BROOME-TIOGA BOCES
435 Glenwood Road
Binghamton, New York 13905-1699

Group Dental Plan D02
Custom Schedule B

Effective January 1, 2015

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Section One
Introduction To Your Dental Benefits Plan

This part of the booklet explains your dental benefits under the Broome-Tioga BOCES Dental Benefits Plan ("Plan"). The Plan is funded by Broome-Tioga BOCES ("Plan Administrator"). Lifetime Benefit Solutions, Inc. ("LBS") administers the claims for the dental benefits of the Plan on behalf of the Plan Administrator.

Section Two
Important Terms and Phrases You Need To Know

It is important that you understand all aspects of the Plan in order to get the most out of your coverage. To help make the information easier to understand, the definitions of important words and phrases used throughout the document are described below.

You should understand that information and definitions in one section may be used in later sections.

1. **Active work (actively at work).** Active work means the performance of all duties that pertain to your work at the place where it is normally done, or where it is required by your employer to be done.

2. **Charge.** Charge is the amount the provider actually bills for a covered service or supply. A charge for a covered service or supply is considered to have been incurred on the date the service or supply was provided to you.

3. **Covered service.** A covered service is a service or supply specified in the Plan and for which a benefit payment is made.

4. **Medically Necessary** or **Medical Necessity**. Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

    a. in accordance with generally accepted standards of medical practice;
    b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
    c. not primarily for the convenience of the patient, physician, or other health care provider, and
    d. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

    "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community when available, Physician Specialty Society recommendations, the views of prudent

physicians practicing in relevant, clinical areas, and any other clinically relevant factors.

The fact that any particular physician, dentist, or health care professional may prescribe, order, recommend, or approve a service, supply or technology does not, in itself, make the services medically necessary. Services, supplies, and technologies that are not medically necessary include, but are not limited to, the following:

a. services provided over a longer period of time than is necessary for effective diagnosis and treatment of your illness or injury;
b. services provided, if you fail fully to comply with the medical or dental regime established by the provider of services or the physician or dentist.

5. **Plan Administrator.** The Plan Administrator is Broome-Tioga BOCES.

6. **Plan Year.** The Plan Year begins January 1st and ends December 31st.

7. **Professional providers.** Professional providers are: individuals licensed to practice dentistry and/or to perform oral surgery, and other health care professionals who are licensed to provide the services covered under the Plan. Benefits are only provided for services that are usually billed by the provider.

Section Three
Who Is Covered And When Coverage Begins

1. **Eligibility.** You may select coverage for yourself only (individual coverage); or you may select coverage for yourself and your spouse and/or your eligible dependents (family coverage). You must meet the Plan's eligibility requirements for this coverage.

If an individual who is otherwise eligible for coverage under a health plan or insurer declines coverage because he or she is covered under another plan, that individual and his/her qualifying family members may enroll in the health plan or insurer during a period of special enrollment if his or her eligibility for the other coverage ceases.

In order to qualify for this special enrollment period, the individual must have had other coverage when the coverage at issue was declined. In addition, a health plan or insurer may require that when declining coverage, an individual specifically put in writing that coverage is being declined because of other coverage. If a plan or insurer chooses to require this written statement in order to later qualify for a special enrollment period, then the plan or insurer must provide notice of the requirement at the time coverage is declined and explain the consequences of a failure to state in writing that coverage is being declined due to other coverage. If an individual does not state that coverage is being declined because of other coverage, then no special enrollment period need be given.

2. **How to apply for coverage.** To apply for coverage, you must complete a form approved by LBS. The form must state whether you want individual coverage or family coverage. You must give the form to the Plan Administrator.

3. **Who is covered.** Only you are covered under the Plan if you selected individual coverage. If you selected family coverage, you may also cover all of the following:

   a. your legal spouse.
   b. your unmarried eligible dependents to their 25th birthday. Eligible dependent means:

      i. your biological child;
      ii. a child of your spouse;
      iii. a child for whom you are legal guardian; and
      iv. your adopted child or a child who has been placed with you for adoption;

      provided you claim the child on your federal income tax return or you can prove to LBS that you provide more than 50% of the child's financial support; and provided at least one of the following has occurred:

      i. the eligible dependent starts living with you in a regular parent-child relationship; or
      ii. a court of law places a child with you for adoption by accepting a consent to adopt and you enter into an agreement to support the dependent; or
      iii. a court of law make you, or your spouse, legally responsible for the support and maintenance of the dependent.

   c. your unmarried eligible dependents who are unable to work or support themselves. Your dependent must be incapable of working because of mental illness, developmental disability or mental retardation, all as defined in the New York Mental Hygiene Law, or because of physical disability. The condition must have occurred: before the dependent reached age 25. For your dependents to be covered under this paragraph, you must notify the Plan Administrator within 30 days of the date your dependent's eligibility would otherwise end.

   If you have selected family coverage, all the covered services available to you are also available to your spouse, and eligible dependents. Remember, you must notify the Plan Administrator when you gain a spouse or eligible dependent, or when your spouse or eligible dependent no longer qualifies for coverage.

4. **When coverage starts.** The Plan Administrator establishes the date you are eligible for coverage under this Plan.

   a. If you apply for coverage before the day you become eligible, your coverage begins on the eligibility day.

   b. If you apply for coverage within 30 days after you are eligible, coverage starts on the date the application is accepted by the Plan Administrator.

c. If you are not actively at work on the day you would normally become eligible, you will be eligible on the day you return to work.

d. If you have individual coverage and apply for family coverage before a person becomes your spouse or eligible dependent (other than a newborn child), family coverage will start on the date the person, except for a newborn child, becomes your spouse or eligible dependent. If you have individual coverage and apply for family coverage within 30 days after a person becomes your spouse or eligible dependent (other than a newborn child), family coverage will start on the date the application is accepted by the Plan Administrator. Coverage for your newborn child is discussed in e. below.

e. If you have family coverage, your newborn child is covered at birth. If you have individual coverage at the time your child is born, you may change to family coverage and obtain coverage for your newborn child from the moment of birth. You must apply for family coverage, and the Plan Administrator must receive the applicable premium for the new coverage, within 30 days of the birth. If you are in the process of adopting the newborn, there are additional requirements (explained below).

f. If you have family coverage, or if you apply for family coverage and the Plan Administrator receives the applicable family premium for the new coverage within 30 days of the birth of a child you intend to adopt, the child will be covered from the moment of birth if:

   i. you take physical custody of the child upon discharge from the hospital or birth center; and
   ii. within 30 days of the child's birth, you file a petition to adopt or for temporary legal guardianship under the New York Domestic Relations Law.

   The Plan will not provide coverage if a notice of revocation of the adoption has been filed, or one of the biological parent's revokes consent to the adoption. If the Plan pays benefits for covered services for an adopted newborn child and the adoption is revoked, or one of the biological parents revokes consent, the Plan has the right to recover any payments that it made for care of the newborn child.

g. Coverage will not begin until the Plan's next reopening date, which occurs once every six months, if:

   i. the Plan Administrator receives your application for coverage later than 30 days after you meet the eligibility requirements;
   ii. the Plan Administrator receives your application for family coverage later than 30 days after a person becomes your spouse or an eligible dependent; or
   iii. the Plan Administrator receives your reapplication for coverage after you choose to end individual or family coverage.

Section Four
Basic Dental Coverage

1. **Basic dental benefits.** Your dental coverage meets the basic needs for preventive dental care. This dental coverage encourages regular visits to the dentist and treatment of minor dental care problems before they become major problems. The basic dental benefits of this Plan cover the most common dental care services for most people. Procedures are diagnostic, restorative, and preventive – all essential to good health.

   a. **simple extractions** – deciduous and permanent teeth

   b. **fillings** consisting of silver amalgam and synthetic restorations

   c. **prophylaxis**, including scaling and polishing – 2 cleanings in a calendar year

   d. **periodontal prophylaxis**, 2 cleanings in a calendar year

   d. **oral evaluations** – 2 exams in a calendar year

   e. **periapical and bitewing x-rays** – 2 sets in a calendar year, 1 every 36 months for panorex or full mouth x-ray

   a. **topical fluoride applications** for dependents under age 25. 4 applications in a calendar year

   g. **repair of dentures**

   h. **endodontics**, including pulpotomy, pulp capping and root canal treatment

   i. **palliative emergency treatment** of dental pain as needed

   j. **sealants –** one per molar, per 36 months

Section Five
Additional Dental Coverage

1. **Additional dental benefits.** The following benefits are in addition to the dental benefits described in Section Four.

   a. **oral surgery**

   b. **anesthesia**

   b. **crowns**, not part of a bridge or inserted over an implant

   a. **inlays**, **onlays**, not part of a bridge

b. **veneers**, not covered for cosmetic reasons

c. **space maintainers -** one (1) per tooth per lifetime, for dependents to age 25

d. **apicoectomy** (surgical removal of the tip of a tooth root, usually in connection with root canal therapy).

Section Six
Orthodontic Services Coverage

1. **Orthodontic benefits.** Your dental benefits cover comprehensive orthodontic services for eligible children up to age 25 including:

   a. **diagnosis, models and x-rays**;

   b. **comprehensive monthly treatment**; and

   c. **subsequent retention of treatment**.

2. **Payment schedule –** Benefit paid 75/25. The initial 75% payment is processed upon receipt of a claim stating that the appliance was placed. (Payment is determined using case fee and total months expected in treatment.) The remaining 25% payment will be paid upon the Plan's receipt of the ortho confirmation letter from the provider during the final stages of treatment.

3. **Lifetime maximum payment**. The lifetime maximum amount payable for each person covered under this section is $2,085.00. When the amount payable for a person reaches $2,085.00, coverage for that person's orthodontic services stop. Services covered under this section do not apply to the contract's calendar year maximum that is mentioned in Section Seven.

Section Seven
Periodontic Services Coverage

1. **Periodontic benefits.** Benefits are available for dental procedures for the treatment of gum disease, the greatest single cause of teeth loss by persons over age 35. This coverage includes:

   a. **gingival curettage** (scraping of gums);

   b. **gingivectomy and gingivoplasty** (gum surgery and rebuilding gums);

   c. **osseous surgery**, including flap entry and closure (bone surgery); and

   d. **mucogingivoplastic** surgery (cutting gums and mucus membranes)

Section Eight
Dental Prosthetics Coverage

1. **Dental prosthetics benefits.** Your dental benefits under this Plan includes coverage for necessary treatment that usually follows removal of a tooth, including:

   a. **full or partial dentures;**

   b. **fixed or removable bridge; or**

   c. **endosseous implants.**

   d. **Relines/rebases.**

   Benefits are not available for denture replacement within 5 years after receiving dentures under this Plan, or denture replacement in the event of loss.

Section Nine
Schedule of Allowances

See Attachment A.

Section Ten
Exclusions

In addition to the exclusions and limitations described in other sections, the Plan does not cover the following:

1. **No coverage.** The Plan does not cover any service or care given to you before your coverage begins under the Plan.

2. **VA/Government/Uniformed Service Hospitals.** The Plan does not cover any service or care you receive in an institution owned or operated by: the Veterans Administration; a federal, state, or local government; or by the United States uniformed services, except as follows:

   a. **VA hospitals.** The Plan will cover service and care for non-service related conditions received in an institution owned or operated by the VA.

   b. **Government hospitals.** The Plan will cover service and care received in institutions owned or operated by a federal, state, or local government if you are a patient in a hospital that is state or municipally owned and operated, and the hospital usually charges for its services.

c. **Uniformed Service hospitals.** The Plan will cover service and care while an inpatient in a hospital operated by the United States uniformed services for the following covered persons: retired military personnel and their dependents; and dependents of military personnel on active duty.

d. **Emergency care.** The Plan will cover service and care in any of the above hospitals if:

i. you suffer a sudden and serious illness or serious injury;
ii. you are treated immediately at the hospital because of its closeness;
iii. it is impossible to transfer you to another institution; and
iv. you stay in that hospital only as long as emergency care is necessary.

3. **Government programs.** The Plan will not cover any benefits that are payable under Medicare, or any other federal, state or local government program, except when required by state or federal law. When you are eligible for a government program, benefits will be reduced by the amount the government program would have paid for the services. If you are eligible for a government program, this reduction is made even if: you fail to enroll; you do not pay the charges for the program; or you receive services at a hospital that cannot bill Medicare.

4. **Workers' compensation.** The Plan will not cover any service or care for which you are eligible under a Workers' Compensation Act or similar law. The Plan will not cover the services even if you do not receive benefits because: a proper or timely claim for the benefits available to you under the Act was not submitted; or you fail to appear at a Workers' Compensation hearing.

5. **No-fault automobile insurance.** The Plan will not cover any service or care that is eligible for coverage by no-fault automobile insurance until you have used up all the benefits under the no-fault policy. If your claim for no-fault benefits is denied, you must file for an arbitration hearing if requested to do so. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under any available mandatory no-fault policy. The Plan will pay for services covered under this contract when you have exceeded the maximum benefits of the no-fault policy.

   Should you be denied benefits under the no-fault policy because it has a deductible, the Plan will pay for covered services.

6. **Free care.** The Plan will not cover any service or care if furnished to you without charge, or if it would have been furnished to you without charge if you were not covered under this Plan.

7. **Employer services.** The Plan will not cover any service or care furnished by a medical department or clinic provided by your employer.

8. **Cosmetic surgery.** The Plan will not cover any service or care related to cosmetic or beautifying surgery. This exclusion applies when it is determined the service is not medically necessary and is intended only to improve your appearance. However, the Plan will cover services in connection with reconstructive surgery as a result of an infection, injury or disease. The Plan will

also cover reconstructive surgery to correct a functional birth defect of a covered dependent child.

9. **Experimental and investigational services.** Benefits will not be provided for any treatment, procedure, facility, equipment, drug, device or supply (collectively, "Service") that is determined to be experimental or investigational. It may be determined that a Service is experimental or investigational even if it has received governmental approval or is ordered by your professional provider.

   "Experimental or investigational" means:

   a. the Service is considered experimental or investigational by the Plan or any appropriate technological assessment body established by a state or federal government; or
   b. the Service does not have appropriate governmental or regulatory approval when it is provided to you; or
   c. reliable Evidence (defined below) shows that the Service is not customarily recognized as standard medical treatment for your condition; or
   d. reliable Evidence (defined below) shows that the Service is, or there is consensus among experts that it should be, the subject of further study or ongoing clinical trials to determine maximum tolerated dosage; toxicity; safety; effectiveness; or effectiveness as specifically compared with the standard means of treatment or diagnosis for your condition.

   "Reliable Evidence" includes:

   a. the views and practices of medical or dental communities throughout the country.
   b. reports and articles published in authoritative medical, dental, and scientific literature.
   c. the opinion of professional consultants.
   d. written protocols used by your professional provider or any other professional provider studying substantially the same Service.
   e. informed consent forms used by your professional provider or any other professional provider studying substantially the same Service.

10. **Unnecessary care.** The Plan will not cover any service or care when it is determined that the care is not needed for your proper medical care or treatment. This exclusion applies wherever you receive the service or care.

11. **Criminal behavior.** The Plan will not cover any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred.

12. **Prohibited referral.** The Plan will not cover any pharmacy services, clinical laboratory, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York State Public Health Law.

13. **Special charges.** The Plan will not cover charges for telephone consultations, missed appointments, or fees that may be added for completing a claim form.

14. **Act of war.** The Plan will not cover an illness or injury that occurs as a result of any war or act of war, whether declared or undeclared.

15. **Other non-covered services.** In addition to the exclusions listed above, benefits are also not provided for the following: sealants, myofunctional therapy; athletic mouth guards; oral hygiene, dietary, plaque control, and other educational programs; porcelain veneered crowns or pontics placed on or in place of a tooth behind the second bicuspid, to the extent the charges would be more than the charge that would have been a covered benefit for acrylic veneered crowns or pontics.

    However, benefits may be available for some of the following services under a medical surgical or major medical type contract: excision of tumors; removal of cysts and neoplasms; excision of bone tissue; surgical incision; treatment of fractures; repair of traumatic wounds; and other repair procedures.

16. **Services not listed**. The Plan will not cover any services or care not specifically listed as a covered benefit by the Plan.

Section Eleven
Coordination of Benefits

1. **Other health benefits programs.** This section only applies if you, your spouse, or an eligible dependent is also covered under another health benefits program that provides dental benefits. These programs, whether insured or self-insured, include the following group programs:

    a. group contracts issued by a hospital service, health service, or medical expense indemnity corporation (such as a BlueCross or BlueShield Plan) or a dental expense indemnity corporation;
    b. group or group remittance insurance contracts;
    c. HMOs, and other prepayment group practice and individual practice plans;
    d. labor-management, union, employer organization, or employee benefit plans;
    e. blanket contracts, except school accident or similar coverage where the organization pays the premium; or
    f. governmental programs for hospital, medical and surgical benefits offered, required, or provided by law, except Medicare and Medicaid. These programs do not include programs whose benefits, by law, are in addition to any private or nongovernmental health benefits program.

        It also includes health benefits coverage in group and individual mandatory automobile “no-fault” and traditional mandatory automobile “fault” type contracts.

2. **Purpose.** Coordination of benefits (COB) means that the coverage provided under this Plan is coordinated with coverage available to you under another health benefits program. The purpose of COB is to avoid both programs paying benefits for the same services.

3. **Payment rule.** When you are covered under this Plan and another health benefits program, you have primary and secondary coverage. Primary means the program that is required to pay its benefits first. Secondary means the program paying second.

In deciding which program is primary, the first of the following rules that applies will be used:

a. if a program does not have a COB provision like this one, it is primary;
b. the program is which the patient is covered as an employee or member (that is, other than as a dependent) is primary, except that:

    i. if the patient is also a Medicare beneficiary;
    ii. if the rules established by the Social Security Act of 1965, as amended, make Medicare primary to the program covering the patient as an employee or member; and
    iii. if the rules established by the Social Security Act of 1965, as amended, make Medicare secondary to the program covering the patient as a dependent of a person in current employment status (defined as an employee, employer, or person associated with an employer in a business relationship) with respect to the employer maintaining the program; then
    iv. the following rules apply:

        - ♦ the program covering the patient as a dependent of a person in current employment status pays first,
        - ♦ Medicare pays second,
        - ♦ the program covering the patient as an employee or member pays third.

c. if a child is covered as a dependent of two people (parents/married or joint custodians of the child without a court decree establishing financial responsibility for health care expenses) under different programs, the following rules apply:

    i. the program of the parent whose birthday (month and day) is earlier in the year is primary
    ii. if both parents have the same birthday, the program that covered a parent longer is primary; however,
    iii. if the parents are divorced or separated, and joint custody has not been decreed, the special rule in (d) may apply

    However, some programs may not have adopted this “birthday rule”. When the two COB provisions do not agree on which program is primary, the following will be used: if the other program has a rule based on the parent’s gender, the program under which the child is a dependent of a male is primary.

d. for children of divorced or separated parents the following rules apply:

   i. if there is a court decree establishing financial responsibility for the health care expenses of the child of divorced or separated parents, the program that covers the child as a dependent of the parent with financial responsibility will be primary, if the program has actual knowledge of the court decree. If the program has no actual knowledge, the following rules apply.
   ii. if the parents are divorced or separated, the program that covers the child as a dependent of the parent with custody is primary; provided, the parent with custody has not remarried.
   iii. if the parents are divorced and the parent with custody of the child has remarried, the primary program is the first of the following to apply:

      - the program that covers the child as a dependent of a parent with custody;
      - the program that covers the child as a dependent of the spouse of the parent with custody; or
      - the program that covers the child as a dependent of the parent without custody.

e. when the above rules do not determine priority, the program that covered the patient for the longest time is primary. The other program is secondary, except when:

   i. the program in which the patient is covered as an employee but not as a laid-off or retired employee or the dependent of such an employee is primary; the program in which the patient is covered as a laid-off or retired employee or the dependent of such an employee is secondary; and
   ii. if both programs do not have a provision like this for laid-off or retired employees, then this rule will not apply.

4. **How COB affects payments.**

a. **When the Plan is primary.** The Plan will pay for covered services as if there were no COB provision, when the Plan is primary.

b. **When the Plan is secondary.** The Plan bases its payments, when it is secondary, on allowable expenses during a claim determination period. Allowable expenses are the necessary, reasonable, and customary items of expense for health care that are covered at least in part by one or more health benefit programs. A claim determination period means a calendar year; it does not include any part of a year when you were not covered by this Plan.

   The Plan will pay for covered services after the payment by the primary program. Benefits may be reduced so the total of all benefits available to you from the Plan and the primary program is not more than the allowable expenses.

The Plan counts as actually paid by the primary program any items of expense that would have been if you had made the proper claim. If the primary program claims it is "excess only" or "always secondary," information will be requested from that program so they can process your claim. If the primary program does not respond within 30 days, it will be assumed that its benefits are the same as under the Plan. If the primary program sends the information after 30 days, payment under the plan will be adjusted, if necessary. When the Plan is secondary, benefit payment will never be more than the full amount of benefits due under the Plan had the Plan been primary.

5. **Right to receive and release necessary information.** Without your permission and without notice to you, LBS or the Plan Administrator may release to, or obtain from, any person, company or organization information that is believed to be necessary to carry out the purposes of this section. Neither LBS nor the Plan Administrator will be legally responsible to anyone for releasing or obtaining information. You must furnish to LBS or the Plan Administrator any information that they request. If you do not furnish the information to them, benefits may be denied under the Plan until you do.

6. **Payments to other health benefits programs.** Benefits may be repaid to any other health benefits program that were paid for your covered services under the Plan, if it is decided that the Plan should have paid. These payments are the same as benefits paid to you, and they satisfy any obligation to you under the Plan.

7. **Right to recover payment.** In some cases, payment may have been made even though you had coverage under another program. If this happens, you must refund the amount of the Plan's payment. The Plan also has the right to recover the payment from the other program. You must sign any document that is needed to help recover payment.

Section Twelve
How Your Coverage May End

This section describes how your benefits under the Plan may end and how your coverage stops. When the benefits or your coverage ends, benefit payments stop on the termination date. This applies even if you are receiving benefits under the Plan, except as otherwise specifically provided under the Plan.

1. **If your benefits terminate.** Your benefits may be terminated at any time if the Plan Administrator and LBS agree to end their arrangement.

2. **When you no longer qualify.** When you fail to meet the eligibility requirements of the Plan Administrator, your coverage will end.

3. **On your death.** Your coverage will automatically end on the day after your death. If you have family coverage, your spouse's and eligible dependents' coverage will also end on the day after your death.

4. **Termination of marriage.** If you have family coverage and you become legally separated or divorced, the coverage of your spouse will end automatically on the date the legal separation agreement or decree is actually filed. You should immediately notify the Plan Administrator of your change in marital status.

5. **Termination of coverage of an eligible dependent.** Coverage of your eligible dependent will end on:

   a. your dependent's 25th birthday;
   b. the day your dependent marries;
   c. the day you no longer claim the dependent on your federal income tax return, or provide more than 50% financial support.
   d. the day your dependent over 25 years of age no longer has a mental illness, developmental disability, mental retardation or physical handicap, or can support himself or herself.

Section Thirteen
Miscellaneous

1. **General information.** This Plan is maintained for the exclusive benefit of employees of Broome-Tioga BOCES. Employees' rights under this Plan are legally enforceable. It is the intention of Broome-Tioga BOCES that this Plan be maintained for an indefinite period of time.

2. **Effective date.**

   If you are in regular full-time employment on the Plan effective date, and have satisfied all eligibility requirements, you and your dependents will be eligible for coverage on that date. The Plan effective date is July 1, 2005.

3. **When a charge is incurred.** A charge is incurred on:

   a. the date the dentures or fixed bridges are completed;
   b. the date the crown has been inserted/seated;
   c. the date the work on the tooth is begun, in the case of root canal therapy; or
   d. the date the work is done, in the case of any other work.

Section Fourteen
Submitting a Claim

When you or an eligible dependent has an appointment with a dentist you should proceed as follows:

1. Obtain a claim form from the Human Resources Department at Broome-Tioga BOCES. Complete and sign the top portion of the claim form indicating the name of the patient who is to be treated by a dentist and the employee's name, and fill in other information requested on the form. You must sign the section authorizing use of claim information. If you sign the section authorizing plan

payment to the dentist, any plan payment will be made payable to the dentist. If you do not sign this section, any payment will be made directly to you.

2. You must give the claim form to the dentist. The dentist is expected to fill out the form upon completion of services and send the form to LBS at the address printed on the top of the form. Applicable benefits will be determined and payment will be made by LBS on behalf of the Plan Administrator. The amount of coverage will be determined by LBS on behalf of the Plan Administrator, in accordance with the terms of the Plan. If for any reason you are unable to obtain a claim form in advance of treatment (for example, if an emergency service is required, or service is required while you are on vacation), you should attach a copy of the dentist's bill to a claim form obtained as soon afterward as possible. After completing the appropriate portion of the claim form, YOU MUST SUBMIT IT TO LIFETIME BENEFIT SOLUTIONS.

3. The Plan will pay the applicable benefit amount for all completed work to the dentist or directly to you. If you are not entitled to payment, you will receive an explanation of the amount of benefits paid. Upon receipt, the explanation of benefits should be examined for accuracy and any questions directed to LBS or the Plan Administrator.

4. When another dental appointment is scheduled, you should obtain another claim form for the dentist to complete.

5. The Plan reserves the right to deny payment relative to any claim form received more than 180 days following the last date of treatment on the form.

6. If a claim for benefits under the Plan is denied, LBS will provide you with the reason for denial, in writing, within 15 calendar days following receipt of the claim.

   You, or a person on your behalf, may ask for a review of the denied claim in writing within 180 days of receipt of the denial notice. This written request for review should state the reason(s) why you feel your claim should not have been denied. It should include any additional documents (medical or dental records, etc.) that you feel support your claim. You may ask additional questions or make comments, and you may review pertinent documents. In normal cases, you will receive the final decision within 15 days of the date that your request for review is received by LBS.

   All requests for Plan Administrator *review of denied claims* should be sent to:

   Lifetime Benefit Solutions, Inc.
   Attn: Claim Denial Department
   P.O. Box 778
   Liverpool, NY 13088-0778

   You have the right to appeal any claim denial to your Plan Administrator. The Plan Administrator has the duty and the authority to conduct a final full and fair review of any claim(s) denied in full or part by the Plan.

All requests for Plan Administrator *review of denied claims appeal* should be sent to:

Lifetime Benefit Solutions, Inc.
Attn: Claim Appeals Department
P.O. Box 778
Liverpool, NY 13088-0778

Section Fifteen
Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a child or children with health coverage. If the Plan received a QMCSO for your child or children, you will be contacted about the procedure for the QMCSO. Copies of the Plan's QMCSO procedures are available, without charge, from Human Resources, Broome-Tioga BOCES, 435 Glenwood Road, Binghamton, New York 13905-1699.

Section Sixteen
COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you and/or your covered family members may have a right to continue your coverage under this Plan, when your coverage would otherwise end. If you are eligible to continue your coverage under COBRA, the Plan Administrator should give you notice. If you do not receive notice, ask the Plan Administrator if you qualify.

Section Seventeen
Your Rights Under ERISA

The Federal Employee Retirement Income Security Act of 1974, as amended (ERISA) provides certain rights and protections to participants whose employer group health plans are subject to the requirements of ERISA. If ERISA applies to this Plan, the Plan Administrator is responsible for complying with its requirements. The Plan Administrator can advise you what rights, if any, you have under ERISA.

Plan Administrator

Broome-Tioga BOCES

Plan Year

January 1st – December 31st

Attachment A SCHEDULE OF ALLOWANCE

D0100-D0999 I. DIAGNOSTIC		*AMOUNT*
CLINICAL ORAL EVALUATIONS		
D0120	PERIODIC ORAL EVALUATION	$15.00
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	$10.00
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	$10.00
D0160	DETAIL & EXTEN ORAL EVAL-PROB FOCUSED, BY REPORT	$10.00
D0170	RE-EVAL LIMITED, PROBLEM FOCUSED (ESTAB PT NOT POSTOP)	$10.00
D0180	COMPREHENSIVE PERIODONTAL EVALUATION – NEW OR ESTABLISHED PATIENT	$10.00
RADIOGRAPHS/DIAGNOSTIC IMAGING		
D0210	INTRAORAL - COMPLETE SERIES (INCLUDING BITEWINGS)	$31.00
D0220	INTRAORAL - PERIAPICAL FIRST FILM	$5.00
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL FILM	$3.00
D0240	INTRAORAL - OCCLUSAL FILM	$8.00
D0250	EXTRAORAL - FIRST FILM	$10.00
D0260	EXTRAORAL - EACH ADDITIONAL FILM	$8.00
D0270	BITEWING - SINGLE FILM	$5.00
D0272	BITEWING - TWO FILMS	$9.00
D0274	BITEWING - FOUR FILMS	$17.00
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS	$34.00
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL & FACIAL BONE SURVEY FILM	$28.00
D0310	SIALOGRAHY	$49.00
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	$0.00
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS, BY REPORT	$16.00
D0322	TOMOGRAPHIC SURVEY	$0.00
D0330	PANORAMIC FILM	$26.00
D0340	CEPHALOMETRIC FILM	$49.00
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES	$0.00
TESTS AND EXAMINATIONS		
D0415	COLLECTION OF MICROORGANISMS FOR CULTURE AND SENSITIVITY	$0.00
D0416	VIRAL CULTURE	$0.00
D0421	GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASES	$0.00
D0425	CARIES SUSCEPTIBLITY TESTS	$0.00
D0431	ADJUNCTIVE PRE-DIAGNOSTIC TEST	$0.00
D0460	PULP VITALITY TESTS	$9.00
D0470	DIAGNOSTIC CASTS	$21.00
ORAL PATHOLOGY LABORATORY (USE CODES D0472 -D0474)		
D0472	ACCESSION OF TISSUE, GROSS EXAM, PREP & TRANS OF WRITTEN REPORT	$0.00
D0473	ACCESSION OF TISSUE, GROSS & MICRO EXAM, PREP & TRANS OF WRITTEN REPORT	$0.00
D0474	ACCESS. OF TISSUE, GROSS & MICRO EXAM, INCL. ASSESS/SURG. MARGINS FOR PRESENCE OF DISEASE, PREP & TRANS OF WRITTEN REPORT	$0.00
D0475	DECALCIFICATION PROCEDURE	$0.00
D0476	SPECIAL STAINS FOR MICROORGANISMS	$0.00
D0477	SPECIAL STAINS, NOT FOR MICROORGANISMS	$0.00
D0478	IMMUNOHISTOCHEMICAL STAINS	$0.00

D0479	ITSSUE IN-SITU HYBRIDIZATION, INCLUDING INTERPRETATION	$0.00
D0480	PROC. & INTERPRET OF CYTOLOGIC SMEARS, INCL. PREP & TRANS/WRITTEN REPORT	$0.00
D0481	ELECTRON MICROSCOPY - DIAGNOSTIC	$0.00
D0482	DIRECT IMMUNOFLUORESCENCE	$0.00
D0483	INDIRECT IMMUNOFLUORESCENCE	$0.00
D0484	CONSULTATION ON SLIDES PREPARED ELSEWHERE	$0.00
D0485	CONSULTATION, INCLUDING PREPARATION OF SLIDES FROM BIOPSY MATERIAL SUPPLIED BY REFERRING SOURCE	$0.00
D0502	OTHER ORAL PATHOLOGY PROCEDURES BY REPORT	$0.00
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT	$0.00

D1000-D01999 II. PREVENTIVE

DENTAL PROPHYLAXIS

D1110	PROPHYLAXIS – ADULT	$25.00
D1120	PROPHYLAXIS – CHILD	$20.00

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

D1201	TOPICAL FLUORIDE (INC PROPHYLAXIS) CHILD	$30.00
D1203	TOPICAL FLUORIDE (PROPHY NOT INCLUDED) CHILD	$10.00
D1204	TOPICAL FLUORIDE (PROPHY NOT INCLUDED) ADULT	$10.00
D1205	TOPICAL FLUORIDE (INC PROPHYLAXIS) ADULT	$30.00
D1208	TOPICAL APPLICATION OF FLUORIDE	

OTHER PREVENTIVE SERVICES

D1310	NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE	$0.00
D1320	TOBACCO COUNSELING FOR THE CONTROL & PREV OF ORAL DISEASE	$0.00
D1330	ORAL HYGIENE INSTRUCTIONS	$0.00
D1351	SEALANT PER TOOTH	$15.00

SPACE MAINTENANCE (PASSIVE APPLIANCES)

D1510	SPACE MAINTAINER FIXED UNILATERAL	$90.00
D1515	SPACE MAINTAINER FIXED BILATERAL	$117.00
D1520	SPACE MAINTAINER REMOVABLE UNILATERAL	$76.00
D1525	SPACE MAINTAINER REMOVABLE BILATERAL	$90.00
D1550	RECEMENTATION OF SPACE MAINTAINER	$21.00

D2000-D2999 III. RESTORATIVE

AMALGAM RESTORATIONS (INCLUDING POLISHING)

D2140	AMALGAM ONE SURFACE PRIMARY OR PERMANENT	$20.00
D2150	AMALGAM TWO SURFACES PRIMARY OR PERMANENT	$26.00
D2160	AMALGAM THREE SURFACES PRIMARY OR PERMANENT	$32.00
D2161	AMALGAM FOUR/MORE SURFACES PRIMARY OR PERMANENT	$38.00

RESIN-BASED COMPOSITE RESTORATIONS – DIRECT

D2330	RESIN-BASED COMPOSITE-ONE SURFACE, ANTERIOR	$20.00
D2331	RESIN-BASED COMPOSITE-TWO SURFACES, ANTERIOR	$25.00
D2332	RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR	$30.00
D2335	RESIN-BASED COMPOSITE-FOUR/MORE SURFACES/INCISAL ANGLE ANT	$50.00
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	$138.00
D2391	RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR	$25.00
D2392	RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR	$30.00

D2393	RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR	$32.00
D2394	RESIN-BASED COMPOSITE-FOUR/MORE SURFACES, POSTERIOR	$50.00

GOLD FOIL RESTORATIONS

D2410	GOLD FOIL - ONE SURFACE	$0.00
D2420	GOLD FOIL - TWO SURFACES	$0.00
D2430	GOLD FOIL - THREE SURFACES	$0.00

INLAY/ONLAY RESTORATIONS

D2510	INLAY - METALLIC-ONE SURFACE	$138.00
D2520	INLAY - METALLIC-TWO SURFACES	$206.00
D2530	INLAY - METALLIC-THREE OR MORE SURFACES	$227.00
D2542	ONLAY - METALLIC-TWO SURFACES	$173.00
D2543	ONLAY - METALLIC -THREE SURFACES	$241.00
D2544	ONLAY - METALLIC-FOUR OR MORE SURFACES	$262.00
D2610	INLAY - PORCELAIN/CERAMIC-ONE SURFACE	$100.00
D2620	INLAY - PORCELAIN/CERAMIC-TWO SURFACES	$150.00
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	$175.00
D2642	ONLAY - PORCELAIN/CERAMIC-TWO SURFACES	$135.00
D2643	ONLAY - PORCELAIN/CERAMIC-THREE SURFACES	$185.00
D2644	ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SURFACES	$210.00
D2650	INLAY - RESIN-BASED COMPOSITE-ONE SURFACE	$100.00
D2651	INLAY - RESIN-BASED COMPOSITE-TWO SURFACES	$150.00
D2652	INLAY - RESIN-BASED COMPOSITE-THREE SURFACES	$175.00
D2662	ONLAY - RESIN-BASED COMPOSITE-TWO SURFACES	$135.00
D2663	ONLAY - RESIN-BASED COMPOSITE-THREE SURFACES	$185.00
D2664	ONLAY - RESIN-BASEDS COMPOSITE-FOUR OR MORE SURFACES	$210.00

CROWNS - SINGLE RESTORATIONS ONLY

D2710	CROWN - RESIN (INDIRECT)	$138.00
D2712	CROWN – 3/4 RESIN-BASED COMPOSITE (INDIRECT)	$206.00
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	$241.00
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	$206.00
D2722	CROWN - RESIN WITH NOBLE METAL	$189.00
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$206.00
D2750	CROWN - PORCELAIN FUSED HIGH NOBLE METAL	$337.00
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$309.00
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	$309.00
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	$241.00
D2781	CROWN - 3/4 CAST PREDOMINATELY BASE METAL	$206.00
D2782	CROWN - 3/4 CAST NOBLE METAL	$206.00
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	$206.00
D2790	CROWN - FULL CAST HIGH NOBLE METAL	$241.00
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	$206.00
D2792	CROWN - FULL CAST NOBLE METAL	$206.00
D2794	CROWN - TITANIUM	$206.00
D2799	PROVISIONAL CROWN	$0.00

OTHER RESTORATIVE SERVICES

D2910	RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION	$16.00
D2915	RECEMENT CAST OR PREFABRICATED POST AND CORE	$0.00

D2920	RECEMENT CROWN	$16.00
D2929	PREFAB PORC/CERAMIC CROWN PRIMARY TOOTH	$42.00
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	$42.00
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERM TOOTH	$42.00
D2932	PREFABRICATED RESIN CROWN	$138.00
D2933	PREFABRICATED STAINLESS STEEL CROWN W/RESIN WINDOW	$42.00
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	$42.00
D2940	SEDATIVE FILLING	$20.00
D2950	CORE BUILDUP, INCLUDING ANY PINS	$69.00
D2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	$8.00
D2952	CAST POST AND CORE IN ADDITION TO CROWN	$69.00
D2953	EACH ADDITIONAL CAST POST - SAME TOOTH	$69.00
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	$95.00
D2955	POST REMOVAL (NOT IN CONJUNCTION W/ENDODONTIC THERAPY)	$0.00
D2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	$95.00
D2960	LABIAL VENEER (RESIN LAMINATE) – CHAIRSIDE	$0.00
D2961	LABIAL VENEER (RESIN LAMINATE) – LABORATORY	$0.00
D2962	LABIAL VENEER (PORCELAIN LAMINATE) – LABORATORY	$0.00
D2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL FRAMEWORK	$0.00
D2975	COPING	$0.00
D2980	CROWN REPAIR, BY REPORT	$49.00
D2981	REPAIR OF INLAY	$49.00
D2982	REPAIR OF ONLAY	$49.00
D2983	REPAIR OF VENEER	$49.00
D2990	RESIN INFILTRATION	$15.00
D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	$0.00

D3000-D3999 IV. ENDODONTICS

PULP CAPPING

D3110	PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	$10.00
D3120	PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)	$10.00

PULPOTOMY

D3220	THERAP PULPOTOMY-REMOV PULP & APPLIC MEDS	$30.00
D3221	PULPAL DEBRIDEMENT, PRIM & PERM TEETH	$15.00

ENDODONTIC THERAPY ON PRIMARY TEETH

D3230	PULPAL THERAPY – ANTERIOR, PRIM TOOTH (EXCLD FINAL RESTOR)	$40.00
D3240	PULPAL THERAPY – POSTERIOR, PRIM TOOTH (EXCLD FINAL RESTOR)	$40.00

ENDOD. THERAPY (INCLD TREAT. PLAN, CLINC PROC & FOLLOWUP)

D3310	ANTERIOR (EXCLUDING FINAL RESTORATION)	$150.00
D3320	BICUSPID (EXCLUDING FINAL RESTORATION)	$200.00
D3330	MOLAR (EXCLUDING FINAL RESTORATION)	$250.00
D3332	INCOMP. ENDODONTICS THERAPY; INOPERABLE OR FRACT. TOOTH	$0.00
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	$0.00

ENDODONTIC RETREATMENT

D3346	RETREATMENT OF PREV. ROOT CANAL THERAPY – ANTERIOR	$165.00

D3347	RETREATMENT OF PREV. ROOT CANAL THERAPY – BICUSPID	$230.00
D3348	RETREATMENT OF PREV. ROOT CANAL THERAPY – MOLAR	$300.00

APEXIFICATION/RECALCIFICATION PROCEDURES

D3351	APEXIFICATION/RECALCIFICATION - INITIAL VISIT	$84.00
D3352	APEXIFICATION/RECALCIFICATION - INTERIM MEDIC. REPLACEMENT	$100.66
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$117.33

APICOECTOMY/PERIRADICULAR SERVICES

D3410	APICOETOMY/PERIRADICULAR SURGERY – ANTERIOR	$100.00
D3421	APICOETOMY/PERIRADICULAR SURGERY-BICUSPID (1ST ROOT)	$100.00
D3425	APICOETOMY/PERIRADICULAR SURGERY-MOLAR (1ST ROOT)	$100.00
D3426	APICOETOMY/PERIRADICULAR SURGERY (EACH ADD ROOT)	$100.00
D3430	RETROGRADE FILLING - PER ROOT	$35.00
D3450	ROOT AMPUTATION - PER ROOT	$103.00
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	$0.00
D3470	INTENTIAL REIMPLANTATION (INCLD NECES SPLINTING)	$0.00

OTHER ENDODONTIC PROCEDURES

D3910	SURGICAL PROC. FOR ISOLATION OF TOOTH W/RUBBER DAM	$0.00
D3920	HEMISECTION (INC ROOT REMOVAL) W/O ROOT CANAL	$0.00
D3950	CANAL PREP & FITTING OF PREFORMED DOWEL OR POST	$0.00
D3999	UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT	$0.00

D4000-D4999 V. PERIODONTICS

SURGICAL SERVICE (INC. USUAL POST-OPER. CARE)

D4210	GINGIVECTOMY OR GINGIVOPLASTY – FOUR/MORE CONTIQUOUS TTH OR BOUNDED TTH PER QUAD	$138.00
D4211	GINGIVECTOMY OR GINGIVOPLASTY – ONE TO THREE TEETH PER QUAD	$25.00
D4240	GINGIVAL FLAP PROC, INC ROOT PLAN-FOUR/MORE CONTIQUOUS TTH OR BOUNDED TTH PER QUAD	$138.00
D4241	GINGIVAL FLAP PROCUDURE, INC ROOT PLAN-ONE TO THREE TEETH, PER QUAD	$0.00
D4245	APICALLY POSITIONED FLAP	$138.00
D4249	CLINICAL CROWN LENGTHENING – HARD TISSUE	$206.00
D4260	OSSEOUS SURGERY (INC FLAP ENTRY/CLOSE) FOUR/MORE CONT TTH OR BOUNDED TTH SPACED PER QUAD	$206.00
D4261	OSSEOUS SURGERY (INC FLAP ENTRY/CLOSE) ONE TO THREE TEETH PER QUAD	$138.00
D4263	BONE REPLACEMENT GRAFT-FIRST SITE IN QUADRANT	$206.00
D4264	BONE REPLACEMENT GRAFT-EACH ADD. SITE IN QUADRANT	$261.00
D4265	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	$151.00
D4266	GUIDED TISS REGEN-RESORBABLE BARRIER, PER SITE	$151.00
D4267	GUIDED TISS REGEN-NONRESORBABLE BARRIER, PER SITE	$151.00
D4268	SURGICAL REVISION PROCEDURE, PER TOOTH	$151.00
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$151.00
D4271	FREE SOFT TISSUE GRAFT PROC. (INC. DONOR SITE SURGERY)	$172.00
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROC.	$110.00
D4274	DISTAL OR PROX. WEDGE PROC.	$21.00
D4275	SOFT TISSUE ALLOGRAFT	$151.00
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT	$151.00
D4277	FREE SOFT TISSUE GRAFT	$151.00

D4278	FREE SOFT TISSUE GRAFT ADD'L TOOTH	$151.00

NON-SURGICAL PERIODONTAL SERVICE

D4320	PROVISIONAL SPLINTING – INTRACORONAL	$52.35
D4321	PROVISIONAL SPLINTING – EXTRACORONAL	$47.00
D4341	PERIODONTAL SCALING & ROOT PLANING – FOUR/MORE CONT TTH OR BOUNDED TTH SPACING PER QUADRANT	$35.00
D4342	PERIODONTAL SCALING & ROOT PLANING – ONE TO THREE TEETH PER QUAD	$14.00
D4355	FULL MOUTH DECRIDEMENT/ENABLE COMP. EVAL. & DIAG.	$42.00
D4381	LOCAL DELIV. CHEMO, PER TOOTH, PER REPORT	$35.00

OTHER PERIODONTAL SERVICES

D4910	PERIODONTAL MAINTENANCE	$35.00
D4920	UNSCEDULED DRESSING CHANGE (OTHER THAN TREATING DENTIST)	$0.00
D4999	UNSPECIFIED PERIODENTAL PROC., BY REPORT	$0.00

D5000-D5899 VI. PROSTHODONTICS (REMOVABLE)

COMPLETE DENTURES (INC. ROUTINE POST-DEVL. CARE)

D5110	COMPLETE DENTURE – MAXILLARY	$344.00
D5120	COMPLETE DENTURE – MANDIBULAR	$344.00
D5130	IMMEDIATE DENTURE – MAXILLARY	$344.00
D5140	IMMEDIATE DENTURE – MANDIBULAR	$344.00

PARTIAL DENTURES (INCL. ROUTINE POST-DELV. CARE)

D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	$403.10
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	$481.00
D5213	MAXIL PART DENT-CAST METAL W/RESIN DENT BASES	$515.00
D5214	MANDIB PART DENT-CAST METAL W/RESIN DENT BASES	$515.00
D5225	MAXIL PART DENT - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS & TEETH)	$515.00
D5226	MANDIB PART DENT - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS & TEETH)	$515.00
D5281	REMOVE UNILAT PART DENT-ONE PIECE CAST METAL	$403.10

ADJUSTMENT TO DENTURES

D5410	ADJUST COMPLETE DENTURE – MAXILLARY	$14.00
D5411	ADJUST COMPLETE DENTURE – MANDIBULAR	$14.00
D5421	ADJUST PARTIAL DENTURE – MAXILLARY	$14.00
D5422	ADJUST PARTIAL DENTURE – MANDIBULAR	$14.00

REPAIRS TO COMPLETE DENTURES

D5510	REPAIR BROKEN COMPLETE DENTURE BASE	$34.25
D5520	REPLACE MISS/BROKE TEETH-COMP. DENTURE (EACH TOOTH)	$45.00

REPAIRS TO PARTIAL DENTURES

D5610	REPAIR RESIN DENTURE BASE	$30.00
D5620	REPAIR CAST FRAMEWORK	$35.00
D5630	REPAIR/REPLACE BROKEN CLASP	$45.00
D5640	REPLACE BROKEN TEETH PER TOOTH	$30.00
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	$40.00
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	$40.00
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	$30.00
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	$0.00

DENTURE REBASE PROCEDURES

D5710	REBASE COMPLETE MAXILLARY DENTURE	$138.00
D5711	REBASE COMPLETE MANDIBULAR DENTURE	$138.00
D5720	REBASE MAXILLARY PARTIAL DENTURE	$138.00
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$138.00

DENTURE RELINE PROCEDURES

D5730	RELINE MAXILLARY COMPLETE DENTURE (CHAIRSIDE)	$103.00
D5731	RELINE MANDIBULAR COMPLETE DENTURE (CHAIRSIDE)	$75.00
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	$83.00
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	$60.00
D5750	RELINE MAXILLARY COMPLETE DENTURE (LABORATORY)	$103.00
D5751	RELINE MANDIBULAR COMPLETE DENTURE (LABORATORY)	$103.00
D5760	RELINE MAXILLARY PARTIAL DENTURE ((LABORATORY)	$83.00
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	$80.00

INTERIM PROSTHESIS

D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$0.00
D5811	INTERIM COMPLETE DENTURE (MANIBULAR)	$0.00
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	$0.00
D5821	INTERIM PARTIAL DENTURE (MANIBULAR)	$0.00

OTHER REMOVABLE PROSTHETIC SERVICES

D5850	TISSUE CONDITIONING, MAXILLARY	$0.00
D5851	TISSUE CONDITIONING, MANDIBULAR	$0.00
D5860	OVERDENTURE - COMPLETE, BY REPORT	$0.00
D5861	OVERDENTURE - PARTIAL, BY REPORT	$0.00
D5862	PRECISION ATTACHMENT, BY REPORT	$0.00
D5867	REPLACE OF REPLACEABLE PART / SEMI-PREC. 0R PREC ATTACH.	$0.00
D5875	MODIF. OF REMOVABLE PROSTHESIS FOLLOW IMPLANT SURG.	$0.00
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROC., BY REPORT	$0.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS

D5911	FACIAL MOULAGE (SECTIONAL)	$0.00
D5912	FACIAL MOULAGE (COMPLETE)	$0.00
D5913	NASAL PROSTHESIS	$0.00
D5914	AURICULAR PROSTHESIS	$0.00
D5915	ORBITAL PROSHTHESIS	$0.00
D5916	OCULAR PROSHESIS	$0.00
D5919	FACIAL PROSTHESIS	$0.00
D5922	NASAL SEPTAL PROSTHESIS	$0.00
D5923	OCULAR PROSTHESIS, INTERIM	$0.00
D5924	CRANIAL PROSTHESIS	$0.00
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS	$0.00
D5926	NASAL PROSTHESIS, REPLACEMENT	$0.00
D5927	AURICULAR PROSTHESIS, REPLACEMENT	$0.00
D5928	ORBITAL PROSTHESIS, REPLACEMENT	$0.00
D5929	FACIAL PROSTHESIS, REPLACEMENT	$0.00
D5931	OBTURATOR PROSTHESIS, SURGICAL	$0.00
D5932	OBTURATOR PROSTHESIS, DEFINITIVE	$0.00

D5933	OBTURATOR PROSTHESIS, MODIFICATION	$0.00
D5934	MANDIBULAR RESECTION PROSTHESIS W/GUIDE FLANGE	$0.00
D5935	MANDIBULAR RESECTION PROSTHESIS W/O GUIDE FLANGE	$0.00
D5936	OBTURATOR PROSTHESIS, INTERIM	$0.00
D5937	TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)	$0.00
D5951	FEEDING AID	$0.00
D5952	SPEECH AID PROSTHESIS, PEDIATRIC	$0.00
D5953	SPEECH AID PROSTHESIS, ADULT	$0.00
D5954	PALATAL AUGMENTATION PROSTHESIS	$0.00
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE	$0.00
D5958	PALATAL LIFT PROSTHESIS, INTERIM	$0.00
D5959	PALATAL LIFT PROSTHESIS, MODIFICATION	$0.00
D5960	SPEECH AID PROSTHESIS, MODIFICATION	$0.00
D5982	SURGICAL STENT	$0.00
D5983	RADIATION CARRIER	$0.00
D5984	RADIATION SHIELD	$0.00
D5985	RADIATION CONE LOCATOR	$0.00
D5986	FLOURIDE GEL CARRIER	$0.00
D5987	COMMISSURE SPLINT	$0.00
D5988	SURGICAL SPLINT	$0.00
D5999	UNSPEC. MAXILLOFACIAL PROSTHESIS, BY REPORT	$0.00

D6000-D6199 VIII. IMPLANT SERVICES

D6010	SURGICAL PLACEMENT OF IMPLANT BODY; ENDOSTEAL IMPLANT	$275.00
D6040	SURGICAL PLACEMENT: EPOSTEAL IMPLANT	$275.00
D6050	SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT	$275.00

IMPLANT SUPPORTED PROSTHETICS

D6053	IMPLANT/ABUTMENT SUPPORT REMOVEABLE DENTURE, COMPLETE EDENTULOUS ARCH	$344.00
D6054	IMPLANT/ABUTMENT SUPPORT REMOVEABLE DENTURE, PARTIALLY EDENTULOUS ARCH	$515.00
D6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	$0.00
D6056	PREFABRICATED ABUTMENT	$206.00
D6057	CUSTOM ABUTMENT	$337.00
D6058	ABUTMENT SUPPORT. PORCELAIN/CERAMIC CROWN	$309.00
D6059	ABUT. SUPP. PORC. FUSED/METAL CROWN (HIGH NOBLE METAL)	$309.00
D6060	ABUT. SUPP. PORC. FUSED/METAL CROWN (PREDOMIN. BASE METAL)	$309.00
D6061	ABUT. SUPP. PORC. FUSED/METAL CROWN (NOBLE METAL)	$309.00
D6062	ABUTMENT SUPPORT. CAST METAL CROWN (HIGH NOBLE METAL)	$227.00
D6063	ABUT. SUPP. CAST METAL CROWN (PREDOMINANTLY BASE METAL)	$227.00
D6064	ABUT. SUPP. CAST METAL CROWN (NOBLE METAL)	$227.00
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$309.00
D6066	IMPLANT SUPP. PORC. FUSED TO METAL CROWN	$309.00
D6067	IMPLANT SUPP. METAL CROWN	$227.00
D6068	ABUTMENT SUPP. RETAINER FOR PORCELAIN/CERAMIC FPD	$309.00
D6069	ABUT. SUPP. RETAINER/PORC. FUSED TO METAL FPD (HIGH NOBLE METAL)	$309.00
D6070	ABUT. SUPP. RETAINER/PORC. FUSED TO METAL FPD (PREDOM. BASE METAL)	$309.00
D6071	ABUT. SUPP. RETAINER/PORC. FUSED TO METAL FPD (NOBLE METAL)	$309.00
D6072	ABUT. SUPP. RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$227.00
D6073	ABUT. SUPP. RETAINER FOR CAST METAL FPD (PREDOM. BASE METAL)	$227.00
D6074	ABUT. SUPP. RETAINER FOR CAST METAL FPD (NOBLE METAL)	$227.00

D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$309.00
D6076	IMPLANT SUPP. RETAINER/PORC. FUSED TO METAL FPD	$309.00
D6077	IMPLANT SUPP. RETAINER FOR CAST METAL FPD	$227.00
D6078	IMPLANT/ABUTMENT SUPP. FIXED DENTURE/COMPL. EDENTULOUS ARCH	$344.00
D6079	IMPLANT/ABUTMENT SUPP. FIXED DENTURE/PARTIALLY EDENTULOUS ARCH	$515.00

OTHER IMPLANT SERVICES

D6080	IMPLANT MAINT. PROC: REMOVE-CLEANS-ABUT & REINSERT. OF PROSTHESIS	$0.00
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	$0.00
D6094	ABUTMENT SUPPORTED CROWN – (TITANIUM)	$309.00
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	$0.00
D6100	IMPLANT REMOVAL, BY REPORT	$0.00
D6104	BONE GRAFT AT TIME OF IMPLANT	$206.00
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$0.00
D6194	ABUT. SUPP. RETAINER CROWN FOR FPD – (TITANIUM)	$227.00
D6199	UNSPEC. IMPLANT PROCEDURE, BY REPORT	$0.00

D6200-D6999 IX. PROSTHODONTICS, FIXED

FIXED PARTIAL DENTURE PONTICS

D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE	$227.00
D6210	PONTIC - CAST HIGH NOBLE METAL	$206.00
D6211	PONTIC - CAST PREDOMINANTLY BASE METAL	$206.00
D6212	PONTIC- CAST NOBLE METAL	$206.00
D6214	PONTIC - TITANIUM	$206.00
D6240	PONTIC - PORC. FUSED TO HIGH NOBLE METAL	$275.00
D6241	PONTIC - PORC. FUSED TO PREDOMINANTLY BASE METAL	$275.00
D6242	PONTIC- PORCELAIN FUSED TO NOBLE METAL	$275.00
D6245	PONTIC - PORCELAIN/CERAMIC	$227.00
D6250	PONTIC - RESIN WITH HIGH NOBLE METAL	$227.00
D6251	PONTIC - RESIN WITH PREDOMINANTLY BASE METAL	$227.00
D6252	PONTIC - RESIN WITH NOBLE METAL	$227.00
D6253	PROVISIONAL PONTIC	$0.00

FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS

D6545	RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTH.	$100.00
D6548	RETAINER - PORC./CERAMIC FOR RESIN BONDED FIXED PROSTH.	$100.00
D6600	INLAY – PORCELAIN/CERAMIC, TWO SURFACES	$150.00
D6601	INLAY – PORCELAIN/CERAMIC, THREE OR MORE SURFACES	$175.00
D6602	INLAY – CAST HIGH NOBLE METAL, TWO SURFACES	$227.00
D6603	INLAY – CAST HIGH NOBLE METAL, THREE OR MORE SURFACES	$254.00
D6604	INLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES	$227.00
D6605	INLAY – CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES	$254.00
D6606	INLAY – CAST NOBLE METAL, TWO SURFACES	$227.00
D6607	INLAY – CAST NOBLE METAL, THREE OR MORE SURFACES	$254.00
D6608	ONLAY – PORCELAIN/CERAMIC, TWO SURFACES	$135.00
D6609	ONLAY – PORCELAIN/CERAMIC, THREE OR MORE SURFACES	$185.00
D6610	ONLAY – CAST HIGH NOBLE METAL, TWO SURFACES	$173.00
D6611	ONLAY – CAST HIGH NOBLE METAL, THREE OR MORE SURFACES	$262.00
D6612	ONLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES	$173.00
D6613	ONLAY – CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES	$262.00

D6614	ONLAY – CAST NOBLE METAL, TWO SURFACES	$173.00
D6615	ONLAY – CAST NOBLE METAL, THREE OR MORE SURFACES	$262.00
D6624	INLAY - TITANIUM	$227.00
D6634	ONLAY – TITANIUM	$173.00

FIXED PARTIAL DENTURE RETAINERS – CROWNS

D6710	CROWN - INDIRECT RESIN BASED COMPOSITE	$138.00
D6720	CROWN - RESIN WITH HIGH NOBLE METAL	$275.00
D6721	CROWN - RESIN WITH PREDOMIN. BASE METAL	$275.00
D6722	CROWN - RESIN WITH NOBLE METAL	$275.00
D6740	CROWN - PORCELAIN/CERAMIC	$309.00
D6750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$309.00
D6751	CROWN - PORC. FUSED TO PREDOMINANTLY BASE METAL	$309.00
D6752	CROWN - PORCELAIN FUSED TO NOBLE METAL	$309.00
D6780	CROWN - 3/4 CAST HIGH NOBLE METAL	$206.00
D6781	CROWN - 3/4 CAST PREDOMINATELY BASED METAL	$227.00
D6782	CROWN - 3/4 CAST NOBLE METAL	$227.00
D6783	CROWN - 3/4 PORCELAIN/CERAMIC	$227.00
D6790	CROWN - FULL CAST HIGH NOBLE METAL	$227.00
D6791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	$227.00
D6792	CROWN - FULL CAST NOBLE METAL	$227.00
D6793	PROVISIONAL RETAINER CROWN	$0.00
D6794	CROWN - TITANIUM	$227.00

OTHER FIXED PARTIAL DENTURE SERVICES

D6920	CONNECTOR BAR	$0.00
D6930	RECEMENT FIXED PARTIAL DENTURE	$20.00
D6940	STRESS BREAKER	$35.00
D6950	PRECISION ATTACHMENT	$0.00
D6970	CAST POST/CORE IN ADD. TO FIX PART. DENTURE RETAINER	$69.00
D6971	CAST POST AS PART OF FIXED PART. DENTURE RETAINER	$69.00
D6972	PREFAB. POST/CORE IN ADD. TO FIX PART. DENTURE RETAINER	$69.00
D6973	CORE BUILD UP FOR RETAINER, INCLUDING ANY PINS	$50.00
D6975	COPING – METAL	$0.00
D6976	EACH ADDITIONAL CAST POST – SAME TOOTH	$69.00
D6977	EACH ADDITIONAL PREFAB. POST - SAME TOOTH	$69.00
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	$55.00
D6985	PEDIATRIC PARTIAL DENTURE, FIXED	$481.00
D6999	UNSPEC., FIXED PROSTHODONTIC PROC., BY REPORT	$0.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

EXTRACTIONS (INCL. LOCAL ANESTHESIA, SUTURING, IF NEEDED& ROUTINE POSTOPERATIVE CARE)

D7111	CORONAL REMNANTS – DECIDUOUS TOOTH	$25.00
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	$25.00

SURGICAL EXTRACTIONS (INCL. LOCAL ANESTHESIA, SUTURING, IF NEEDED & ROUTINE POSTOPERATIVE CARE)

D7210	REMOV ERUPT TTH-W/MUCOPERIOSTL FLP-REMOV BNE/TTH	$42.00
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	$62.00
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	$83.00
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	$117.00
D7241	REMOVAL OF IMPACTED TOOTH - COMP. BONY, UNUSUAL SURG. COMPL.	$117.00
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROC.)	$49.00

OTHER SURGICAL PROCEDURES

D7260	OROANTRAL FISTULA CLOSURE	$0.00
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$0.00
D7270	TTH REIMPLNT/STABIBZ EVULSD DISPLCD TTH	$0.00
D7272	TTH TRANSPL (INC REIMPLNT & SPLNT &/OR STABILZ)	$0.00
D7280	SURG. ACCESS UNERUPTED TTH	$69.00
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$69.00
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	$0.00
D7285	BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)	$50.00
D7286	BIOPSY OF ORAL TISSUE - SOFT (ALL OTHERS)	$50.00
D7287	CYTOLOGY SAMPLE COLLECTION	$0.00
D7288	BRUSH BIOPSY – TRANSEPITHELIAL SAMPLE COLLECTION	$0.00
D7290	SURGICAL REPOSITIONING OF TEETH	$0.00
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	$0.00

ALVEOLOPLASTY - SURGICAL PREP./RIDGE FOR DENTURE

D7310	ALVEOLO. IN CONJUNCTION W/EXTRACTIONS - PER QUADRANT	$42.00
D7311	ALVEOLO. IN CONJUNCTION W/EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	$21.00
D7320	ALVEOLO. NOT IN CONJUNCTION W/EXTRACTIONS - PER QUADRANT	$69.00
D7321	ALVEOLO. NOT IN CONJUNCTION W/EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	$35.00

VESTIBULOPLASTY

D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECOND. EPITHELIALIZATION)	$206.00
D7350	VESTIBULOPLASTY-RIDGE EXTEN (W/SOFT TISS GFT)	$206.00

SURGICAL EXCISION OF REACTIVE INFLAMMATORY LESIONS (SCAR TISSUE OR LOCALIZED CONGENITAL LESIONS)

D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	$0.00
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	$0.00
D7412	EXCISION OF BENIGN LESION, COMPLICATED	$0.00
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	$0.00
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM	$0.00
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED	$0.00

REMOVAL OF TUMORS, CYSTS AND NEOPLASMS

D7440	EXCISION OF MALIGNANT TUMOR - LESION DIA. UP TO 1.25 CM	$0.00
D7441	EXCISION OF MALIGNANT TUMOR - LESION DIA.>1.25 CM	$0.00
D7450	REMOVE OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIA. TO 1.25 CM	$69.00
D7451	REMOVE OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIA. >1.25 CM	$83.00
D7460	REMOVE OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIA.TO 1.25 CM	$0.00
D7461	REMOVE OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIA.>1.25 CM	$0.00
D7465	DESTRUCT-LESION(S) BY PHYS. OR CHEM. METHOD, BY REPORT	$0.00

EXCISION OF BONE TISSUE

D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXIALLA OR MANDIBLE)	$0.00
D7472	REMOVAL OF TORUS PALATINUS	$0.00
D7473	REMOVAL OF TORUS MANDIBULARIS	$0.00
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	$0.00
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE	$0.00

SURGICAL INCISION

D7510	INCISION & DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	$35.00
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED	$35.00
D7520	INCISION & DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE	$49.00
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE - COMPLICATED	$0.00
D7530	REMOVE- FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE	$42.00
D7540	REMOVE-REAC.-PRODUCE FOREIGN BODIES, MUSCULOSKELETAL SYSTEM	$0.00
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE	$0.00
D7560	MAXILLARY SINUSOTOMY FOR REMOVE-TOOTH FRAG. OR FOREIGN BODY	$0.00

TREATMENT OF FRACTURES – SIMPLE

D7610	MAXILLA - OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)	$714.00
D7620	MAXILLA - CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)	$429.00
D7630	MANDIBLE - OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)	$714.00
D7640	MANDIBLE - CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)	$429.00
D7650	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	$412.00
D7660	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	$138.00
D7670	ALVEOLUS – CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH	$138.00
D7671	ALVEOLUS – OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH	$138.00
D7680	FACIAL BONES - COMPL. REDUCT. W/FIXATION & MULT. SURG. APPROACH	$0.00

TREATMENT OF FRACTURES – COMPOUND

D7710	MAXILLA - OPEN REDUCTION	$714.00
D7720	MAXILLA - CLOSED REDUCTION	$429.00
D7730	MANDIBLE - OPEN REDUCTION	$714.00
D7740	MANDIBLE - CLOSED REDUCTION	$429.00
D7750	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	$412.00
D7760	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	$138.00
D7770	ALVEOLUS – OPEN REDUCTION STABILIZATION OF TEETH	$138.00
D7771	ALVEOLUS, CLOSED REDUCTION STABILIZATION OF TEETH	$138.00
D7780	FACIAL BONES - COMPL. REDUCT. W/FIXATION & MULT. SURG. APPROACH	$0.00

REDUCTION OF DISLOCATION & MANAGEMENT OF OTHER TEMPORO MANDIBULAR JOINT DYSFUNCTIONS

D7810	OPEN REDUCTION OF DISLOCATION	$0.00
D7820	CLOSED REDUCTION OF DISLOCATION	$0.00
D7830	MANIPULATION UNDER ANESTHESIA	$0.00
D7840	CONDYLECTOMY	$0.00
D7850	SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT	$0.00
D7852	DISC REPAIR	$0.00
D7854	SYNOVECTOMY	$0.00
D7856	MYOTOMY	$0.00
D7858	JOINT RECONSTRUCTION	$0.00

D7860	ARTHROTOMY	$0.00
D7865	ARTHROPLASTY	$0.00
D7870	ARTHROCENTESIS	$0.00
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	$0.00
D7872	ARTHROSCOPY - DIAGNOSIS, WITH OR WITHOUT BIOPSY	$0.00
D7873	ARTHROSCOPY - SURGICAL; LAVAGE AND LYSIS OF ADHESIONS	$0.00
D7874	ARTHOSCOPY - SURG.; DISC REPOSITION/STABIL.	$0.00
D7875	ARTHROSCOPY - SURGICAL; SYNOVECTOMY	$0.00
D7876	ARTHROSCOPY - SURGICAL; DISCECTOMY	$0.00
D7877	ARTHROSCOPY - SURGICAL; DEBRIDEMENT	$0.00
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	$0.00
D7899	UNSPECIFIED TMD THERAPY, BY REPORT	$0.00

REPAIR OF TRAUMATIC WOUNDS

D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	$49.00

COMPLICATED SUTURING

D7911	COMPLICATED SUTURE - UP TO 5 CM	$0.00
D7912	COMPLICATED SUTURE - GREATER THAN 5 CM	$0.00

OTHER REPAIR PROCEDURES

D7920	SKIN GRAFT (IDENTIFY DEFECT COVERED, LOC. & TYPE OF GRAFT)	$0.00
D7940	OSTEOPLASTY - FOR ORTHOGNATHIC DEFORMITIES	$0.00
D7941	OSTEOTOMY - MANDIBULAR RAMI	$0.00
D7943	OSTEOTOMY - MANDIB. RAMI W/BONE GRAFT;INCL. OBTAIN. THE GRAFT	$0.00
D7944	OSTEOTOMY - SEGMENTED OR SUBAPICAL - PER SEXTANT OR QUAD.	$0.00
D7945	OSTEOTOMY - BODY OF MANDIBLE	$0.00
D7946	LEFORT I (MAXILLA - TOTAL)	$0.00
D7947	LEFORT I (MAXILLA - SEGMENTED)	$0.00
D7948	LEFORT I OR LEFORT III (OSTEOPLAST. OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) – W/O BONE GRAFT	$0.00
D7949	LEFORT II OR LEFORT III - WITH BONE GRAFT	$0.00
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES – AUTOGENOUS, BY REPORT	$0.00
D7952	SINUS AUGMENTATION VIA VERTICAL APPROACH	$0.00
D7953	BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION – PER SITE	$0.00
D7955	REPAIR OF MAXILLOFACIAL SOFT AND HARD TISSUE DEFECT	$0.00
D7960	FRENULECTOMY (FRENECTOMY OR FRENOTOMY) – SEPARATE PROC.	$0.00
D7963	FRENULOPLASTY	0.00
D7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	$62.00
D7971	EXCISION OF PERICORONAL GINGIVA	$29.00
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	$0.00
D7980	SIALOLITHOTOMY	$0.00
D7981	EXCISION OF SALIVARY GLAND, BY REPORT	$0.00
D7982	SIALODOCHOPLASTY	$0.00
D7983	CLOSURE OF SALIVARY FISTULA	$0.00
D7990	EMERGENCY TRACHEOTOMY	$0.00
D7991	CORONOIDECTOMY	$0.00
D7995	SYNTHETIC GRAFT - MANDIBLE OR FACIAL BONES, BY REPORT	$0.00
D7996	IMPLANT-MANDIBLE FOR AUGMENT. PURPOSES, BY REPORT	$0.00
D7997	APPLIANCE REMOVAL, INCL. REMOVAL OF ARCHBAR	$0.00
D7999	UNSPECIFIED ORAL SURGERY PROC., BY REPORT	$0.00

D8000-D8999 XI. ORTHODONTICS

DENTITION

LIMITED ORTHODONTIC TREATMENT

D8010	LIMITED ORTHOODONTIC TREAT. OF THE PRIMARY DENTITION	$0.00
D8020	LIMITED ORTHOODONTIC TREAT. OF THE TRANSITIONAL DENTITION	$0.00
D8030	LIMITED ORTHO. TREAT. OF THE ADOLESCENT DENTITION	$0.00
D8040	LIMITED ORTHO. TREAT. OF THE ADULT DENTITION	$0.00

INTERCEPTIVE ORTHODONTIC TREATMENT

D8050	INTERCEPTIVE ORTHO. TREAT. OF THE PRIMARY DENTITION	$103.00
D8060	INTERCEPTIVE ORTHO. TREAT. OF THE TRANSITIONAL DENTITION	$0.00

COMPREHENSIVE ORTHODONTIC TREATMENT

D8070	COMPREHENSIVE ORTHO. TREAT. OF THE TRANSITIONAL DENTITION	$0.00
D8080	COMPREHENSIVE ORTHO. TREAT. OF THE ADOLESCENT DENTITION	$0.00
D8090	COMPREHENSIVE ORTHO. TREAT. OF THE ADULT DENTITION	$0.00

MINOR TREATMENT TO CONTROL HARMFUL HABITS

D8210	REMOVABLE APPLIANCE THERAPY	$138.00
D8220	FIXED APPLIANCE THERAPY	$138.00

MINOR ORTHODONTIC SERVICES

D8660	PRE-ORTHODONTIC TREATMENT VISIT	$103.00
D8670	PERIODIC ORTHO. TREAT. VISIT	$52.00
D8680	ORTHO. RETENTION	$110.00
D8690	ORTHO. TREATMENT	$0.00
D8691	REPAIR OF ORTHO. APPLIANCE	$0.00
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	$0.00
D8999	UNSPECIFIED ORTHO. PROC., BY REPORT	$0.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

UNCLASSIFIED TREATMENT

D9110	PALLIATIVE TREATMENT OF DENTAL PAIN – MINOR PROC.	$15.00

ANESTHESIA

D9210	LOCAL ANEST. NOT CONJUNC. W/OPER. OR SURG. PROC.	$0.00
D9211	REGIONAL BLOCK ANESTHESIA	$0.00
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	$0.00
D9215	LOCAL ANESTHESIA	$0.00
D9220	DEEP SEDATION/GENERAL ANESTHESIA – FIRST 30 MINS.	$14.00
D9221	DEEP SEDATION/GENERAL ANESTHESIA – EACH ADD. 15 MINS.	$7.70
D9230	ANALGESIA, ANXIOLYSIS, INHAL. OF NITROUS OXIDE	$0.00
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - FIRST 30 MINS.	$14.00
D9242	INTRA. CONSCIOUS SEDATION/ANALGESIA - EACH ADD. 15 MINS.	$7.70
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	$0.00

PROFESSIONAL CONSULTATION

D9310	CONSULT. (DIAG. SERV. PROV. BY DENT/PHYS. OTHER THAN PRACT. PROVIDE TREATMENT)	$0.00

PROFESSIONAL VISITS

D9410	HOUSE/EXTENDED CARE FACILITY CALL	$10.00
D9420	HOSPITAL CALL	$20.00
D9430	OFFICE VISIT OBSERVATION - NO SERV. PERFORMED	$0.00
D9440	OFFICE VISIT - AFTER REG. SCHEDULED HRS.	$0.00
D9450	CASE PRESENTATION, DETAILED AND EXTENSIVE TREATMENT PLANNING	$0.00

DRUGS

D9610	THERAPEUTIC DRUG INJECTION, BY REPORT	$0.00
D9630	OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT	$0.00

MISCELLANEOUS SERVICES

D9910	APPLICATION OF DESENSITIZING MEDICAMENT	$0.00
D9911	APPLIC.-DESENSIT. RESIN-CERV. &/OR ROOT SURF., PER TOOTH	$0.00
D9920	BEHAVIOR MANAGEMENT, PER REPORT	$0.00
D9930	TREAT. OF COMPLIC. (POST SURG.) - UNUSUAL CIRCU,. BY REPORT	$0.00
D9940	OCCLUSAL GUARD, BY REPORT	$0.00
D9941	FABRICATION OF ATHLETIC MOUTHGUARD	$0.00
D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	$0.00
D9950	OCCLUSION ANALYSIS - MOUNTED CASE	$0.00
D9951	OCCLUSAL ADJUSTMENT – LIMITED	$35.00
D9952	OCCLUSAL ADJUSTMENT – COMPLETE	$35.00
D9970	ENAMEL MICROABRASION	$0.00
D9971	ODONTOPLASTY 1-2 TEETH, INCL. REMOVE OF ENAMAL PROJ.	$0.00
D9972	EXTERNAL BLEACHING - PER ARCH	$0.00
D9973	EXTERNAL BLEACHING - PER TOOH	$0.00
D9974	INTERNAL BLEACHING - PER TOOH	$0.00
D9999	UNSPEC. ADJUNCTIVE PROC., BY REPORT	$0.00