual Product Schedule of Fees

06794	CROWN - TITANIUM	\$375
06930	RECEMENT BRIDGE	\$100
06934	REMOVE BRIDGE/CUT BRIDGE	\$100
06970	CAST POST AND CORE IN ADDITION TO BRIDGE RETAINER	\$175
06971	CAST POST AS PART OF BRIDGE RETAINER	\$175
06972	PREFABRICATED POST AND CORE IN ADD. TO BRIDGE RETAINER	\$175
06973	CORE BUILD UP FOR RETAINER, INCLUDING ANY PINS	\$105
06980	BRIDGE REPAIR, BY REPORT	\$175
07111	CORONAL REMNANTS - DECIDUOUS TOOTH	\$70
07140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	\$85
07210	SURGICAL REMOVAL OF ERUPTED TOOTH	\$125
07220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	\$125
07230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	\$175
07240	REMOVAL OF IMPACTED TOOTH- COMPLETELY BONY	\$200
07241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH SURGICAL COMPLICATIONS	\$240
07250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	\$135
07260	ORALANTRAL FISTULA CLOSURE	\$300
07261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$300
07270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	\$180
07291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	\$100
07310	ALVEOPLASTY IN CONJUNCTION W/ EXTRACTIONS- PER QUAD	\$150
07311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUAD	\$100
07320	ALVEOPLASTY NOT IN CONJUNCTION W/ EXTRACTIONS- PER QUAD	\$200
07321	ALVEOLOPLASTY NOT INCONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUAD	\$150
07471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	\$200
07472	REMOVAL OF TORUS PALATINUS	\$200
07473	REMOVAL OF TORUS MANDIBULARIS	\$200
07485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	\$100
07510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	\$175
07511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFTE TISSUE - COMPLICATED	\$175
09110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURES	\$150
09120	FIXED PARTIAL DENTURE SECTIONING DRUGS	\$75
09215	LOCAL ANESTHESIA	\$50
09230	ANALGESIA	\$70
09248	Non-Intravenous Conscious Sedation	\$70
09310	CONSULTATION	\$80
09910	APPLICATION OF DESENSITIZING MEDICAMENTS	\$25
09911	Application of desensitizing resin for cervical and/or root surface, per tooth	\$25
09951	OCCLUSAL ADJUSTMENT - LIMITED	\$70