

**LIST OF COVERED DENTAL SERVICES**

The following is a complete list of those dental Services which will be considered for payment by Constitution Life Insurance Company after the expiration of any applicable Waiting Period. These Services must be Started while insured and Completed while insured or during the Extension of Benefits period, if any.

No payment will be made for any expense or for any Service not included in the list of Covered Dental Services or included in the list of Exclusions.

**HIGH BENEFIT PLAN**

**Type I Dental Services:**

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
0120	0120	Periodic Oral Evaluation	\$18.00	\$22.50	\$27.00
0150	0150	Comprehensive Oral Evaluation	\$25.20	\$31.50	\$37.80
0120, 0150 – Limited to one time in any 6 consecutive month period.					
1110	1110	Prophylaxis - Adult	\$38.40	\$48.00	\$57.60
1110 – Limited to one time in any 180 consecutive day period. This frequency limit is combined with the 180 day frequency limit for periodontal maintenance (code 4910). Only one occurrence of either procedure is payable in any 180 consecutive day period.					

**Type II Dental Services:**

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
0210	0210	Intraoral - Complete Series (inc bitewings)	\$54.00	\$67.50	\$81.00
0330	0330	Panoramic Film	\$43.20	\$54.00	\$64.80
0210, 0330 – Limited to one time in any 60 consecutive month period. For benefit determination purposes, a full mouth series will be deemed to include bitewings and 10 or more periapical x-rays.					
0220	0220	Intraoral - Periapical - First Film	\$9.60	\$12.00	\$14.40
0230	0230	Intraoral - Periapical - Each Addl Film	\$4.80	\$6.00	\$7.20
0220-0230 – A maximum of 4 periapical x-rays are payable per 12 month period.					
0240	0240	Intraoral - Occlusal Film	\$14.40	\$18.00	\$21.60
0240 – Limited to two films in any 12 consecutive month period.					
0270	0270	Bitewing - Single Film	\$9.60	\$12.00	\$14.40
0272	0272	Bitewings - Two Films	\$15.60	\$19.50	\$23.40
0274	0274	Bitewings - Four Films	\$24.00	\$30.00	\$36.00
0270-0274 – Limited to one set in any 12 consecutive month period. Reimbursement will be limited to a maximum of 4 films per occurrence.					
2140	2140	Amalgam - One Surface	\$48.00	\$60.00	\$72.00
2150	2150	Amalgam - Two Surfaces	\$60.00	\$75.00	\$90.00
2160	2160	Amalgam - Three Surfaces	\$72.00	\$90.00	\$108.00
2161	2161	Amalgam - Four or More Surfaces	\$84.00	\$105.00	\$126.00
2140-2161 – Multiple restorations on one surface will be paid as a single filling. Benefits for the replacement of an existing amalgam restoration are only payable if at least 24 months have passed since the existing amalgam was placed.					
2330	2330	Resin-based Composite - One Surface, Anterior	\$60.00	\$75.00	\$90.00

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
2331	2331	Resin-based Composite - Two Surfaces, Anterior	\$72.00	\$90.00	\$108.00
2332	2332	Resin-based Composite - Three Surfaces, Anterior	\$84.00	\$105.00	\$126.00
2335	2335	Resin-based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	\$96.00	\$120.00	\$144.00
2385	2391	Resin-based Composite - One Surface, Posterior	\$48.00	\$60.00	\$72.00
2386	2392	Resin-based Composite - Two Surfaces, Posterior	\$60.00	\$75.00	\$90.00
2387	2393	Resin-based Composite - Three Surfaces, Posterior	\$72.00	\$90.00	\$108.00
2388	2394	Resin-based Composite - Four or More Surfaces, Posterior	\$84.00	\$105.00	\$126.00
2330-2388 – Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations. Benefits for the replacement of an existing composite resin restoration are only payable if at least 24 months have passed since the existing filling was placed. Benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration.					
7110	No Code	Extraction - Single Tooth	\$60.00	\$75.00	\$90.00
7120	No Code	Extraction - Each Additional Tooth	\$48.00	\$60.00	\$72.00
7130	7140	Root Removal - Exposed Roots	\$72.00	\$90.00	\$108.00
7110-7130 – The benefit includes an allowance for local anesthesia and routine post-operative care.					
9110	9110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	\$30.00	\$37.50	\$45.00
9110 – Paid as a separate benefit only if no other Service is rendered during the visit except x-rays.					

**Type III Dental Services:**

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A -	Area B -	Area C -
0415	0415	Bacteriologic Studies for Determination of Pathologic Agents	\$48.00	\$60.00	\$72.00
0415 – Only payable in conjunction with a covered biopsy procedure (codes 7285, 7286).					
5510	5510	Repair Broken Complete Denture Base	\$60.00	\$75.00	\$90.00
5520	5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	\$54.00	\$67.50	\$81.00
5610	5610	Repair Resin Denture Base	\$66.00	\$82.50	\$99.00
5620	5620	Repair Cast Framework	\$72.00	\$90.00	\$108.00
5630	5630	Repair or Replace Broken Clasp	\$72.00	\$90.00	\$108.00
5640	5640	Replace Broken Teeth - Per Tooth	\$60.00	\$75.00	\$90.00
5650	5650	Add Tooth to Existing Partial Denture	\$72.00	\$90.00	\$108.00
5660	5660	Add Clasp to Existing Partial Denture	\$84.00	\$105.00	\$126.00
5510-5660 – Limited to repairs performed more than 12 months after initial insertion of the denture and then not more frequently than once per denture in any 12 consecutive month period.					
2910	2910	Recement Inlay	\$36.00	\$45.00	\$54.00
2920	2920	Recement Crown	\$36.00	\$45.00	\$54.00

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A -	Area B -	Area C -
2910-2920 – Payable only when performed more than 12 months after initial insertion.					
6930	6930	Recement Fixed Partial Denture	\$54.00	\$67.50	\$81.00
6930 – Payable only when performed more than 12 months after initial insertion of the denture.					
7285	7285	Biopsy of Oral Tissue - Hard (Bone, Tooth)	\$240.00	\$300.00	\$360.00
7286	7286	Biopsy of Oral Tissue - Soft (All Others)	\$150.00	\$187.50	\$225.00
7285-7286 – The benefit includes an allowance for local anesthesia and routine post-operative care.					

**Type IV Dental Services:**

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
5410	5410	Adjust Complete Denture - Maxillary	\$30.00	\$37.50	\$45.00
5411	5411	Adjust Complete Denture - Mandibular	\$30.00	\$37.50	\$45.00
5421	5421	Adjust Partial Denture - Maxillary	\$30.00	\$37.50	\$45.00
5422	5422	Adjust Partial Denture - Mandibular	\$30.00	\$37.50	\$45.00
5410-5422 – Only covered one time in any 12 consecutive month period, and only if performed more than 12 months after the initial insertion of the denture.					
3310	3310	Anterior (Excluding Final Restoration)	\$300.00	\$375.00	\$450.00
3320	3320	Bicuspid (Excluding Final Restoration)	\$360.00	\$450.00	\$540.00
3330	3330	Molar (Excluding Final Restoration)	\$420.00	\$525.00	\$630.00
3310-3330 – Includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care. Payable once per tooth in any 36 consecutive month period.					
3346	3346	Retreatment of Previous Root Canal Therapy - Anterior	\$300.00	\$375.00	\$450.00
3347	3347	Retreatment of Previous Root Canal Therapy - Bicuspid	\$360.00	\$450.00	\$540.00
3348	3348	Retreatment of Previous Root Canal Therapy - Molar	\$420.00	\$525.00	\$630.00
3346-3348 – Subject to review by our dental consultant. Only payable if the original root canal procedure was performed at least 36 months earlier.					
3351	3351	Apexification/Recalcification - Initial Visit (Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	\$90.00	\$112.50	\$135.00
3352	3352	Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	\$60.00	\$75.00	\$90.00
3353	3353	Apexification/Recalcification - Final Visit (Includes Completed Root Canal Therapy - Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	\$240.00	\$300.00	\$360.00
3410	3410	Apicoectomy/Periradicular Surgery - Anterior	\$210.00	\$262.50	\$315.00
3421	3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$270.00	\$337.50	\$405.00

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
3425	3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	\$300.00	\$375.00	\$450.00
3426	3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$90.00	\$112.50	\$135.00
3351-3426 – Includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care. Payable once per tooth in any 36 consecutive month period.					
3430	3430	Retrograde Filling - Per Root	\$72.00	\$90.00	\$108.00
3430 – Includes all pre-operative, operative and post-operative x-rays, local anesthesia and routine follow-up care. Payable once per tooth in any 36 consecutive month period.					
3450	3450	Root Amputation - Per Root	\$180.00	\$225.00	\$270.00
3920	3920	Hemisection (Including Any Root Removal), Not Incl. Root Canal Therapy	\$144.00	\$180.00	\$216.00
3450-3920 – Includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.					
5710	5710	Rebase Complete Maxillary Denture	\$204.00	\$255.00	\$306.00
5711	5711	Rebase Complete Mandibular Denture	\$204.00	\$255.00	\$306.00
5720	5720	Rebase Maxillary Partial Denture	\$204.00	\$255.00	\$306.00
5721	5721	Rebase Mandibular Partial Denture	\$204.00	\$255.00	\$306.00
5730	5730	Reline Complete Maxillary Denture (Chairside)	\$108.00	\$135.00	\$162.00
5731	5731	Reline Complete Mandibular Denture (Chairside)	\$108.00	\$135.00	\$162.00
5740	5740	Reline Maxillary Partial Denture (Chairside)	\$108.00	\$135.00	\$162.00
5741	5741	Reline Mandibular Partial Denture (Chairside)	\$108.00	\$135.00	\$162.00
5750	5750	Reline Complete Maxillary Denture (Laboratory)	\$144.00	\$180.00	\$216.00
5751	5751	Reline Complete Mandibular Denture (Laboratory)	\$144.00	\$180.00	\$216.00
5760	5760	Reline Maxillary Partial Denture (Laboratory)	\$144.00	\$180.00	\$216.00
5761	5761	Reline Mandibular Partial Denture (Laboratory)	\$144.00	\$180.00	\$216.00
5710-5761 – Limited to relining or rebasing done more than 12 months after the initial insertion, and then not more than one time per denture in any 36 consecutive month period.					
5850	5850	Tissue Conditioning, Maxillary	\$48.00	\$60.00	\$72.00
5851	5851	Tissue Conditioning, Mandibular	\$48.00	\$60.00	\$72.00
5850-5851 – Payable only if at least 12 months have elapsed since the insertion of a full or partial denture and only once in any 36 consecutive month period.					
4341	4341	Periodontal Scaling and Root Planing – Four or More Teeth Per Quadrant	\$72.00	\$90.00	\$108.00
4342	4342	Periodontal Scaling and Root Planing – One to Three Teeth Per Quadrant	\$36.00	\$45.00	\$54.00
4341-4342 – Limited to one time per quadrant of the mouth in any 24 consecutive month period. Not separately payable if performed on the same treatment plan as prophylaxis.					
4355	4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	\$48.00	\$60.00	\$72.00

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
4355 – Payable once per patient per lifetime. Not payable if performed on same date as prophylaxis (code 1110).					
4910	4910	Periodontal Maintenance	\$48.00	\$60.00	\$72.00
4910 – Payable only if at least 6 months have passed since the completion of active periodontal surgery and only one time thereafter in any 6 consecutive month period. Not payable if performed within 6 months of a prophylaxis (code 1110). The benefit for this procedure includes an allowance for an exam and scaling and root planing.					
7210	7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	\$90.00	\$112.50	\$135.00
7220	7220	Removal of Impacted Tooth - Soft Tissue	\$132.00	\$165.00	\$198.00
7230	7230	Removal of Impacted Tooth - Partially Bony	\$156.00	\$195.00	\$234.00
7240	7240	Removal of Impacted Tooth - Completely Bony	\$192.00	\$240.00	\$288.00
7241	7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	\$240.00	\$300.00	\$360.00
7250	7250	Surgical Removal of Residual Tooth Roots (cutting Procedure)	\$72.00	\$90.00	\$108.00
7310	7310	Alveoloplasty in Conjunction with Extractions - Per Quadrant	\$96.00	\$120.00	\$144.00
7320	7320	Alveoloplasty Not in Conjunction with Extractions - Per Quadrant	\$210.00	\$262.50	\$315.00
7470	7471	Removal of Lateral Exostosis (Maxilla or Mandible)	\$180.00	\$225.00	\$270.00
7510	7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	\$90.00	\$112.50	\$135.00
7520	7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	\$90.00	\$112.50	\$135.00
7960	7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	\$192.00	\$240.00	\$288.00
7970	7970	Excision of Hyperplastic Tissue - Per Arch	\$168.00	\$210.00	\$252.00
7971	7971	Excision of Pericoronal Gingiva	\$72.00	\$90.00	\$108.00
7210-7971 – The benefit includes an allowance for local anesthesia and routine post-operative care.					
9220	9220	General Anesthesia - First 30 Minutes	\$120.00	\$150.00	\$180.00
9221	9221	General Anesthesia - Each Additional 15 Minutes	\$48.00	\$60.00	\$72.00
9241	9241	Intravenous Sedation – First 30 Min	\$96.00	\$120.00	\$144.00
9241	9242	Intravenous Sedation – Ea Add 15 Min	\$30.00	\$37.50	\$45.00
9220-9241 – Paid as a separate benefit only when Necessary, as determined by Us, and when administered in conjunction with complex oral surgical procedures which are covered under the Policy.					
9940	9940	Occlusal Guard, By Report	\$210.00	\$262.50	\$315.00
9940 – Limited to one appliance in any 24 consecutive month period.					
9951	9951	Occlusal Adjustment, Limited	\$42.00	\$52.50	\$63.00
9952	9952	Occlusal Adjustment, Complete	\$150.00	\$187.50	\$225.00

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
9951-9952 – Payable once in any 36 month period.					

**Type V Dental Services:**

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
2520	2520	Inlay - Metallic - Two Surfaces	\$360.00	\$450.00	\$540.00
2530	2530	Inlay - Metallic - Three or More Surfaces	\$450.00	\$562.50	\$675.00
2542	2542	Onlay - Metallic - Two Surfaces	\$360.00	\$450.00	\$540.00
2543	2543	Onlay - Metallic - Three Surfaces	\$450.00	\$562.50	\$675.00
2544	2544	Onlay - Metallic - Four or More Surfaces	\$480.00	\$600.00	\$720.00
2620	2620	Inlay - Porcelain/ceramic - Two Surfaces	\$360.00	\$450.00	\$540.00
2630	2630	Inlay - Porcelain/ceramic - Three or More Surfaces	\$450.00	\$562.50	\$675.00
2642	2642	Onlay - Porcelain/ceramic - Two Surfaces	\$360.00	\$450.00	\$540.00
2643	2643	Onlay - Porcelain/ceramic - Three Surfaces	\$450.00	\$562.50	\$675.00
2644	2644	Onlay - Porcelain/ceramic - Four or More Surfaces	\$480.00	\$600.00	\$720.00
2651	2651	Inlay - Composite-Resin - Two Surfaces (Laboratory Processed)	\$360.00	\$450.00	\$540.00
2652	2652	Inlay - Composite-Resin - Three or More Surfaces (Laboratory Processed)	\$450.00	\$562.50	\$675.00
2662	2662	Onlay - Composite-Resin - Two Surfaces (Laboratory Processed)	\$360.00	\$450.00	\$540.00
2663	2663	Onlay - Composite-Resin - Three Surfaces (Laboratory Processed)	\$450.00	\$562.50	\$675.00
2664	2664	Onlay - Composite-Resin - Four or More Surfaces (Laboratory Processed)	\$480.00	\$600.00	\$720.00
2520-2664 – Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than 7 years have elapsed since the last placement. The benefit includes an allowance for any filling paid on the same tooth during the 90 day period preceding the preparation date of the inlay or onlay.					
2720	2720	Crown - Resin with High Noble Metal	\$360.00	\$450.00	\$540.00
2721	2721	Crown - Resin w/ Predominantly Base Metal	\$360.00	\$450.00	\$540.00
2722	2722	Crown - Resin with Noble Metal	\$360.00	\$450.00	\$540.00
2740	2740	Crown - Porcelain/ceramic Substrate	\$420.00	\$525.00	\$630.00
2750	2750	Crown - Porcelain Fused to High Noble Metal	\$480.00	\$600.00	\$720.00
2751	2751	Crown - Porcelain Fused to Predominantly Base Metal	\$480.00	\$600.00	\$720.00
2752	2752	Crown - Porcelain Fused to Noble Metal	\$480.00	\$600.00	\$720.00
2780	2780	Crown – ¾ Cast High Noble Metal	\$420.00	\$525.00	\$630.00
2781	2781	Crown – ¾ Cast Predominantly Base Metal	\$420.00	\$525.00	\$630.00

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
2782	2782	Crown – ¾ Cast Noble Metal	\$420.00	\$525.00	\$630.00
2790	2790	Crown - Full Cast High Noble Metal	\$420.00	\$525.00	\$630.00
2791	2791	Crown - Full Cast Predominantly Base Metal	\$420.00	\$525.00	\$630.00
2792	2792	Crown - Full Cast Noble Metal	\$420.00	\$525.00	\$630.00
2720-2792 – Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than 7 years have elapsed since the last placement. The benefit for a crown includes an allowance for any filling paid on the same tooth in the 90 day period preceding the preparation date of the crown.					
2950	2950	Core Buildup, including any Pins	\$72.00	\$90.00	\$108.00
2950 – Covered only under unusual circumstances when required for retention and preservation of the tooth and only if the crown, inlay or onlay on the same tooth is covered. Includes all pins and/or prefabricated posts.					
2952	2952	Cast Post and Core in Addition to Crown	\$156.00	\$195.00	\$234.00
2954	2954	Prefabricated Post and Core in Addition to Crown	\$120.00	\$150.00	\$180.00
2952-2954 – Covered only for an endodontically treated tooth requiring a cast restoration and only if the crown, inlay or onlay on the same tooth is covered.					
2960	2960	Labial Veneer (Resin Laminate) - Chairside	\$240.00	\$300.00	\$360.00
2960 – Covered only when the tooth cannot be restored by a composite resin filling, and then only if more than 5 years have elapsed since last placement.					
6520/ 6543	6600, 6602, 6604, 6606, 6608, 6610, 6612, 6614	Inlay/Onlay - Two Surfaces	\$420.00	\$525.00	\$630.00
6530/ 6544	6601, 6603, 6605, 6607, 6609, 6611, 6613, 6615	Inlay/Onlay - Three or More Surfaces	\$450.00	\$562.50	\$675.00
6545	6545	Cast Metal Retainer for Resin-Bonded Bridge	\$210.00	\$262.50	\$315.00
6545 – Benefits for the replacement of an existing resin-bonded Bridge is payable only if the existing resin-bonded bridge is more than 5 years old, is not serviceable, and cannot be repaired. Benefits for resin-bonded Bridge pontics are based on the Customary Fee for base metal substrates. Fixed Bridges (including resin-bonded Bridges) that consist of multiple contiguous units are deemed to be a single Bridge for benefit determination. The expense for a Fixed Bridge is deemed incurred in the Policy Year when the Bridge was cemented permanently in the mouth.					
6720	6720	Crown - Resin with High Noble Metal	\$360.00	\$450.00	\$540.00
6721	6721	Crown - Resin with Predominantly Base Metal	\$360.00	\$450.00	\$540.00
6722	6722	Crown - Resin with Noble Metal	\$360.00	\$450.00	\$540.00
6750	6750	Crown - Porcelain Fused to High Noble Metal	\$480.00	\$600.00	\$720.00
6751	6751	Crown - Porcelain Fused to Predominantly Base Metal	\$480.00	\$600.00	\$720.00
6752	6752	Crown - Porcelain Fused to Noble Metal	\$480.00	\$600.00	\$720.00
6780	6780	Crown - ¾ Cast High Noble Metal	\$420.00	\$525.00	\$630.00
6781	6781	Crown – ¾ Cast Predominantly Base Metal	\$420.00	\$525.00	\$630.00

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
6782	6782	Crown – ¾ Cast Noble Metal	\$420.00	\$525.00	\$630.00
6790	6790	Crown - Full Cast High Noble Metal	\$420.00	\$525.00	\$630.00
6791	6791	Crown - Full Cast Predominantly Base Metal	\$420.00	\$525.00	\$630.00
6792	6792	Crown - Full Cast Noble Metal	\$420.00	\$525.00	\$630.00
<p>6720-6792 – Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 7 years old, is not serviceable, and cannot be repaired unless there is a Necessary extraction of an additional Functioning Natural Tooth which was not an abutment to an existing denture or resin-bonded Bridge that is less than 5 years old or an existing fixed bridge that is less than 7 years old.</p> <p>Fixed Bridges (including resin-bonded Bridges) that consist of multiple contiguous units are deemed to be a single Bridge for benefit determination. The expense for a Fixed Bridge is deemed incurred in the Policy Year when the Bridge was cemented permanently in the mouth.</p>					
6970	6970	Cast Post and Core in Addition to Fixed Partial Denture Retainer	\$156.00	\$195.00	\$234.00
6972	6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	\$120.00	\$150.00	\$180.00
<p>6970-6972 – Covered only for an endodontically treated tooth requiring a cast restoration and only if the bridge retainer on the same tooth is also covered.</p>					
6973	6973	Core Build Up for Retainer, Including Any Pins	\$72.00	\$90.00	\$108.00
<p>6973 – Covered only under unusual circumstances when required for retention and preservation of the tooth and only if the bridge retainer on the same tooth is also covered. Includes all pins and/or prefabricated posts.</p>					
6210	6210	Pontic - Cast High Noble Metal	\$420.00	\$525.00	\$630.00
6211	6211	Pontic - Cast Predominantly Base Metal	\$420.00	\$525.00	\$630.00
6212	6212	Pontic - Cast Noble Metal	\$420.00	\$525.00	\$630.00
6240	6240	Pontic - Porcelain Fused to High Noble Metal	\$420.00	\$525.00	\$630.00
6241	6241	Pontic - Porcelain Fused to Predom. Base Metal	\$420.00	\$525.00	\$630.00
6242	6242	Pontic - Porcelain Fused to Noble Metal	\$420.00	\$525.00	\$630.00
6250	6250	Pontic - Resin with High Noble Metal	\$360.00	\$450.00	\$540.00
6251	6251	Pontic - Resin with Predominantly Base Metal	\$360.00	\$450.00	\$540.00
6252	6252	Pontic - Resin with Noble Metal	\$360.00	\$450.00	\$540.00
<p>6210-6252 – Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 7 years old, is not serviceable, and cannot be repaired unless there is a Necessary extraction of an additional Functioning Natural Tooth which was not an abutment to an existing denture or resin-bonded Bridge that is less than 5 years old or an existing fixed bridge that is less than 7 years old.</p> <p>Fixed Bridges (including resin-bonded Bridges) that consist of multiple contiguous units are deemed to be a single Bridge for benefit determination. The expense for a Fixed Bridge is deemed incurred in the Policy Year when the Bridge was cemented permanently in the mouth.</p>					
0470	0470	Diagnostic Casts	\$30.00	\$37.50	\$45.00
<p>0470 – Not covered for orthodontic evaluation. Limited to one time in any 36 consecutive month period and only if diagnostic casts are required for extensive bilateral prosthetic dentistry other than dentures.</p>					
5110	5110	Complete Denture - Maxillary	\$576.00	\$720.00	\$864.00
5120	5120	Complete Denture - Mandibular	\$576.00	\$720.00	\$864.00
5130	5130	Immediate Denture - Maxillary	\$576.00	\$720.00	\$864.00

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
5140	5140	Immediate Denture - Mandibular	\$576.00	\$720.00	\$864.00
5110-5140 – There are no additional benefits for personalized dentures or for overdentures and associated procedures. Limited to one denture per arch per 5 years.					
5211	5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	\$420.00	\$525.00	\$630.00
5212	5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	\$420.00	\$525.00	\$630.00
5213	5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	\$600.00	\$750.00	\$900.00
5214	5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	\$600.00	\$750.00	\$900.00
5211-5214 – There are no additional benefits for precision or semi-precision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Limited to one partial denture per arch per 5 years unless there is a Necessary extraction of an additional Functioning Natural Tooth.					
4210	4210	Gingivectomy or Gingivoplasty – Four or More Teeth Per Quadrant	\$168.00	\$210.00	\$252.00
4211	4211	Gingivectomy or Gingivoplasty – One to Three Teeth Per Quadrant	\$60.00	\$75.00	\$90.00
4240	4240	Gingival Flap Procedure, Including Root Planing - Four or More Teeth Per Quadrant	\$240.00	\$300.00	\$360.00
4241	4241	Gingival Flap Procedure, Including Root Planing - One to Three Teeth Per Quadrant	\$120.00	\$150.00	\$180.00
4260	4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Teeth Per Quadrant	\$450.00	\$562.50	\$675.00
4261	4261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Teeth Per Quadrant	\$228.00	\$285.00	\$342.00
4210-4261 – Only one periodontal surgical procedure is covered per area of the mouth in any 36 consecutive month period. If less than a full quadrant is treated or requires treatment, benefits will be prorated to reflect the portion of the quadrant actually treated or the portion which requires treatment. Includes local anesthesia and routine post-operative care.					
4263	4263	Bone Replacement Graft - 1st Site in Quadrant	\$168.00	\$210.00	\$252.00
4264	4264	Bone Replacement Graft - Each Additional Site in Quadrant	\$84.00	\$105.00	\$126.00
4263-4264 – Includes local anesthesia and routine post-operative care.					
4266	4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	\$192.00	\$240.00	\$288.00
4267	4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	\$216.00	\$270.00	\$324.00
4266-4267 – Only one periodontal surgical procedure is covered per area of the mouth in any 36					

CDT-3 Procedure Code	CDT-4 Procedure Code	Description of Service	Maximum Covered Expense		
			Area A	Area B	Area C
consecutive month period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery. Includes local anesthesia and routine post-operative care.					
4270	4270	Pedicle Soft Tissue Graft Procedure	\$300.00	\$375.00	\$450.00
4271	4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	\$330.00	\$412.50	\$495.00
4273	4273	Subepithelial Connective Tissue Graft Procedures	\$360.00	\$450.00	\$540.00
4274	4274	Distal or Proximal Wedge Procedure	\$132.00	\$165.00	\$198.00
4270-4274 – Includes local anesthesia and routine post-operative care. Includes local anesthesia and routine post-operative care.					
4274 – Not payable on same date as codes 4260, 4261.					