



KINGSTON TRUST FUND

Dental Plan

2019 SUMMARY PLAN DESCRIPTION – PART D

NEW Plan Information is in RED

KTF Preferred Provider (PPO) Network Administered by: KINGSTON TRUST FUND

- This Summary Plan Description/Plan Document, along with interpretive memoranda and operational policies, will govern in all cases.
- The Summary Plan Description is organized in four (4) parts:
 - KTF Part A (Eligibility Rules, Medical Schedule of Benefits and Exclusions)
 - KTF Part B (Appeals, Eligibility Rules, Subrogation, etc.)
 - KTF Part C (Important Employee Notices regarding Your Rights, Specific Plan Rules)
 - KTF Part D (Dental Schedule of Benefits, Covered Codes and Exclusions)

Grandfathered Status for Dental Plan

- ✓ This dental plan is a standalone plan and is not a part of the group health plan.
- ✓ This dental plan has the same eligibility and other plan rules as the group health plan.
- ✓ This plan is considered a grandfathered plan for purposes of Health Care Reform Act of 2010.

Restatement/Amendment Date:	January 1, 2019
Benefit Year/Deductible Year Ends:	December 31
Trust Plan Year Ends:	June 30
Last Amendment:	January 1, 2014
Printed:	December 2018

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BASIC DENTAL BENEFIT PLAN

Accidental Injury to Teeth

Injuries due to biting and chewing are not covered. Other injuries are covered as a medical benefit payable as any other benefit, with no deductible. PPO providers are paid at 90% and out of network providers will be paid at 70% after the NPPO deductible.

Allowable Charges, previously referred to as Usual Customary & Reasonable (UCR)

- ◆ **KTF Dental PPO Providers** – Fees are negotiated with providers. The PPO discount (*actual charges less eligible or allowable charges*) is written off by the provider and you may not be balance billed for the discount.
- ◆ **Non-PPO Dental Providers** – Allowable charges shall be limited to the 80th percentile of Context for Health's UCR rates. Members will be responsible for excess charges over the allowable UCR charges in addition to the above coinsurance for NPPO Providers.

Appeals

See Part B and C. Same rules apply to the Dental Plan as for the Group Health Plan.

Basic Plan Rules

See Plan Parts A, B and C. While the Dental Plan is a standalone plan, the basic plan rules and eligibility, COBRA, appeals, etc. are the same as for the Group Health Plan.

Benefit Year

Your deductible and annual benefit limits are based on the Calendar Year.

Claims

Claims must be filed within 90 days of date of service. All claims must be typed or printed and include plan and member ID numbers. *See Part B and C for Appeal Rules and Penalties for late filed claims.*

Contacts and Important Plan Information:

Mail Dental Claims to: Syntonic Systems/KTF KTF: 844-583-3863
111 John Street, Suite 1700
New York, NY 10038

Dental Coverage After Retirement

Retirees may elect to continue their dental coverage after retirement under COBRA rules. However, dental coverage is voluntary and subject to payment of current dental premiums and rules set up by the Trust. If a member drops their dental coverage, they may re-enroll during the next open enrollment period. Effective 1/1/2014, the Trust will pay the second half semi-annual premium for all retirees presently enrolled in the Dental Plan.

Dental Deductible

There will be a Dental Deductible of \$50/Individual and \$150/Family. The deductible applies to in and out-of-network providers combined.

Basic Dental Benefit Plan Rules Continued

Dental Eligibility

Eligibility for the Dental Plan is subject to the terms of your collective bargaining agreement. Otherwise, the eligibility rules are the same as for group health. It is important to have a current enrollment form on file and to submit an updated enrollment form which lists all covered dependents anytime there is a material change in information or coverage, including any change in your spouse's dental or health coverage or employment status.

If only electing dental coverage, your enrollment form must indicate the health coverage elected or if the Opt Out is elected for medical due to spousal medical coverage.

Extended Benefits (must be completed within 30 days of termination)

Benefits will be extended for a dental procedure that began before the date a person's coverage is terminating and completed within 30 days after the termination date, if the covered charge is for any of the following:

- ◆ A removable appliance or modification for which an impression is made.
- ◆ A fixed bridge, crown, gold or cast restoration when the tooth or teeth are fully prepared.
- ◆ Root canal therapy when the pulp chamber is opened and explored to the apex, provided you or your dependents do not become covered under any other group dental plan for that dental procedure.

Grandfathered Plan

This is a grandfathered plan under the Affordable Care Act.

Group Health Plan Provisions are Incorporated by Reference

Please refer to Plan Part A, B and C for additional information on plan rules. Precertification is not required for dental benefits. Coordination of Benefit rules are the same as the Group Health Plan.

Maximum Annual Dental Benefit (Limited Benefit Plan)

1. \$2,000 Annual Limit on total benefits paid in any calendar year for all services, both in and out-of-network, except Orthodontia.
2. \$2,000 Lifetime Orthodontia limit for children under age 19 (payable quarterly over the treatment period).

Medical Benefits for Dental Procedures

Except for the removal of impacted wisdom teeth, dental related procedures are generally not paid under the medical plan except in the case of an accident or in conjunction with congenital defect or disorder. Pre-approval is required for any dental procedure that is to be paid as a medical benefit. The oral surgeon or dentist will not be paid as a PPO provider unless he/she is also enrolled as a KTF Medical PPO provider.

Basic Dental Benefit Plan Rules Continued

KTF Sole PPO Provider Network for Dental Services

The only dental PPO Network is the KTF Network. Dentists in the Dental PPO network are not considered PPO providers for medical services, except in the event of an accident, unless they are approved as a Medical PPO Provider in addition to being a Dental PPO Provider. Members are responsible for determining the PPO status of a provider prior to treatment.

Out of Area (OOA)

There are **no** special OOA benefits for the dental plan. PPO or Non PPO benefits apply based on the provider used. Non PPO dentists will be paid per the NPPO Dental Schedule of Benefits.

Plan Year

The Plan Year shall begin July 1 and end June 30.

Prior Authorization of Services Not Required

You or your provider may request an estimate (predetermination) of benefits from the Claims Dept. However, no prior approval is needed for any dental service, except for any service that is to be paid as a medical procedure. All medical related procedures involving dental work must be preapproved by the plan.

Removal of Impacted Wisdom Teeth

Removal of an impacted wisdom tooth is covered as a surgical procedure under the medical plan as the primary plan and then it is covered under the dental plan, as secondary for individuals covered under both the medical and dental plan with KTF.

Standalone Plan

Enrollment in this Dental Plan is not dependent upon enrollment in the KTF Group Health Plan. The same basic plan rules for the Group Health Plan also apply to the Dental Plan for COBRA, HIPAA, Appeals, Eligibility, etc. *See Plan Parts A, B and C.*

Timely Filing of Claims – Penalties for Late Filing

All claims are to be filed by the provider (or the member in situations where the member pays in full for the services in advance) within 90 days of the date of service. Late filing penalties apply for late filed claims and benefits will be reduced.

TMJ (Temporomandibular) Treatment or Devices

TMJ treatment or devices are not covered except as specifically provided in the Schedule of Benefits for the Dental and/or Group Health Plan.

KINGSTON TRUST DENTAL SCHEDULE OF BENEFITS

Dental Benefits are payable according to the following schedule up to the maximum benefit of <u>\$2,000</u> a year (<u>\$2,000</u> lifetime for Orthodontia).	KTF PPO Providers	Out of Network Providers	Maximum Benefit
Deductible	<u>\$50/Individual; \$150/Family</u>		
Class 1 - Preventive	<u>80%</u>	<u>60%</u>	<u>\$2,000 Annual Maximum</u>
Class 2 - Basic Restorative	<u>70%</u>	<u>60%</u>	
Class 3 - Major Restorative	<u>60%</u>	<u>50%</u>	
Class 3 - Implants, Dentures & Bridges **	<u>60%</u>	<u>50%</u>	
Orthodontia (children to age 19) **	<u>50%</u>	<u>40%</u>	<u>\$2,000 Lifetime</u>
TMJ <u>is not</u> covered under the dental plan (<i>see medical plan</i>).	N/A	N/A	N/A

** (Proof of coverage for 12 months including prior dental coverage for major dental services and orthodontia without a break in coverage of more than 63-days is required.)

Class 1 – Preventive and Basic Dental Services

1. Two bitewing series of x-rays during any Benefit Year - one preventive and one additional bitewing series will be covered if medically necessary.
2. Occlusal and extra oral x-rays will not be paid for more than 2 films within any 2 Benefit Years. Panoramic or full mouth x-rays are limited to one set every three Benefit Years.
3. Space maintainers for children up to age 14 and any adjustments made within six months of the installation of the space maintainers.
4. Emergency exams or emergency palliative treatments for the purpose of removing or alleviating pain and sedative fillings are limited to one annually.
5. Benefits for a filling include local anesthesia and conscious sedation (including nitrous oxide) or direct pulp capping on the same date as the filling.
6. If over age 18, two periodontal prophylaxes shall be covered for those previously treated for periodontal disease. Periodontal maintenance is limited to twice in any Benefit Year period or in conjunction with regular cleanings with no more than 4 visits/cleanings per Benefit Year in total.
7. Two regular prophylaxes (cleanings) during any Benefit Year, including polishing and scaling.
8. Two fluoride applications for children age 18 and younger during any Benefit Year. Sealants shall be covered to age 18 or as medically necessary.
9. Two routine oral examinations during any benefit year.
10. If additional dental services are provided on the same day as an emergency examination, we will not make payment for the examination.

Class 2 – Basic Dental Repairs

Restorations: Amalgam and composite fillings, pulp caps and nitrous oxide. The fillings may consist of silver amalgam and/or tooth color restorations using synthetic materials.

Inlay/Onlay: Porcelain/ceramic for up to three or more surfaces, including re-cementation and partial restoration.

Periodontal Scaling & Root Planning: Benefit includes teeth quad and maintenance.

Dentures: Includes denture adjustments, realignment and repair of broken denture base.

Consultations: Only one consultation visit will be covered in any Benefit Year, other than an emergency consult.

Class 3 – Major Periodontics, Endodontics & Repair & Root Canals

Covered services include local or general anesthesia (including nitrous oxide) in conjunction with:

1. Surgical periodontics examination, gingival curettage, gingivectomy and gingivoplasty, osseous surgery including flap entry and enclosure, mucogingivoplastic surgery, and management of acute infections and oral lesions.
2. Oral surgery to extract teeth may consist of treatment of fractures and dislocations and diagnosis and treatment of cysts, abscesses and impaction.
3. Periodontic treatment (scaling/planning) of the same portion of the mouth (quadrant) is once annually.
4. Apicectomy which may include flap surgery, apical curettage, local anesthesia, x-rays and post-operative care.
5. Inlay/onlay services are covered when teeth cannot be restored by filling, local anesthesia, direct pulp capping on the same date as cementation, indirect pulp capping, lab charges, base, pins, gum preparation and temporary restoration. Replacement of inlays are limited to once every five years.
6. For child crowns (up to age 14) covered services include pulpotomy, including local anesthesia, x-rays, pulp capping, temporary fillings and post-operative care.
7. Repairs or adjustments to bridges or dentures.
8. Root canal therapy, including anesthesia, x-rays, pulpotomy, temporary fillings and post-operative care.
9. Crowns are covered when a tooth cannot be restored by other means and when the crown is not part of a bridge. Crowns can be replaced once every five years, if medically necessary.

Class 3 – Implants, Dentures and Bridges (after 12 months in Plan)

Major services shall include the following, provided the member has been covered under this plan or another dental plan covering such major services for the previous 12 months prior to the date of service (*HIPAA Certificate or proof of coverage is required*):

1. New bridges
2. New dentures

Implants or any prosthetic device including any attachments, implant crowns, and any procedures related to the implant (that are *not separately covered, e.g. removal of a tooth*), subject to the annual benefit limit same as any other dental procedure. Removal of a tooth for purposes of later installing an implant is covered as oral surgery for the tooth removal.

Orthodontia (Children to Age 19)

- ◆ Includes treatment of Transitional Primary Dentition or Permanent Dentition, including Class I, II and III Malocclusion.
- ◆ Radiographs, cephalometric film and casts.
- ◆ Minor or interceptive treatment for tooth guidance, including removable appliance therapy and fixed or cemented appliance therapy.

Orthodontia is covered at 50% for PPO and 40% for NPPO for any dependent to age 19 who has been covered under this Plan or who has had continued orthodontia coverage under any other dental plan for at least 12 months will be covered. HIPAA Certificate or proof of coverage is required for prior coverage credit.

Payments shall be made on a monthly or quarterly basis as long as the patient remains a covered member under this Plan. Payments will be made over the treatment program with the first payment payable upon insertion of the device. Payments are subject to the lifetime limit for Orthodontia Treatment for each covered dependent under age 19. Only treatment that begins after the effective date of coverage or the effective date of a new benefit (orthodontia) shall be covered.

Dental Exclusions

Treatment Started Before Coverage or Benefits Begin – Charges for the following are not covered if services began prior to becoming covered under the Dental Plan unless the member provides proof of prior continuous creditable dental coverage with no break in coverage according to HIPAA rules. The member must supply the Plan with a copy of the HIPAA Certificate for any prior dental coverage or other proof of prior coverage before any consideration will be given to coverage for any treatment which began prior to coverage under this Plan. If a new benefit is added, only treatment that begins on or after the effective date of such coverage will be covered.

1. Orthodontia treatment
2. Denture, if the impression for the denture was taken prior to coverage.
3. Crowns, bridges or gold restorations, if preparation of the teeth was begun prior to coverage.
4. Root Canal Therapy

Dental Exclusions - Continued

Non-Covered Services – Charges for the following are not covered unless specifically listed as a covered service in the schedule of benefits or approved due to medical necessity for purposes of either medical or dental care as may be appropriate or determined by the Plan.

1. Any medical procedure relating to dental must be preapproved in advance. Preapproved medical/dental procedures will be covered under the PPO or NPPO depending on the status of the provider. Any dental provider must also be in the medical PPO network to be covered for medical treatment as a PPO benefit.
2. Replacement of a lost or stolen appliance.
3. Instruction in oral hygiene or plaque control, completion of any forms or failure to keep any scheduled appointment.
4. Dental procedures performed solely for cosmetic reasons or to characterize or personalize dentures or bridges. Examples of cosmetic procedures: Porcelain overlays, veneers and teeth whitening are considered cosmetic procedures by the IRS.
5. Appliance or restorations except full dentures, to change vertical dimension, or restore occlusion or correct Temporomandibular Joint Dysfunction (TMJ). Diagnostic procedures and any treatment for each are excluded. *(See your group health plan for TMJ benefits.)*
6. Dental procedures performed while you or your dependent are not insured for these benefits. This includes procedures started before a member's effective date of dental care insurance although partially performed after that date.
7. Dental injuries incurred as a result of "biting" or "chewing" will only be covered under the Dental Plan and not considered as an accident benefit under the Group Health Plan.
8. Charges for filing a claim.
9. Dental procedures performed because of an occupational injury or sickness.
10. Gold foil restoration. Bacteriological studies, caries susceptibility tests, pulp vitality tests, diagnostic photographs or diet planning.
11. Consulting with another dentist on the same day your dentist provides another covered service.
12. Athletic mouth guards, night guards, analgesia, implants except as specifically covered, occlusal analysis, replacement of lost or stolen appliances, myofunctional therapy, precision or semi-precision attachments or denture duplication.
13. Prescription and non-prescription drugs. Prescription drugs prescribed by a dental provider are covered the same as any other Rx under the Health Plan. Use your KTF ID card.
14. Dental services or procedures not specifically included in the schedule of covered services and not considered within the scope of normal, acceptable dental practice nor consistent with the highest ethical dental standards of the dental profession, as medically necessary for dental health.

DENTAL ADA PROCEDURE CODES AND CLASSIFICATIONS

The following ADA Codes will be used to determine the benefit per the Dental Schedule of Benefits. KTF will take into consideration new ADA Codes and place them in the appropriate Class, at their sole discretion and old codes will be discarded based on ADA guidelines. **Certain codes may be considered a covered expense based on individual facts and circumstances, at the discretion of the plan, even though such code is generally not covered.** The following listing will prevail in the event of any discrepancy in other plan language.

Preventive, Basic, Diagnostic, Anesthesia And General		CLASS 1
120	PERIODIC ORAL EVALUATION ESTABLISHED PATIENT	1
140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	1
145	ORAL EVAL PT UND 3 YR AGE CNSL W/PRIM CAREGIVER	1
150	COMP ORAL EVALUATION - NEW/ESTABLISHED PATIENT	1
160	DTL & EXT ORAL EVALUATION - PROBLEM FOCUSED REPOR	1
170	RE-EVALUATION - LIMITED PROBLEM FOCUSED	1
171	RE-EVALUATION – POST OPERATIVE OFFICE VISIT	1
180	COMP PERIODONTAL EVALUATION - NEW/EST PATIENT	1
210	INTRAORAL - COMPLETE SERIES	1
220	INTRAORAL – PERIAPICAL - FIRST FILM	1
230	INTRAORAL – PERIAPICAL - EACH ADDITIONAL FILM	1
240	INTRAORAL - OCCLUSAL FILM	1
251	EXTRAORAL – POST DENTAL RADIO IMAGE	1
270	BITEWING - SINGLE FILM	1
272	BITEWINGS - TWO FILMS	1
273	BITEWINGS - THREE FILMS	1
274	BITEWINGS - FOUR FILMS	1
277	VERTICAL BITEWINGS - 7 TO 8 FILMS	1
330	PANORAMIC FILM	1
351	3D PHOTOGRAPHIC IMAGE	1
1110	PROPHYLAXIS - ADULT	1
1120	PROPHYLAXIS - CHILD	1
1201	TOPICAL APPLICATION OF FLUORIDE - CHILD <15 (twice every 12 months)	1
1206	TOP FLUORIDE VARNISH; TX APPL MOD - HI CARIES RIS (limited to age 18 and younger)	1
1208	TOP FLUORIDE EXCLUDING VARNISH (limited to age 18 and younger)	1
1351	SEALANT - PER TOOTH (limited to under age 18, once every 3 calendar years)	1
1353	SEALANT REPAIR - PER TOOTH	1

1510	SPACE MAINTAINER – FIXED - UNILATERAL	1
1515	SPACE MAINTAINER – FIXED - BILATERAL	1
1520	SPACE MAINTAINER – REMOVABLE - UNILATERAL	1
1525	SPACE MAINTAINER – REMOVABLE - BILATERAL	1
1550	RECEMENTATION OR REBOND OF SPACE MAINTAINER	1
1555	REMOVAL OF FIXED SPACE MAINTAINER	1
9110	PALLIATIVE TREATMENT OF DENTAL PAIN - MINOR PROCEDURE	1
Anesthesia – Sedation		CLASS 1
9220	DEEP SEDATION/GENERAL ANESTHESIA - 1 ST 30 MINUTES	1
9221	DEEP SEDATION/GENERAL ANESTHESIA - EA ADD 15 MIN	1
9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE	1
9241	IV MODERATE CONSCIOUS SEDATION/ANALG - 1ST 30 MINUTES	1
9242	IV MODERATE CONSCIOUS SEDATION/ANALG - EA ADD 15 MINUTES	1
9248	NON-INTRAVENOUS MODERATE CONSCIOUS SEDATION	1
9310	CONSULT DX SERV DENT/PHY NOT REQUESTING DENT/PH	1
9430	OFFICE VISIT OBSERVATION NO OTHER SRVC PERFORMED	1
9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS	1
9610	THERAPEUTIC PARENTAL DRUG - SINGLE ADMINISTRATION	1
9612	THERAPEUTIC PARENTAL DRUGS - TWO OR MORE ADMINISTRATIONS - DIFFERENT DRUGS	1
9941	FABRICATION OF ATHLETIC MOUTHGUARD (ONE PER 12 MONTH PERIOD)	1
D0074	INTERNAL BLEACHING - PER TOOTH - LIMITED TO ONCE PER TOOTH PER 3 YEAR PERIOD FOR ENDONICALLY TREATED ANTERIOR TEETH.	1
Minor Restorative - Endodontic, Periodontal, Prosthodontic & Oral Surgery		CLASS 2
2140	AMALGAM - ONE SURFACE PRIMARY OR PERMANENT	2
2150	AMALGAM - TWO SURFACES PRIMARY OR PERMANENT	2
2160	AMALGAM - THREE SURFACES PRIMARY OR PERMANENT	2
2161	AMALGAM - FOUR/MORE SURFACES PRIMARY/PERMANENT	2
2330	RESIN-BASED COMPOSITE - ONE SURFACE ANTERIOR	2
2331	RESIN-BASED COMPOSITE - TWO SURFACES ANTERIOR	2
2332	RESIN-BASED COMPOSITE - THREE SURFACES ANTERIOR	2
2335	RESIN COMPOS - 4/MORE SURFACES/INVLV INCISAL AN	2
2391	RESIN-BASED COMPOSITE - ONE SURFACE POSTERIOR	2
2392	RESIN-BASED COMPOSITE - TWO SURFACES POSTERIOR	2

2393	RESIN-BASED COMPOSITE - THREE SURFACES POSTERIOR	2
2394	RESIN COMPOS - FOUR OR MORE SURFACES POSTERIOR	2
2610	INLAY - PORCELAIN/CERAMIC - ONE SURFACE	2
2620	INLAY - PORCELAIN/CERAMIC - TWO SURFACES	2
2630	INLAY - PORCELAIN/CERAMIC - THREE/MORE SURFACES	2
2910	RECEMENT OR REBOND INLAY/ONLAY/VENEER OR PART COVERAGE RESTORATION	2
2920	RECEMENT OR REBOND CROWN	2
2930	PREFABR STAINLESS STEEL CROWN - PRIMARY TOOTH	2
2931	PREFABR STAINLESS STEEL CROWN - PERMANENT TOOTH	2
2951	PIN RETENTION - PER TOOTH ADDITION RESTORATION	2
3110	PULP CAP - DIRECT	2
3120	PULP CAP - INDIRECT	2
3220	TX PULP - REMV PULP CORONAL DENTINOCEMENTL JUNC	2
3221	PULPAL DEBRIDEMENT PRIMARY AND PERMANENT TEETH	2
3222	PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMENT TOOTH W INCOMPLETE ROOT DEVELOPMENT	2
3230	PULPAL THERAPY - ANTERIOR PRIMARY TOOTH	2
3240	PULPAL THERAPY - POSTERIOR PRIMARY TOOTH	2
4341	PRDONTAL SCALING & ROOT PLANING 4/MORE TEETH - QUAD	2
4342	PRDONTAL SCALING & ROOT PLANING 1-3 TEETH - QUAD	2
4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION – FULL MOUTH, AFTER ORAL EVALUATION	2
4910	PERIODONTAL MAINTENANCE	2
4921	GINGIVAL IRRIGATION – PER QUADRANT	2
5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE	2
5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE	2
5410	ADJUST COMPLETE DENTURE – MAXILLARY	2
5411	ADJUST COMPLETE DENTURE – MANDIBULAR	2
5421	ADJUST PARTIAL DENTURE – MAXILLARY	2
5422	ADJUST PARTIAL DENTURE – MANDIBULAR	2
5510	REPAIR BROKEN COMPLETE DENTURE BASE	2
5520	REPLACE MISSING/BROKEN TEETH - COMPLETE DENTURE	2
5610	REPAIR RESIN DENTURE BASE	2
5620	REPAIR CAST FRAMEWORK	2
5630	REPAIR OR REPLACE BROKEN CLASP	2

5640	REPLACE BROKEN TEETH - PER TOOTH	2
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	2
5660	ADD CLASP TO EXISTING PARTIAL DENTURE	2
5670	REPLACE ALL TEETH&ACRYLIC CAST METAL FRMEWRK MA	2
5671	REPLACE ALL TEETH&ACRYLIC CAST METL FRMEWRK MAN	2
5710	REBASE COMPLETE MAXILLARY DENTURE	2
5711	REBASE COMPLETE MANDIBULAR DENTURE	2
5720	REBASE MAXILLARY PARTIAL DENTURE	2
5721	REBASE MANDIBULAR PARTIAL DENTURE	2
5730	RELINE COMPLETE MAXILLARY DENTURE CHAIRSIDE	2
5731	RELINE COMPLETE MANDIBULAR DENTURE CHAIRSIDE	2
5740	RELINE MAXILLARY PARTIAL DENTURE CHAIRSIDE	2
5741	RELINE MANDIBULAR PARTIAL DENTURE CHAIRSIDE	2
5750	RELINE COMPLETE MAXILLARY DENTURE LABORATORY	2
5751	RELINE COMPLETE MANDIBULAR DENTURE LABORATORY	2
5760	RELINE MAXILLARY PARTIAL DENTURE LABORATORY	2
5761	RELINE MANDIBULAR PARTIAL DENTURE LABORATORY	2
5850	TISSUE CONDITIONING MAXILLARY	2
5851	TISSUE CONDITIONING MANDIBULAR	2
6930	RECEMENT OR REBOND FIXED PARTIAL DENTURE	2
6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	2
7111	EXTRACTION CORONAL REMNANTS DECIDUOUS TOOTH	2
7140	EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT	2
7210	SURG REMV ERUPTED TOOTH RQR ELEV FLP & REMV BONE	2
7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	2
7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	2
7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	2
7241	REMV IMP TOOTH - CMPL BONY W/UNUSUAL SURG COMPS	2
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	2
7270	TOOTH REIMPL & OR STBL ACC EVULSED/DISPLCD TOOTH	2
7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	2
7310	ALVEOLOPLASTY W/EXTRACTION 4/> TEETH/SPACE QUAD	2
7311	ALVEOLOPLSTY CONJNC XTRACT 1-3 TEETH/SPACES QUAD	2
7320	ALVEOLOPLASTY NOT W/EXTRACTIONS 4/> TEETH/SPACE	2
7321	ALVEOLOPLSTY NOT CNJNC XTRCT 1-3 TEETH/SPCE QUA	2

7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	2
7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	2
7971	EXCISION OF PERICORONAL GINGIVA	2
Major Restorative Services, Endodontic, Periodontal		CLASS 3
322	TOMOGRAPHIC SURVEY	3
360	CONE BEAM CT - CRANIOFACIAL DATA CAPTURE	3
362	CONE BEAM 2-D RECONST EXISTING DATA MULTI IMAGE	3
363	CONE BEAM 3-D RECONST EXISTING DATA MULTI IMAGE	3
364	CONE BEAM CT LESS THAN WHOLE JAW	3
365	CONE BEAM CT CAPTURE AND INTERPRETATION W/FIELD OF VIEW OF ONE FULL DENTAL ARCH – MANDIBLE	3
2510	INLAY - METALLIC - ONE SURFACE	3
2520	INLAY - METALLIC - TWO SURFACES	3
2530	INLAY - METALLIC - THREE OR MORE SURFACES	3
2542	ONLAY - METALLIC - TWO SURFACES	3
2543	ONLAY METALLIC THREE SURFACES	3
2544	ONLAY METALLIC FOUR OR MORE SURFACES	3
2642	ONLAY - PORCELAIN/CERAMIC - TWO SURFACES	3
2643	ONLAY - PORCELAIN/CERAMIC - THREE SURFACES	3
2644	ONLAY - PORCELAIN/CERAMIC - 4 OR MORE SURFACES	3
2662	ONLAY - RESIN COMPOS COMPOS/RESIN - 2 SURFACES	3
2663	ONLAY - RESIN COMPOS COMPOS/RESIN - 3 SURFACES	3
2664	ONLAY - RSN COMPOS COMPOS/RSN - 4/MORE SURFACES	3
2710	CROWN RESINBASED COMPOSITE INDIRECT	3
2712	CROWN 3/4 RESINBASED COMPOSITE INDIRECT	3
2720	CROWN - RESIN WITH HIGH NOBLE METAL	3
2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	3
2722	CROWN - RESIN WITH NOBLE METAL	3
2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	3
2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	3
2751	CROWN - PORCELAIN FUSED PREDOMINANTLY BASE META	3
2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	3
2780	CROWN - 3/4 CAST HIGH NOBLE METAL	3
2781	CROWN - 3/4 CAST PREDOMINATELY BASE METAL	3
2782	CROWN - 3/4 CAST NOBLE METAL	3

2783	CROWN - 3/4 PORCELAIN/CERAMIC	3
2790	CROWN - FULL CAST HIGH NOBLE METAL	3
2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	3
2792	CROWN - FULL CAST NOBLE METAL	3
2794	CROWN TITANIUM	3
2950	CORE BUILDUP INCLUDING ANY PINS	3
2952	POST AND CORE ADDITION TO CROWN INDIRECTLY FAB	3
2953	EACH ADDITIONAL INDIRECTLY FAB POST SAME TOOTH	3
2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	3
2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	3
2980	CROWN REPAIR, BY REPORT	3
Endodontic Services		CLASS 3
3310	ANTERIOR ROOT CANAL (EXCLUDING FINAL RESTORATION)	3
3320	BICUSPID ROOT CANAL (EXCLUDING FINAL RESTORATION)	3
3330	MOLAR - ENDODONTIC THERAPY	3
3346	RETREATMENT PREVIOUS RC THERAPY - ANTERIOR	3
3347	RETREATMENT PREVIOUS RC THERAPY - BICUSPID	3
3348	RETREATMENT PREVIOUS ROOT CANAL THERAPY - MOLAR	3
3351	APEXIFICATION/RECALCIFICATION - INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATION, ROOT RESORPTION, ECT)	3
3352	APEXIFICAT/RECALCIFICAT - INTERIM MEDREPL	3
3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	3
3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR	3
3421	APICOECTOMY/PERIRADICULAR SURGERY - BICUSPID	3
3425	APICOECTOMY/PERIRADICULAR SURGERY - MOLAR	3
3426	APICOECTOMY/PERIRADICULAR SURGERY	3
3430	RETROGRADE FILLING - PER ROOT	3
3450	ROOT AMPUTATION - PER ROOT	3
3920	HEMISECTION NOT INCLUDING ROOT CANAL THERAPY	3
Periodontal Services		CLASS 3
4210	GINGIVECT/PLSTY 4/>CNTIG/BOUND TEETH SPACES - QUAD	3
4211	GINGIVECT/PLSTY 1-3 CNTIG/BOUND TEETH SPACE - QUAD	3
4212	GINGIVECT/PLSTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE – PER TOOTH	3
4240	GINGL FLP PROC 4/> CONTIG/BOUND TEETH SPACE - QUAD	3

4241	GINGL FLP PROC 1-3 CONTIG/BOUND TEETH SPACE - QUAD	3
4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	3
4260	OSSEOUS SURG (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES - QUAD	3
4261	OSSEOUS SURG (INCLUDING ELEVATION OF A FULL THICKNESS FLAP CLOSURE) 1-3 CONTIG/BOUND TEETH SPACES - QUAD	3
4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	3
4271	FREE SOFT TISSUE GRAFT PROCEDURE	3
4273	SUBEPITHEL CONECTIVE TISSUE GRAFT PROC PER TOOTH	3
4277	FREE SOFT TISSUE GRAFT, FIRST/EDENT	3
4278	FREE SOFT TISSUE GRAFT, EACH ADDTN	3
4320	PROVISIONAL SPLINTING - INTRACORONAL	3
4355	FULL MOUTH DEBRID ENABLE COMP EVALUATION&DX - ONCE EVERY 5 YEARS	3
Prosthodontic Services		CLASS 3
5110	COMPLETE DENTURE - MAXILLARY	3
5120	COMPLETE DENTURE - MANDIBULAR	3
5130	IMMEDIATE DENTURE - MAXILLARY	3
5140	IMMEDIATE DENTURE - MANDIBULAR	3
5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	3
5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	3
5213	MAX PART DENTUR - CAST METL FRMEWRK W/RSN BASE	3
5214	MAND PART DENTUR - CAST METL FRMEWRK W/RSN BASE	3
5225	MAXILLARY PARTIAL DENTURE FLEXIBLE BASE	3
5226	MANDIBULAR PARTIAL DENTURE FLEXIBLE BASE	3
5281	REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH) - LIMITED TO 1 EVERY 60 MONTHS.	3
6010	SURG PLACEMENT IMPLANT BODY: ENDOSTEAL IMPLANT	3
6012	SURG PLCMT INTERIM IMPL TRNSITIONL PROS - ENDOS	3
6040	SURGICAL PLACEMENT - EPOSTEAL IMPLANT	3
6050	SURGICAL PLACEMENT - TRANSOSTEAL IMPLANT	3
6055	DENTAL IMPLANT SUPPORTED CONNECTING BAR	3
6056	PREFABRICATED ABUTMENT INCLUDES PLACEMENT	3
6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	3
6059	ABUT SUPP PORCELAIN TO METL CROWN HI NOBLE METL	3

6060	ABUT SUPP PORCELAIN TO MTL CROWN PREDOM BASE MT	3
6061	ABUT SUPP PORCELAIN TO METAL CROWN NOBLE METAL	3
6062	ABUTMENT SUPP CAST METAL CROWN HIGH NOBLE METAL	3
6063	ABUTMENT SUPP CAST METAL CROWN PREDOM BASE META	3
6064	ABUTMENT SUPP CAST METAL CROWN NOBLE METAL	3
6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	3
6066	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROW	3
6067	IMPLANT SUPPORTED METAL CROWN	3
6068	ABUT SUPPORTED RETAINER PORCELAIN/CERAMIC FPD	3
6069	ABUT RETAINR PORCELN TO METL FPD HI NOBL METL	3
6070	ABUT RETN PORCELN TO METL FPD PREDOM BASE METL	3
6071	ABUT SUPPORTED RETAINER PORCELN FUSED METAL FPD	3
6072	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD	3
6073	ABUT RETAINR CAST METL FPD PREDOM BASE METL	3
6074	ABUTMENT RETAINR CAST METAL FPD NOBLE METAL	3
6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	3
6076	IMPLANT SUPPORTED RETAINER PORCELN FUSED METAL FP	3
6077	IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD	3
6080	IMPL MAINT PROC REMV CLEANS PROSTH&ABUTS REINS	3
6090	REPAIR IMPLANT PROSTHESIS	3
6091	REPL ATTACHMNT IMPL/ABUT SUPP PROS PER ATTACHMN	3
6092	RECEMENT OR REBOND IMPLANT/ABUTMENT SUPPORTED CROWN	3
6093	RECEMENT OR REBOND IMPL/ABUTMNT SUPPORTED FIX PART DENTUR	3
6094	ABUTMENT SUPPORTED CROWN TITANIUM	3
6095	REPAIR IMPLANT ABUTMENT	3
6100	IMPLANT REMOVAL	3
6110	IMPLANT/ABUTMENT SUPPORTED REMOVAL DENTURE FOR EDENTULOUS ARCH - MAXILLARY	3
6111	IMPLANT/ABUTMENT SUPPORTED REMOVAL DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	3
6112	IMPLANT/ABUTMENT SUPPORTED REMOVAL DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	3
6113	IMPLANT/ABUTMENT SUPPORTED REMOVAL DENTURE FOR PARTIALLY EDENTULOUS ARCH - MANDIBULAR	3
6114	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY	3

6115	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR	3
6116	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY	3
6117	IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH - MANDIBULAR	3
6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX BY REPORT	3
6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD	3
6205	PONTIC INDIRECT RESIN BASED COMPOSITE	3
6210	PONTIC - CAST HIGH NOBLE METAL	3
6211	PONTIC - CAST PREDOMINANTLY BASE METAL	3
6212	PONTIC - CAST NOBLE METAL	3
6214	PONTIC TITANIUM	3
6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	3
6241	PONTIC - PORCELAIN FUSED PREDOMINANTLY BASE METAL	3
6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	3
6245	PONTIC - PORCELAIN/CERAMIC	3
6520	INLAY - METALLIC - TWO SURFACES	3
6530	INLAY - METALLIC - THREE OR MORE SURFACES	3
6543	ONLAY - METALLIC - THREE SURFACES	3
6544	ONLAY - METALLIC - FOUR OR MORE SURFACES	3
6545	RETAINER - CAST METAL RESIN BONDED FIX PROSTH	3
6548	RETAINER - PORCELAIN/CERAMIC RESIN BONDED FIX PROSTH	3
6601	INLAY - PORCELAIN/CERAMIC THREE OR MORE SURFACE	3
6604	INLAY - CAST PREDOMINANTLY BASE METAL 2 SURFACE	3
6605	INLAY - CAST PREDOMINANTLY BASE METAL 3/MORE SURFACES	3
6613	ONLAY - CAST PREDOMINANTLY BASE METAL 3/MORE SURFACES	3
6740	CROWN - PORCELAIN/CERAMIC	3
6750	CROWN PORCELAIN FUSED TO HIGH NOBLE METAL - DENTURE	3
6751	CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL	3
6752	CROWN - PORCELAIN FUSED TO NOBLE METAL	3
6780	CROWN - 3/4 CAST HIGH NOBLE METAL	3
6781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	3
6782	CROWN - 3/4 CAST NOBLE METAL - DENTURE	3
6783	CROWN - 3/4 PORCELAIN/CERAMIC - DENTURE	3
6790	CROWN FULL CAST HIGH NOBLE METAL - DENTURE	3

6791	CROWN FULL CAST PREDOMINANTLY BASE METAL - DENTURE	3
6792	CROWN FULL CAST NOBLE METAL - DENTURE	3
6794	CROWN TITANIUM	3
6972	PREFAB POST & CORE ADD FIX PART DENTUR RETAIN	3
6973	CORE BUILD UP FOR RETAINER INCLUDING ANY PINS	3
6985	PEDIATRIC PARTIAL DENTURE FIXED	3
7292	SURG PLCMT - TEMP ANCHORAGE DEVICE (SCREW RETAINED PLATE) RQR FLAP; INCLUDED DEVICE REMOVAL	3
7261	PRIMARY CLOSURE OF A SINUS PERFORATION	3
7272	TOOTH TRANSPLANTATION	3
7293	SURG PLCMT: TEMP ANCHORAGE DEVICE RQR FLAP; INCLUDES DEVICE REMOVAL	3
7294	SURG PLCMT: TEMP ANCHORAGE DEVICE W/O SURG FLAP; INCLUDES DEVICE REMOVAL	3
7471	REMOVAL OF LATERAL EXOSTOSIS	3
7911	COMPLICATED SUTURE - UP TO 5 CM	3
7912	COMPLICATED SUTURE - GREATER THAN 5 CM	3
9940	OCCLUSAL GUARD, BY REPORT (1 EVERY 12 MONTHS FOR PATIENTS 13 AND OLDER)	3
9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	3
9950	OCCLUSION ANALYSIS - MOUNTED CASE	3
9951	OCCLUSAL ADJUSTMENT - LIMITED	3
9952	OCCLUSAL ADJUSTMENT - COMPLETE	3
Orthodontia (To age stated in Schedule of Benefits)		CLASS 4
Excluded: Repair of damaged orthodontic appliances, replacement of lost or missing appliance, services to alter vertical dimension and/or restore or maintain the occlusions. Such procedures include, but are not limited to equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth. Any general exclusion listed under the Schedule of Benefits.		
340	CEPHALOMETRIC FILM	ORTHO
350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGES OBTAINED INTRA/EXTRA ORALLY	ORTHO
470	DIAGNOSTIC CASTS	ORTHO
8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	ORTHO
8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL PRIMARY DENTITION	ORTHO
8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	ORTHO
8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	ORTHO

8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	ORTHO
8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	ORTHO
8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	ORTHO
8090	PRE-ORTHODONTIC TREATMENT VISIT	ORTHO
8210	REMOVABLE APPLIANCE THERAPY	ORTHO
8220	FIXED APPLIANCE THERAPY	ORTHO
8660	PRE-ORTHODONTIC TREATMENT EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT	ORTHO
8670	PERIODIC ORTHODONTIC TREATMENT VISIT (PART OF CONTRACT)	ORTHO
8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCE CONSTRUCTION/PLACEMENT OF RETAINER(S))	ORTHO
8690	ORTHODONTIC TREATMENT (ALTERNATIVE BILLING/CONTRACT FEE)	ORTHO
TMJ Treatment (If covered in Schedule of Benefits)		CLASS 5
320	TEMPOROMANDIBULAR JOINT ARTHROGRAM INCL INJ	TMJ
321	OTHER TMJ FILMS	TMJ
7880	TMJ APPLIANCE	TMJ
7889	TMJ THERAPY	TMJ
Excluded Procedures Unless Covered In Schedule of Benefits		
250	EXTRAORAL - FIRST FILM	Excluded
260	EXTRAORAL - EACH ADDITIONAL FILM	Excluded
290	POST-ANT/LAT SKULL & FACIAL BONE SURVEY FILM	Excluded
310	SIALOGRAPHY	Excluded
393	TREATMENT SIMULATION USING 3D IMAGE VOLUME	Excluded
415	COLLECTION MICROORGANISMS CULTURE & SENSITIVITY	Excluded
416	VIRAL CULTURE	Excluded
421	GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASE	Excluded
425	CARIES SUSCEPTIBILITY TESTS	Excluded
431	ADJUNCTIVE PREDX TST NOT INCL CYTOLOGY/BX PROC	Excluded
460	PULP VITALITY TEST	Excluded
472	ACCESSION OF TISSUE GROSS EXAMINATION PREP/REPR	Excluded
473	ACCESS TISSUE GR & MIC EXAMINATION PREP/REPRT	Excluded
474	ACCESS TISS GR & MIC EX ASSESS SURG MARG PREP/RPT	Excluded
476	SPECIAL STAINS FOR MICROORGANISMS	Excluded

477	SPECIAL STAINS NOT FOR MICROORGANISMS	Excluded
478	IMMUNOHISTOCHEMICAL STAINS	Excluded
479	TISSUE INSITU HYBRIDIZATION INCL INTERPRETATION	Excluded
480	ACCESS EXFOLIATIVE CYTOL SMEAR MIC EXAM PREP/REP	Excluded
481	ELECTRON MICROSCOPY	Excluded
482	DIRECT IMMUNOFLUORESCENCE	Excluded
483	INDIRECT IMMUNOFLUORESCENCE	Excluded
484	CONSULTATION ON SLIDES PREPARED ELSEWHERE	Excluded
485	CONSULT INCL PREP SLIDES BX MATL SPL REF SRC	Excluded
486	ACCESSION BRUSH BX SAMPLE MIC EXAM PREP/REPRT	Excluded
1204	TOPICAL APPLICATION OF FLUORIDE - ADULT	Excluded
1205	TOPICAL APPLICATION OF FLUORIDEW/PROPHY - ADULT	Excluded
1310	NUTRITIONAL COUNSELING CONTROL OF DENTAL DISEASE	Excluded
1320	TOBACCO CNSL CONTROL&PREVENTION ORAL DISEASE	Excluded
1330	ORAL HYGIENE INSTRUCTIONS	Excluded
2390	RESIN-BASED COMPOSITE CROWN ANTERIOR	Excluded
2410	GOLD FOIL - ONE SURFACE	Excluded
2420	GOLD FOIL - TWO SURFACES	Excluded
2430	GOLD FOIL - THREE SURFACES	Excluded
2650	INLAY - RESIN COMPOS COMPOSITE/RESIN - 1 SURFACE	Excluded
2651	INLAY - RESIN COMPOS COMPOS/RESIN - 2 SURFACES	Excluded
2652	INLAY – RSN COMPOS COMPOS/RSN - 3/MORE SURFACES	Excluded
2799	PROVISIONAL CROWN	Excluded
2915	RECEMENT OR REBOND INDIRECTLY FABRICATED OR PREFABIRICATED POST AND CORE	Excluded
2932	PREFABRICATED RESIN CROWN	Excluded
2933	PREFABR STAINLESS STEEL CROWN W/RESIN WINDOW	Excluded
2934	PREFAB ESTHETIC COAT STNLESS STEEL CROWN PRIM	Excluded
2940	SEDATIVE FILLING	Excluded
2955	POST REMOVAL	Excluded
2960	LABIAL VENEER – CHAIRSIDE	Excluded
2961	LABIAL VENEER – LABORATORY	Excluded
2962	LABIAL VENEER – LABORATORY	Excluded
2970	TEMPORARY CROWN	Excluded
2971	ADD PROC NEW CRWN UND XSTING PART DENTUR FRMEWR	Excluded

2975	COPING	Excluded
3331	TREATMENT RC OBSTRUCTION - NON-SURGICAL ACCESS	Excluded
3332	INCOMPLETE ENDO TX - INOP UNRESTORABLE/FX TOOTH	Excluded
3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	Excluded
3460	ENDODONTIC ENDOSSEOUS IMPLANT	Excluded
3470	INTENTIONAL REIMPLANTATION	Excluded
3910	SURGICAL PROCEDURE ISOLATION TOOTH W/RUBBER DAM	Excluded
3950	CANAL PREPARATION&FITTING PREFORMED DOWEL/POST	Excluded
4230	ANAT CROWN EXP 4/> CONTIGUOUS TEETH PER QUAD	Excluded
4231	ANATOMICAL CROWN EXPOSURE 1-3 TEETH PER QUADRAN	Excluded
4245	APICALLY POSITIONED FLAP	Excluded
4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	Excluded
4264	BONE REPLACEMENT GRAFT - EA ADD SITE QUADRANT	Excluded
4265	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	Excluded
4266	GUID TISSUE REGEN - RESORBABLE BARRIER PER SITE	Excluded
4267	GUID TISSUE REGEN - NONRESORB BARRIER PER SITE	Excluded
4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	Excluded
4275	SOFT TISSUE ALLOGRAFT	Excluded
4276	COMB CNCTIVE TISSUE&DBL PEDICLE GRAFT PER TOOTH	Excluded
4321	PROVISIONAL SPLINTING - EXTRACORONAL	Excluded
4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS WITH REPORT	Excluded
4920	UNSCHEDULED DRESSING CHANGE	Excluded
5281	REMV UNILAT PART DENTURE - 1 PIECE CAST METAL	Excluded
5810	INTERIM COMPLETE DENTURE MAXILLARY	Excluded
5811	INTERIM COMPLETE DENTURE MANDIBULAR	Excluded
5820	INTERIM PARTIAL DENTURE MAXILLARY	Excluded
5821	INTERIM PARTIAL DENTURE MANDIBULAR	Excluded
5911	FACIAL MOULAGE SECTIONAL	Excluded
5912	FACIAL MOULAGE COMPLETE	Excluded
5913	NASAL PROSTHESIS	Excluded
5914	AURICULAR PROSTHESIS	Excluded
5915	ORBITAL PROSTHESIS	Excluded
5916	OCULAR PROSTHESIS	Excluded
5919	FACIAL PROSTHESIS	Excluded

5922	NASAL SEPTAL PROSTHESIS	Excluded
5923	OCULAR PROSTHESIS (INTERIM)	Excluded
5927	AURICULAR PROSTHESIS (REPLACEMENT)	Excluded
5928	ORBITAL PROSTHESIS (REPLACEMENT)	Excluded
5929	FACIAL PROSTHESIS (REPLACEMENT)	Excluded
5931	OBTURATOR PROSTHESIS SURGICAL	Excluded
5932	OBTURATOR PROSTHESIS DEFINITIVE	Excluded
5934	MANDIBULAR RESECTION PROSTHESIS W/GUIDE FLANGE	Excluded
5935	MANDIBULAR RESECTION PROSTHESIS W/O GUIDE FLANGE	Excluded
5936	OBTURATOR/PROSTHESIS INTERIM	Excluded
5937	TRISMUS APPLIANCE NOT TMD TX	Excluded
5951	FEEDING AID	Excluded
5952	SPEECH AID PROSTHESIS PEDIATRIC	Excluded
5953	SPEECH AID PROSTHESIS ADULT	Excluded
5954	PALATAL AUGMENTATION PROSTHESIS	Excluded
5955	PALATAL LIFT PROSTHESIS DEFINITIVE	Excluded
5982	SURGICAL STENT	Excluded
5983	RADIATION CARRIER	Excluded
5984	RADIATION SHIELD	Excluded
5985	RADIATION CONE LOCATOR	Excluded
5986	FLUORIDE GEL CARRIER	Excluded
5987	COMMISSURE SPLINT	Excluded
6057	CUSTOM ABUTMENT INCLUDES PLACEMENT	Excluded
6250	PONTIC - RESIN WITH HIGH NOBLE METAL	Excluded
6251	PONTIC - RESIN WITH PREDOMINANTLY BASE METAL	Excluded
6252	PONTIC - RESIN WITH NOBLE METAL	Excluded
6253	PROVISIONAL PONTIC	Excluded
6519	INLAY/ONLY - PORCELAIN/CERAMIC	Excluded
6549	RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS	Excluded
6600	INLAY - PORCELAIN/CERAMIC TWO SURFACES	Excluded
6602	INLAY - CAST HIGH NOBLE METAL TWO SURFACES	Excluded
6603	INLAY - CAST HIGH NOBLE METAL 3/MORE SURFACES	Excluded
6606	INLAY - CAST NOBLE METAL TWO SURFACES	Excluded
6607	INLAY - CAST NOBLE METAL THREE OR MORE SURFACES	Excluded
6608	ONLAY - PORCELAIN/CERAMIC 2 SURFACES	Excluded

6609	ONLAY - PORCELAIN/CERAMIC THREE OR MORE SURFACE	Excluded
6610	ONLAY - CAST HIGH NOBLE METAL TWO SURFACES	Excluded
6611	ONLAY - CAST HIGH NOBLE METAL 3/MORE SURFACES	Excluded
6612	ONLAY - CAST PREDOMINANTLY BASE METAL 2 SURFACE	Excluded
6614	ONLAY - CAST NOBLE METAL TWO SURFACES	Excluded
6615	ONLAY - CAST NOBLE METAL THREE OR MORE SURFACES	Excluded
6624	INLAY TITANIUM	Excluded
6634	ONLAY TITANIUM	Excluded
6710	CROWN INDIRECT RESIN BASED COMPOSITE	Excluded
6720	CROWN - RESIN WITH HIGH NOBLE METAL	Excluded
6721	CROWN RESIN W/PREDOMINANTLY BASE METAL - DENTURE	Excluded
6722	CROWN - RESIN WITH NOBLE METAL	Excluded
6793	PROVISIONAL RETAINER CROWN	Excluded
6920	CONNECTOR BAR	Excluded
6940	STRESS BREAKER	Excluded
6950	PRECISION ATTACHMENT	Excluded
6970	POST & CORE ADD FIXED PART DENTURE RETAINER FAB	Excluded
6971	CAST POST AS PART FIXED PARTIAL DENTURE RETAINERS	Excluded
6976	EACH ADD INDIRECTLY FABRICATED POST SAME TOOTH	Excluded
6977	EACH ADD PREFABRICATED POST - SAME TOOTH	Excluded
7260	OROLANTRAL FISTULA CLOSURE	Excluded
7282	MOBILIZ ERUPTED/MALPOSITIONED TOOTH AID ERUPTIO	Excluded
7283	PLCMT DEVICE FACILITATE ERUPTION IMPACTED TOOTH	Excluded
7285	INCISIONAL BIOPSY OF ORAL TISSUE HARD (BONE, TOOTH)	Excluded
7286	INCISIONAL BIOPSY OF ORAL TISSUE SOFT	Excluded
7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	Excluded
7288	BRUSH BIOPSY TRANSEPITHELIAL SAMPLE COLLECTION	Excluded
7290	SURGICAL REPOSITIONING OF TEETH	Excluded
7340	VESTIBULOPLASTY - RIDGE EXT 2ND EPITHELIALIZATION	Excluded
7350	VESTIBULOPLASTY - RIDGE EXT W/SOFT TISS GRAFTS	Excluded
7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	Excluded
7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	Excluded
7412	EXCISION OF BENIGN LESION COMPLICATED	Excluded
7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	Excluded
7414	EXCISION OF MALIGNANT LESION > 1.25 CM	Excluded

7415	EXCISION OF MALIGNANT LESION COMPLICATED	Excluded
7440	EXC MALIG TUMOR - LESION DIAMETER UP TO 1.25 CM	Excluded
7441	EXC MALIG TUMOR - LESION DIAM GREATER THAN 1.25 C	Excluded
7450	REMOVAL BEN ODONTOGENIC CYST/TUMR - UP TO 1.25 C	Excluded
7451	REMOVAL BENIGN ODONTOGENIC CYST/TUMOR - > 1.25 C	Excluded
7460	REMOVAL BEN NONODONTOGENIC CYST/TUMR - UP 1.25 C	Excluded
7461	REMOVAL BEN NONODONTOGENIC CYST/TUMOR - > 1.25 CM	Excluded
7465	DESTRUC LESION PHYSICAL/CHEM METHOD BY REPORT	Excluded
7472	REMOVAL OF TORUS PALATINUS	Excluded
7473	REMOVAL OF TORUS MANDIBULARIS	Excluded
7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	Excluded
7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE	Excluded
7511	I & D ABSCESS INTRAORAL SOFT TISSUE COMPLICATE	Excluded
7520	INCISION & DRAINAGE ABSCESS - EXTRAORAL SOFT TISS	Excluded
7521	I & D ABSCESS EXTRAORAL SOFT TISSUE COMPLICATED	Excluded
7530	REMOVAL FB FROM MUCOSA SKIN/SUBCUT ALVEOL TISSU	Excluded
7540	REMOV REACT - PRODUC FOREIGN BODIES - MUSCULOSKEL SY	Excluded
7550	PART OSTEC/SEQUESTRECTOMY REMOVAL NON-VITAL BON	Excluded
7560	MAXILLARY SINUSOTOMY REMOVAL TOOTH FRAGMENT/FB	Excluded
7610	MAXILLA - OPEN REDUCTION	Excluded
7620	MAXILLA - CLOSED REDUCTION	Excluded
7630	MANDIBLE - OPEN REDUCTION	Excluded
7640	MANDIBLE - CLOSED REDUCTION	Excluded
7650	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	Excluded
7660	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	Excluded
7670	ALVEOLUS - CLOSED REDUCTION W/STABILIZATION TEETH	Excluded
7671	ALVEOLUS - OPEN REDUCTION W/STABILIZATION TEETH	Excluded
7680	FCE BNS - COMP RDUC W/FIX&MX SURG APPRCHES CPT	Excluded
7710	MAXILLA - OPEN REDUCTION	Excluded
7720	MAXILLA - CLOSED REDUCTION	Excluded
7730	MANDIBLE - OPEN REDUCTION	Excluded
7740	MANDIBLE - CLOSED REDUCTION	Excluded
7750	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	Excluded
7760	MALAR AND/OR ZYGOMATIC ARCH CLOSED REDUCTION	Excluded
7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEET	Excluded

7771	ALVEOLUS CLOSED REDUCTION STABILIZATION OF TEET	Excluded
7780	FACIAL BONES - COMP RDUC FIX & MX SURG APPROACHES	Excluded
7810	OPEN REDUCTION OF DISLOCATION	Excluded
7820	CLOSED REDUCTION OF DISLOCATION	Excluded
7830	MANIPULATION UNDER ANESTHESIA	Excluded
7840	CONDYLECTOMY	Excluded
7850	SURGICAL DISCECTOMY - WITH/WITHOUT IMPLANT	Excluded
7852	DISC REPAIR	Excluded
7854	SYNOVECTOMY	Excluded
7856	MYOTOMY	Excluded
7858	JOINT RECONSTRUCTION	Excluded
7860	ARTHROTOMY	Excluded
7865	ARTHROPLASTY	Excluded
7870	ARTHROCENTESIS	Excluded
7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	Excluded
7872	ARTHROSCOPY - DIAGNOSIS WITH OR WITHOUT BIOPSY	Excluded
7873	ARTHROSCOPY SURGICAL - LAVAGE&LYSIS ADHESIONS	Excluded
7874	ARTHROSCOPY SURGICAL - DISC REPSTN&STABILIZATION	Excluded
7875	ARTHROSCOPY - SURGICAL - SYNOVECTOMY	Excluded
7876	ARTHROSCOPY SURGICAL - DISCECTOMY	Excluded
7877	ARTHROSCOPY SURGICAL - DEBRIDEMENT	Excluded
7920	SKIN GRAFT	Excluded
7941	OSTEOTOMY - MANDIBULAR RAMI	Excluded
7943	OSTEOT - MANDIB RAMI W/BONE GRFT - INCL OBTAIN GRAF	Excluded
7944	OSTEOTOMY SEGMENTED OR SUBAPICAL	Excluded
7945	OSTEOTOMY - BODY OF MANDIBLE	Excluded
7946	LEFORT I MAXILLA TOTAL	Excluded
7947	LEFORT I MAXILLA SEGMENTED	Excluded
7948	LEFORT II/LEFORT III - W/O BONE GRAFT	Excluded
7949	LEFORT II/LEFORT III - W/BONE GRAFT	Excluded
7953	BONE REPLCMT GRAFT RIDGE PRESERVATION PER SITE	Excluded
7960	FRENULECTOMY SEPARATE PROCEDURE	Excluded
7963	FRENULOPLASTY	Excluded
7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	Excluded
7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	Excluded

7980	SIALOLITHOTOMY	Excluded
7982	SIALODOCHOPLASTY	Excluded
7983	CLOSURE OF SALIVARY FISTULA	Excluded
7990	EMERGENCY TRACHEOTOMY	Excluded
7991	CORONOIDECTOMY	Excluded
7997	APPLIANCE REMOVAL INCLUDES REMOVAL OF ARCHBAR	Excluded
7998	INTRAORAL PLCMT FIX DEVICE NOT CONJUNCTION W/FX	Excluded
9120	FIXED PARTIAL DENTURE SECTIONING	Excluded
9210	LOCAL ANES - NOT CONJUNCTION W/OP/SURGICAL PROC	Excluded
9211	REGIONAL BLOCK ANESTHESIA	Excluded
9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	Excluded
9215	LOCAL ANESTHESIA	Excluded
9219	EVALUATION FOR DEEP SEDATION OR GENERAL ANESTHESIA	Excluded
9410	HOUSE/EXTENDED CARE FACILITY CALL	Excluded
9420	HOSPITAL CALL	Excluded
9450	CASE PRESENTATION DETAILED&EXTENSIVE TX PLANNIN	Excluded
9630	OTHER DRUGS	Excluded
9910	APPLICATION OF DESENSITIZING MEDICAMENT	Excluded
9911	APPLIC DESENZT RSN CERV &/OR ROOT SURF-TOOTH	Excluded
9931	CLEANING AND INSPECTION OF A REMOVABLE APPLIANCE	Excluded
9970	ENAMEL MICROABRASION	Excluded
9971	ODONTOPLASTY 1 - 2 TEETH; INCL REMOVAL ENAMEL PRO	Excluded
9972	EXTERNAL BLEACHING - PER ARCH	Excluded
9973	EXTERNAL BLEACHING - PER TOOTH	Excluded
9974	INTERNAL BLEACHING - PER TOOTH	Excluded
9986	MISSED APOINTMENT	Excluded
9987	CANCELLED APPOINTMENT	Excluded