Dental Benefits Summary

Delta Dental PPO[SM]

Table of Allowances

County of Middlesex/ Middlesex County Board of Social Services

Group # 9045

Topics Covered in This Booklet

Page	
1	**About This Brochure**
1	**About Delta Dental**
1	**How to Use Your Program**
2	**Locating a Dentist**
2-3	**Why Select a Participating Dentist?**
3	**Where Do You Call/E-Mail?**
4	**If You Have Coverage through Another Plan--COB**
4	**Continuation of Coverage (COBRA)**
5	**Claims and Appeal Procedure**
5	**Health Care Fraud**
6-8	**Frequently Asked Questions**
	Sample Claim Form
	Sample Notification of Delta Dental Benefits
9-10	**Description of Covered Services**
11	**Method of Payment**
11-12	**Eligibility Requirements**
	Table of Allowances
12-13	**Exclusions and Limitations**
14-17	**Glossary**
17	**Product Descriptions**

Please note: The definitions for the words that appear in italics in the following pages can be found in the Glossary. In the event there appears to be any difference between the benefits described in this booklet and those provided in the group contract, the group contract shall prevail.

About This Brochure

This brochure contains a general description of your dental care program for your use as a convenient reference. All benefits are governed by the provisions of your group's contract with Delta Dental of New Jersey, Inc. This is not a summary plan description designed to meet the requirements of ERISA.

About Delta Dental

Delta Dental of New Jersey covers more than one million people in commercial, school board, and government programs. It is our mission to promote oral health to the greatest number of people by providing accessible dental benefits programs of the highest quality, service, and value.

Since 1969, Delta Dental, a not-for-profit dental service corporation, has led the industry in offering innovative programs designed to control costs while ensuring quality of benefits.

Delta Dental is a member of the Delta Dental Plans Association, a national system of not-for-profit dental service corporations covering 28 million people across the country. The national Delta Dental system is the oldest and largest dental benefits system in the country.

How to Use Your Program

At the time of your first appointment, tell your *dentist* that you are covered under this Delta Dental program. Give him or her your group's name and group number, as well as your Social Security number. Your dependents, if covered, also must give your Social Security number.

After your *dentist* performs an examination, he or she may submit a *Pre-Treatment Estimate* of benefits to Delta Dental to determine how much of the charge will be your responsibility.

Before treatment is started, be sure you discuss with your *dentist* the total amount of his or her fee. Although *Pre-Treatment Estimates* are not required, Delta Dental strongly recommends you ask your *dentist* to submit a *Pre-Treatment Estimate* for treatment costing $300 or more. This is especially important when using a *non-participating dentist* because the *Pre-Treatment Estimate* lets you know in advance how much of the costs are your responsibility. Please keep in mind that *Pre-Treatment Estimates* are only estimates and not a guarantee of payment.

Locating a *Dentist*

Delta Dental offers two easy ways to locate a *participating dentist* **24 hours a day, 7 days a week.** Subscribers may either:

- Call 1-800-335-8265
- Search the Internet at www.deltadentalnj.com

By calling the toll-free number, you may obtain a customized list of *participating dentists* within the geographic area of your request. Delta Dental mails the list to your home.

By searching on the Internet, you may obtain a list of *participating dentists* in a specific town. The list may be downloaded immediately, and you may search for as many towns as needed.

Using either method, you may request a list of Delta Dental *participating dentists* within a designated area. You may specify listings of *general dentists* only or specialists only. *Participating dentist* information may be obtained for *dentists* nationwide.

Why Select a *Participating Dentist*?

All Delta Dental *participating dentists* have agreed, in writing, to abide by our claims processing procedures. Through their commitment and support, we, in turn, can provide you with a program that's tailored to meet your dental health wants and needs.

- *Participating dentists* have agreed to accept the least of their actual charge, their prefiled fee, or Delta Dental's maximum allowable fee for the program as payment in full and to not charge patients for amounts in excess of those indicated in the "patient payment" portion of the *Notification of Delta Dental Benefits*.

- *Participating dentists* will usually maintain a supply of *claim forms* (also referred to as Attending Dentist's Statements) in their offices. You may be asked to complete a portion of the form when you visit.

- *Participating dentists* will complete the rest of the form, including a description of the services that were performed or will be performed in the case of a *Pre-Treatment Estimate*, and require that you sign the *claim form* in the appropriate place. For *dentists* who submit claims electronically to Delta Dental, you will need to authorize your *dentist* to maintain your signature on file.

- *Participating dentists* will mail, fax, or electronically submit the *claim form*, together with the appropriate diagnostic materials, directly to our offices for processing.

- *Participating dentists* agree to abide by Delta Dental processing policies. For example, *participating dentists* agree not to bill separate charges for infection control measures. *Non-participating* dentists are not bound by such policies.

- *Participating dentists* will, in the case of dental services which have been completed, receive payment directly from Delta Dental for that portion of the *treatment plan* which is covered by your dental program. You will receive a *Notification of Delta Dental Benefits* with a detailed description of covered benefits and the amount of your obligation.

- If you visit a *non-participating dentist*, you will be responsible for payment. Delta Dental will reimburse you for the portion of your services covered by your program.

We advise that you check with your *dentist* to confirm whether he or she participates in the Delta Dental program under which you are covered. While a *dentist* may participate with Delta Dental, he or she may not participate in all of our programs.

Where Do I Call/E-mail?

Question	Phone Number	E-mail/Internet Address
Customer Service	800-452-9310	service@deltadentalnj.com
Obtain *claim forms*	800-452-9310	service@deltadentalnj.com
Notification of Delta Dental Benefits statement	800-452-9310	service@deltadentalnj.com
Status of a claim	800-452-9310	service@deltadentalnj.com
Eligibility information	800-452-9310	service@deltadentalnj.com
Benefits information	800-452-9310	service@deltadentalnj.com
Completing the *claim form*	800-452-9310	service@deltadentalnj.com
COBRA matters	973-285-4145	administration@deltadentalnj.com
Participating dentist list	800-DELTA-OK 800-335-8265	www.deltadentalnj.com

Please note that all calls to our toll-free number first go through our *Interactive Voice Response* (*IVR*) system. Information available on the *IVR* includes eligibility, benefits, remaining maximum, *deductible*, claim payments, and ordering *claim forms*. Your question may be answered more quickly by the *IVR*, where there is never a wait. You may also use this system to speak with a Customer Service representative. Note: A touch-tone phone is required.

We offer the following services for our non-English speaking and hearing-impaired subscribers:

Language Line Helper - a non-English speaking subscriber may also use our toll-free number. When the call is received, a translator will be obtained for the language in which the caller is fluent and a three-way conversation will be held among the caller, translator, and a Delta Dental customer service representative.

TDD Line - a hearing-impaired subscriber may call 1-800-246-1010 and be connected with a TDD machine to also access our Customer Service representatives.

If You Have Coverage Through Another Plan--*Coordination of Benefits*

Generally, if you are covered by more than one group dental plan and in some cases a group medical plan, your expenses will be shared between the plans, up to the full amount of the allowable charges. This includes dual Delta Dental coverage, as well as coverage by Delta Dental and another group plan.

Make sure you inform your *dentist* that you are covered by more than one plan. If you are covered by more than one Delta Dental of New Jersey plan, you just need to submit the claim once, and we will coordinate your benefits. If you are covered by Delta Dental and another group plan, you need to submit the claim to the primary group plan first. After the primary group plan has issued a statement of benefits, you need to send that statement of benefits to the second group plan along with a *claim form*.

Some groups coordinate benefits according to the *birthday rule* and some groups coordinate benefits according to the *gender rule*. Please see the Eligibility section to determine which rule your group follows for coordination of benefits.

By coordinating benefits, we avoid duplication of payment for the same services thereby managing your benefits dollars for future procedures and ensuring your group that we are effectively administering your benefits.

Continuation of Coverage (*COBRA*)

Under the Consolidated Omnibus Budget Reconciliation Act (*COBRA*), you and/or your eligible dependents may have the right to elect to continue certain group health coverage which would otherwise end as a result of any of the following events:

- your termination of employment for reasons other than gross misconduct;
- a reduction of your hours so that you or your dependents no longer meet the eligibility requirements for coverage;
- your death;
- your legal separation or divorce;
- your child no longer qualifying as a dependent.
- your or your spouse's entitlement to Medicare.

If coverage is to continue, you and/or your eligible dependents will be responsible for paying the contributions and fees required for that coverage. Please see your plan administrator for additional information about *COBRA*.

Claims and Appeal Procedure

Delta Dental will notify you if any services are denied, in whole or in part, stating the reason(s) for the denial, references to pertinent sections of the brochure, additional information you must provide to improve your claim and the procedure available for further review of your claim on *Notification of Delta Dental Benefits* which will be sent to you. Within 60 days after receipt of a notice of denial, you may make a written request for review of such denial by addressing your request to Delta Dental of New Jersey, Inc., Customer Service Department, P.O. Box 222, Parsippany, NJ 07054-0222. You must state the reason(s) you believe Delta Dental should reconsider its determination of benefits.

You must also provide:

- the name(s) and address(es) of the subscriber(s) and the patient(s);
- your Social Security number;
- the claim number(s) you request to be reviewed;
- the name of the dentist;
- the date(s) of the service(s);
- detailed description as to the basis of your appeal.

You must include any additional information or documentation which you believe may support your claim(s). Before making a formal written request for review, you are encouraged to discuss your claim with your plan administrator.

Delta Dental may require additional information for its review. Certain review requests may be referred to one of Delta Dental's consultants. Unless referral to a consultant is required or other unusual circumstances arise, you should receive a written decision on your request for review within 30 days but no longer than 60 days after Delta Dental receives your request. If special circumstances require an extension of time, a written notice of the extension will be sent to you and a decision will be made no later than 120 days after the receipt of the review. Notification of the decision will be clearly described and will specify the reasons for the decision.

Health Care Fraud

It is insurance fraud to submit false information to a plan in order to obtain a larger payment than you are entitled to receive. False claims include submitting a claim for a service not actually rendered, misdescribing a service which was rendered, misrepresenting the amount of the fee the *dentist* charged and intended to collect (including failing to disclose that the *dentist* will waive all or part of the patient's copayment), or using an incorrect date for the actual rendering of the dental service.

Insurance fraud hurts everyone because it reduces the funds available to pay **bona fide** claims and may result in the termination of benefit plans due to increased costs. It has severe criminal and civil consequences to those who participate in the preparation or submission of such claims. We urge all plan participants to refrain from submitting or participating in the submission of false claims and to contact us at 973-285-4167 if you suspect that a false claim has been submitted.

Frequently Asked Questions

- Do I need to have an assigned *dentist*?

  No, this plan allows you to be treated by any licensed *dentist* of your choice. Generally, the least out-of-pocket expense may be achieved by using a *dentist* who participates with your specific plan type (e.g., *Delta Dental Premier, Advantage Program,* or *Delta Dental PPO*). Also, payment for services will be sent directly to a *participating dentist*. If you are treated by a *non-participating dentist*, benefits will be paid to you, not to the *dentist*.

- Do I need a referral to a specialist?

  You are not required to have a referral to a specialist if you or your dependents require specialized care. Generally, you will maximize your benefits by utilizing the services of a specialist who participates with Delta Dental.

- Is it required to have a *Pre-Treatment Estimate* (pre-determination of benefits)?

  No, it is not required by Delta Dental that you obtain a *Pre-Treatment Estimate* of benefits prior to treatment. If your *dentist* indicates the need for treatment with dental charges in excess of $300, it is strongly recommended that you request an estimate of dental benefits before receiving the treatment. Both you and your *dentist* will receive a voucher from Delta Dental showing the estimated payable benefit. It will also indicate your estimated patient responsibility including *deductible* if applicable. Your *dentist* needs to complete this voucher and submit it for payment when work has been completed. *Pre-Treatment Estimates* are only estimates and not a guarantee of payment. Payment of the approved services are subject to eligibility and to contract limitations (e.g., annual maximums) at the time services are rendered.

- Do I need an ID card as proof of coverage when I visit a *dentist*?

  If your employer has issued an identification card, you should show it to your *dentist*. However, it is not required that a *dentist* see an ID card before rendering treatment. An ID card does not verify active coverage. You or your *dentist* may obtain your group number, current eligibility and benefit information by contacting Delta Dental at (800) 452-9310 24 hours a day, 7 days a week.

- Whom may I call if I have questions about my benefits?

  You may call our Customer Service Department at (800) 452-9310 and speak to a representative Monday to Thursday, 8:00 a.m. to 7:00 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST. Also, our *interactive voice response* system can provide benefit, eligibility, remaining maximum and *deductible* information, and history of your recent claims 24 hours a day, 7 days a week.

- How do I file a claim for dental charges?

  There are several easy ways to submit a claim. Your *dentist* may complete a Delta Dental *claim form* or an ADA (American Dental Association) approved form and mail it to: Delta Dental of New Jersey, P.O. Box 222, Parsippany, NJ 07054-0222. The *claim form* may also be faxed to 1-800-324-7939. If your *dentist* files claims electronically through his or her computer, no *claim form* is required. This method also speeds processing time.

  Each individual patient must have his or her own claim filed separately from another family member's claim. Also, each different *dentist* visited must submit a separate claim. However, an individual *dentist* may submit a claim for payment and a *Pre-Treatment Estimate* on the same *claim form*.

- How do eligible children attending college away from home find a *participating dentist*?

  A customized list of *participating dentists* for a specific geographic location may be obtained by calling 1-800-DELTA-OK or 1-800-335-8265. This list will be mailed or may be faxed in case of an emergency situation. Also, listings of *participating dentists* throughout the country are available on our website at www.deltadentalnj.com.

- What form of full-time student documentation will be necessary to file a claim for my college age dependent?

  Students may need to provide Delta Dental with verification of full-time student status with the first claim of every new school year if required under your employer's benefit contract. Examples of student documentation are: a copy of a paid tuition statement, a registrar's certificate or grades showing at least 12 credits, or a current valid student ID card. All documents should reflect the school year which corresponds with dates of treatment provided by your *dentist*.

- Is there a time limit for submitting dental claims?

  Yes, you have one full year from the date of service to submit your dental claims. If there is coordination of benefits involved and Delta Dental is not the primary carrier, you have one year from the date on which the primary carrier(s) issues a statement of benefits. If the claim is submitted more than one year from the date the service is rendered, the service will not be covered.

- How is my plan maximum calculated?

  Your *maximum benefits* payable are either based on a *calendar year* or a coverage period (determined by your employer). All procedures that are paid by Delta Dental will be applied to your plan maximum. If your contract provides benefits for orthodontia or other specific benefits such as TMJ coverage, they may have their own separate annual or lifetime limits. In addition, you may have an individual annual maximum or a combined family maximum for everyone under your coverage.

- If I am not located in the same state as my employer's headquarters, where do I call?

  No matter where you are located in the country, you may still call the same toll-free number (800-452-9310) to reach our Customer Service Department, Monday to Thursday 8:00 a.m. to 7:00 p.m. EST and Friday 8:00a.m. to 5:00p.m. EST. Our *Interactive Voice Response* system is available 24 hours a day, 7 days a week.

- What is an *alternative benefit* provision and how does it work?

  The *alternative benefit* provision of your group contract is applied when there are two ways to treat a dental condition and both procedures are covered. In such cases your benefit is based on the treatment that costs less. This does not mean that your *dentist* made a poor recommendation. In fact, you may use Delta Dental's payment towards the treatment you choose. Since Delta Dental's payment is the same no matter which treatment you choose, you may have higher out-of-pocket expenses if you choose the treatment that costs more.

DELTA DENTAL

See reverse for instructions

Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (check all applicable boxes)
_ Statement of Actual Services – OR – _ Request for Predetermination/Preauthorization
_ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code
Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054

OTHER COVERAGE

4. Other Dental or Medical Coverage? _ No (Skip 5-11) _ Yes (Complete 5-11)

5. Members Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/YY)	7. Gender _ Male _ Female	8. Member Identifier (SSN or ID#)

9. Plan/Group Number	10. Relationship to Primary Member (Check applicable box) _ Self _ Spouse _ Dependent Child _ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY MEMBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/YY)	14. Gender _ Male _ Female	15. Members Identifier (SSN or ID#)

16. Plan/Group Number	17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Member (check applicable box) _ Self _ Spouse _ Dependent Child _ Other	19. Student Status _ FTS _ PTS

20. Name (Last, First, Middle Initial, Suffix, Address, City, State, Zip code

21. Date of Birth (MM/DD/YY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/YY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) _ or Letters _	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION — Permanent — Primary

34. (Place an 'X' on each missing tooth)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X

Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X

Member signature — Date

BILLING DENTIST OR DENTAL ENTITY (leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/member)

48. Name, Address, City, State, Zip Code

49. Provider ID	50. License Number	51. SSN or TIN

52. Phone Number ( ) -

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (check applicable box) _ Provider's Office _ Hospital _ ECF _ Other	39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? _ No (skip 41-42) _ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/YY)

42. Months of Treatment Remaining	43. Replacement of Prosthesis? _ No _ Yes (Complete 44)	44. Date Prior Placement (MM/DD/YY)

45. Treatment Resulting from (Check applicable box)
_ Occupational illness/injury _ Auto accident _ Other accident

46. Date of Accident (MM/DD/YY)	47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X

Signed (Treating Dentist) — Date

54. Provider ID	55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) -	58. Treating Provider Specialty

SAMPLE

General Instructions:

The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope. The upper right blank space is provided for insertion of the third-party payer's claim or control number.

a) All data elements are required unless noted to the contrary on the face of the form or in the Data Element Specific Instructions that follow.
b) When a name and address field is required, the full entity or individual name, address and zip code must be entered (i.e., Items 3, 11, 12, 20,and 48).
c) All dates must include the two-digit year (i.e., Items 6, 13, 21, 24, 36, 37, 41, 44, and 53).
d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form. Both claims forms are submitted to the third-party payer.

Data Element Specific Instructions

1. EPSDT/ Title XIX – Mark box if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment program for persons under age 21.
2. Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
4-11. Leave blank if no other coverage.
8. The member's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
15. The member's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
16. Member's or employer group's Plan or Policy Number. May also be known as the Certificate Number (not the member's identification number).
19-23. Complete only if the patient is **not** the Primary Member (i.e., "Self" not checked in Item 18).
19. Check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank.
23. Enter if dentist's office assigns a unique number to identify the patient that is not the same as the Member Identifier number assigned by the payer (e.g., Chart#).
25. Designate tooth number or letter when procedure code directly involves a tooth. Use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'.
26. Enter applicable ANSI ASC X12 code list qualifier. Use "JP" when designating teeth using the ADA'S Universal/National Tooth Designation System. Use "JO" when using the ANSI/ADA/ISO Specification No 3950.
27. Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported, use a hyphen ('-') to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.
28. Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces:
B = Buccal; D = Distal; F = Facial; L = Lingual; M = Mesial; O = Occlusal.
29. Use appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature*.
31. Dentist's full fee for the dental procedure reported.
32. Used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
33. Total of all fees listed on the claim form.
34. Report missing teeth on each claim submission.
35. Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth.
36. Patient Signature: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
37. Member Signature: Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
38. ECF is the acronym for Extended Care Facility (e.g., nursing home).
48-52. Leave blank if dentist or dental entity is **not** submitting claim on behalf of the patient or insured/member.
48. The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payment or correspondence that will be remitted to the billing dentist.
49. Identifier assigned to Billing Dentist of Dental Entity other than the SSN or TIN. Necessary when assigned by carrier receiving the claim.
50. Refers to the license number of the billing dentist. This may differ from that of the treating (rendering) dentist that appears in the treating dentist's signature block.
52. The Internal Revenue Service requires that either the Social Security Number (SSN) or Tax Identification Number (TIN) of the billing dentist or dental entity be supplied **only** if the provider accepts payment directly from the third-party payer. When the payment is being accepted directly report the 1) SSN if the billing dentist is unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing is a group practice or clinic.
53. The treating, or rendering, dentist's signature and date the claim form was signed. Dentist should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
56. Full address, including city, state and zip code, where treatment was performed by treating (rendering) dentist.
58. Enter the code that indicates the type of dental professional rendering the service from the 'Dental Service Providers' section of the *Healthcare Providers Taxonomy* code list. The current list is posted at: http://www.wpc-edi.com/codes/codes.asp. The available taxonomy codes, as of the first printing of this claim form, follow in **boldface**.

122300000X Dentist – A dentist is a person of qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of the license.

Many dentists are general practitioners who handle a wide variety of dental needs.

1223G0001X General Practice

Other dentists practice in one of nine specialty areas recognized by the American Dental Association:

1223D0001X Dental Public Health
1223E0200X Endodontics
1223P0106X Oral & Maxillofacial Pathology
1223D0008X Oral & Maxillofacial Radiology
1223S0112X Oral & Maxillofacial Surgery
1223X0400X Orthodontics
1223P0221X Pediatric Dentistry (Pedodontics)
1223P0300X Periodontics
1223P0700X Prosthodontics

Delta Dental Offers Enhanced Explanation of Benefits Statements

Delta Dental's Explanation of Benefits statement is presented in a readable, user-friendly format. Developed in consultation with dentists and members, the new form contains more information than before and has been reformatted, making it easier to read.

What Delta Dental's Improved Explanation of Benefits Statement Offers

1. CONTACT INFORMATION, including a special Customer Service toll-free phone number.
2. A PAYMENT SUMMARY BOX, providing at a glance details about charges, payments, deductibles and patient obligations.

   NEW! Dentist Amount Non Billable, which shows the amount the patient is not billable for.
3. PATIENT INFORMATION, including patient's name, date of birth, relationship to subscriber, group ID and name, and plan type.

   NEW! Benefit Period, which shows the benefit period for the patient.
4. *NEW!* CLAIM NUMBER INCREASED, from 9 digits to 15.

continued on other side

Page 1 of 1

Explanation of Benefits – Dentist Copy

(1) DELTA DENTAL

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054

Claim Inquiries: 800-452-9310 Visit us on the Internet: www.deltadentalnj.com

JOHN SMITH DMD
1234 ANY STREET
SAMPLETOWN, NJ 00000-0000

(2) PAYMENT SUMMARY

Total Approved Charges	$000.00
Delta Dental's Total Payment	$000.00
Your Other Insurance Paid	$000.00
Applied to Deductible	$000.00
Dentist Amount Non Billable NEW!	$000.00
Patient Out of Pocket Payment Obligation	$000.00

DO NOT SEND PAYMENT TO DELTA DENTAL

(3)

PATIENT:	ROBERT JONES
PATIENT DATE OF BIRTH:	00/00/0000
RELATIONSHIP:	SUBSCRIBER
GROUP ID:	0000-0000
GROUP NAME:	ABC CORPORATION
PLAN TYPE:	PREMIER
BENEFIT PERIOD: NEW!	00/00/0000 – 00/00/0000

(4) (5)

CLAIM NUMBER:	000000000000000 (4) NEW!
DATE OF ISSUE:	00/00/00
CHECK NUMBER:	0000000000
DENTIST ID NUMBER:	12345NJ
DENTIST NAME:	DR. JOHN SMITH
PAR STATUS:	PREMIER

(6)

Annual	**PLAN MAXIMUM:** NEW!	$0000.00	Individual **Used to Date:**	$000.00
Lifetime	**TMJ MAXIMUM:**	$0000.00	Individual **Used to Date:**	$0.00

(7)

TOOTH NO. OR LETTER	SURFACE	DATE OF SERVICE	SUBMITTED PROCEDURE NO.*	PAID PROCEDURE NO.*	SUBMITTED AMOUNT	APPROVED AMOUNT	AMT USED FOR BENEFIT CALC	DED	% COPAY	DELTA DENTAL PAYMENT	PROCESSING POLICIES
XX	XXXXX	00/00/0000	2391	2140	$000.00	$000.00	$000.00	$00.00	000	$000.00	000, 000, 000

NEW!

***PROCEDURE NO. / DESCRIPTION**
2391 Resin based composite – one surface, posterior
2140 Amalgam – one surface, posterior

PROCESSING POLICIES
Line One
Line Two
Line Three

PLEASE SEE REVERSE SIDE OF THIS FORM FOR INFORMATION RELATED TO OUR NOTICE OF PRIVACY PRACTICES, DEFINITIONS, AND OTHER IMPORTANT INFORMATION.

IMPORTANT NOTICE TO CLAIMANTS

1. Informal Review (Optional to Subscriber)

The covered person (or authorized representative) and/or treating dentist may, within 60 days of the date of mailing of this EOB, request that we informally reconsider this claim decision by following the procedure described in No. 5 below; we will respond within 60 days and notify the subscriber (or authorized representative) and treating dentist of our decision and the reason(s) therefor. If no request is submitted within 60 days, only a formal appeal may be filed. A request for informal review does not constitute an "appeal" for ERISA appeals purposes.

2. Formal Appeal

The covered person (or authorized representative) may, within 240 days of the date of mailing of this EOB, formally appeal this claim decision by following the procedure described in No. 5 below; we will issue our decision to the subscriber (or authorized representative) within 30 days of our receipt of the appeal for ERISA claims and within 45 days of our receipt of the appeal for non-ERISA claims.

3. Right to Sue

A covered person must timely file a formal appeal (as described in No. 2 above) and receive our decision on the appeal as a precondition to commencing any legal proceeding challenging the claim determination.

4. Right to Receive Rules, Guidelines or Detailed Explanations

If the front side of this form indicates that a rule or guideline was relied on, you have a right to receive it free of charge. If the front side indicates that payment was not made for services because they were experimental or not medically necessary, you have a right to receive an explanation of the basis for that decision. To receive either, send your written request to Delta Dental, Attn: Correspondence Department, P.O. Box 222, Parsippany, NJ 07054.

5. Procedure for Requesting Informal Reviews and Formal Appeals
Submit the following information and documentation:

(a) Dentist name, office name, address and license number
(b) Subscriber name, social security number and date of birth
(c) Patient name, social security number and date of birth
(d) Claim number
(e) Whether this is for an informal review or a formal appeal
(f) Description of the reasons why Delta Dental should change its initial decision on the claim and the specific decision which you request
(g) Any supplemental information or diagnostic materials relevant to the claim in question
(h) In lieu of (a), (b), (c) and (d), attach a copy of the claim and the claim determination you are appealing

A form is available for you to use at http://www.deltadentalnj.com/HIPAA/law_compliance.shtml.

You must sign your request; if you are authorized to act for the covered person, you must state that. You may include information and/or documentation pertinent to the claim even if you had not previously submitted it to us. Informal review requests must be addressed to Delta Dental, Attn: Correspondence Department, P.O. Box 222, Parsippany, NJ 07054. Formal appeals must be addressed to Delta Dental, Attn: Formal Appeals Department, P.O. Box 601, Parsippany, NJ 07054.

6. Potential Voluntary Alternative Dispute Options

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency. Those persons covered under a self-funded program may also have a voluntary appeals program available to them; check with your Human Resources Department or Summary Plan Description (SPD) if applicable.

7. Notice of Privacy Practices

You may access Delta Dental's Notice of Privacy Practices on our website at www.deltadentalnj.com. You may also obtain a hard copy of this notice by contacting our compliance manager at (866) 861-4716.

8. Coordination of Benefits

If you are covered by more than one health benefit plan, you should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered.

You should always submit your claim first to your primary carrier and, after receiving their determination, submit your claim to your secondary or tertiary carriers (if applicable).

9. Terminology and Definitions

Approved Amount: The total amount which the dentist is permitted to collect as payment in full for the specified service. It includes the dental benefit plan's payment as well as the patient's deductible and/or copay.

Amount Used for Benefit Calculation: The fee amount that the dental benefit plan provides for use in calculating the dental benefit plan payment for the specified service. The dental benefit plan payment may be less than this fee amount due to patient deductible, copay, plan limitations or exclusions.

10. Any procedures which are disallowed resulting in no Delta Dental payment or patient liability are in accordance with the group contract and dentist participation agreement.

11. Payment for all services is determined in accordance with the terms of the group's dental plan and/or with the terms of Delta Dental's dentist participation agreements.

5. DENTIST INFORMATION, including the Delta Dental program in which he or she participates for that claim.

6. *NEW!* MAXIMUM INFORMATION EXPANDED, to include all maximums applicable to the plan the patient is covered under instead of showing plan maximum only.

7. DETAILED EXPLANATIONS AND DESCRIPTIONS OF INFORMATION IN THE COLUMNS, including descriptions of each procedure number and explanations, if appropriate, of processing policies (up to 3 per line item allowed).

NEW! **Separate 'Submitted Procedure No.' and 'Paid Procedure No.' added,** to better illustrate when an alternative benefit has been applied.

For questions about specific claims, contact the number for Claims Inquiries on your Explanation of Benefits statement, or e-mail Customer Service at **service@deltadentalnj.com**.

Description of Covered Services

See following page for program descriptions

* **Table of Allowances**

Preventive & Diagnostic Services (No Deductible) — 100%*

- Exams, Cleanings, (each twice per calendar year per person, ages 14 and older are considered adults)
- X-rays-full mouth series or panoramic (either one, once in three years)
- X-rays-bitewing (twice per calendar year)
- X-rays-single films (multiple x-rays on the same date of service will not exceed the benefit of a full-mouth series)
- Fluoride Treatment (once per calendar year, for eligible children to age 19, combinations with cleanings are applied to time limits for both)
- Space Maintainers (once per space for missing posterior primary teeth, for children under age 14)
- Consultations are counted as exams for purposes of frequency limitations

Remaining Basic (No Deductible) — 100%*

- Fillings – composite and amalgam (composite fillings on back teeth are given the alternate benefit of an amalgam filling, payable once per year for decay or fracture only)
- Extractions, Oral Surgery (impacted wisdom teeth claims should first go to medical carrier)
- Endodontics (root canals on permanent teeth and root surgery each once per tooth per 24 months)
- Periodontics (have specific frequency limitations, pre-treatment estimate is strongly recommended - e.g. surgery once per 36 months)
- Sealants (1st and 2nd permanent, decay-free molars, once in a lifetime per tooth, for children to age 16)

Prosthodontics & Crowns (No Deductible) — 100%*

- Crowns and crown-related procedures (post and core, core buildup, etc., once per tooth every five years, permanent teeth only, for ages 12 and older)
- Bridge Work (once every 5 years, for ages 16 and older) (bridges with four or more missing teeth in that arch may be given an alternate benefit of a partial denture)
- Repair of Dentures (Repair of existing prosthetic appliances)
- Full and Partial Dentures (either one, once every 5 years, partial dentures for ages 16 and older) (fixed bridges and removable partial dentures are not benefits in the same arch; benefits will be provided for the removable partial denture only)
- Inlays (inlays are only payable when done in conjunction with an onlay; by themselves they are given the alternate benefit of an amalgam filling)
- Perio Surgery

Calendar Year Maximum (per person)	Unlimited
Calendar Year Deductible	
▪ Individual	N/A
▪ Family (family deductible is accumulated by individual deductibles)	N/A

<u>Orthodontia (Dependent Children to Age 19 Only)</u>	100%
Orthodontic treatment is a benefit limited to once every five years.	
▪ Maximum (Lifetime)	$1,300.00
▪ Deductible (Lifetime)	N/A

Description of Programs

<u>Delta Dental PPO^{SM}</u> - See Explanation under "Product Descriptions" section at back of booklet.

*__Table of Allowances__ - See explanation under "Product Descriptions" section at back of booklet.

Under all programs, non-participating dentists may balance bill above the maximum allowable charge.

Payment

If your dentist is a Delta Preferred dentist, then payment will be based upon the least of the doctor's filed fee, charged fee, Delta Preferred fee or the fee listed in the attached Schedule of Allowances.

If your dentist is a Delta Premier dentist or participating specialist, then payment will be based upon the least of the doctor's filed fee, charged fee or the fee listed in the attached Schedule of Allowances.

If your dentist is non-participating, then payment will be based on the lower of the charged fee or the fee listed in the attached Schedule of Allowances.

Orthodontic Payment Schedule

Payment for comprehensive orthodontics will be processed in two (2) equal payments (subject to continuation of treatment and/or eligibility for orthodontic benefits at the time services are rendered).

The first payment will be made upon insertion of appliances. The second and final payment will be made upon the completion of the first twelve (12) months of treatment. These payments will represent Delta Dental's full liability.

When the appliances are inserted prior to the effective date of eligibility, orthodontic benefits will be *pro-rated.*

Eligibility

You and your dependents are eligible on the first of the month following two (2) full months of continuous full time employment.

Dependent(s) are your lawful spouse and unmarried dependent children, including step-children, foster children and legally adopted children until the end of the calendar year in which the dependent reached their twenty-third (23rd) birthday while remaining unmarried and dependent on Member for more than fifty per cent of his/her sustenance. Enrollment may be continued beyond age 23 for an unmarried child who is incapable of self-support because of mental retardation or physical incapacity that began before age 23 for as long as these conditions continue to exist. Proof of disability must be furnished to Delta Dental in order for coverage to be continued.

Termination of Coverage

Coverage for employees and their eligible dependents shall cease on the date of:

1) Termination of employee's employment
2) Death of employee
3) Retirement
4) The Group Policy expires
5) You stop making contributions where required

Coverage for dependent spouse shall terminate on the date of divorce from the covered employee.

Coverage for a dependent child shall terminate upon the end of the calendar year in which attaining the limiting contract age (see eligibility section above).

Change in Enrollment

If you want to change you dependent coverage, consult your County Plan Administrator and Delta Dental. An employee who is single, but marries, or an Employee who has a new child, should contact the County Plan Administrator and Delta Dental immediately to complete a Universal Benefit form.

For coordination of benefits, your group follows the __birthday__ rule.

TABLE OF ALLOWANCES

DIAGNOSTIC (00100-00999)	
00100 **Clinical Oral Examinations**	
00110 Initial oral examination	$30.00
00120 Periodic oral examination	$30.00
00130 Emergency oral examination	$25.00
00140 Limited oral evaluation	$25.00
00150 Comprehensive oral evaluation	$30.00
00160 Detailed and extensive oral evaluation	$30.00
00200 RADIOGRAPHS	
00210 Intraoral-complete series (including bitewings)	$40.00
00220 Intraoral-single film	$ 4.00
00230 Intraoral-each additional film	$ 4.00
00270 Bitewing-single film	$ 4.00
00272 Bitewing-two films	$ 8.00
00273 Bitewing-three films	$12.00
00274 Bitewing-four films	$16.00
00280 Bitewing-each additional	$ 4.00
00400 TESTS & LABORATORY EXAMINATION	
00460 Pulp Vitality Tests	$9.00
PREVENTIVE (01000-01999)	
01100 **Dental Prophylaxis**	
01110 Adults	$35.00
01120 Children	$30.00
01200 **Fluoride Treatments**	
01201 Topical Application of fluoride (including prophylaxis)-child	$66.00
01203 Topical Application of fluoride (excluding prophylaxis)	$36.00
OTHER PREVENTIVE SERVICES	
01500 **Space Maintainers**	
01510 Fixed, unilateral	$ 75.00
01515 Fixed, bilateral	$120.00
01520 Removable, unilateral	$100.50
01525 Removable, bilateral	$100.50
RESTORATIVE (02000-02999)	
02100 **Amalgam Restorations (including polishing)**	
02110 Amalgam-one surface, deciduous	$35.00
02120 Amalgam-two surfaces, deciduous	$50.00
02130 Amalgam-three surfaces, deciduous	$60.00
02131 Amalgam-four surfaces, deciduous	$65.00
02140 Amalgam-one surface, permanent	$50.00
02150 Amalgam-two surfaces, permanent	$60.00
02160 Amalgam-three surfaces, permanent	$46.50
02161 Amalgam-four or more surfaces, permanent	$54.00

TABLE OF ALLOWANCES

02200 **Silicate Restorations**	
02210 Composite resin-one surface	$21.00
02310 Acrylic or plastic restoration	$21.00
Resin Restorations	
02330 Composite-one surface	$28.50
02331 Composite resin-two surfaces	$28.50
02332 Composite resin-three surfaces	$28.50
02335 Composite – four or more surfaces (involving incisal angle)	$28.50
02380 Composite-one surface-posterior primary	$21.00
02381 Composite rein-two surfaces-posterior primary	$32.00
02382 Composite resin-three surfaces-posterior primary	$47.00
02385 Composite resin-one surface-posterior permanent	$22.50
02386 Composite resin-two surfaces-posterior permanent	$38.00
02387 Composite resin-three surfaces-posterior permanent	$55.00
02500 **Gold Inlay Restorations**	
02510 Inlay, metallic-one surface	$ 81.00
02520 Inlay, gold-two surfaces	$117.00
02530 Inlay, three surfaces	$166.50
02610 Inlay, porcelain/ceramic-one surface	$120.00
02620 Inlay, porcelain/ceramic-two surfaces	$120.00
02630 Inlay, porcelain/ceramic-three surfaces	$120.00
02700 **Crowns-Single Restorations Only**	
02710 Plastic (acrylic) (lab)	$147.00
02720 Resin with high noble metal	$186.00
02721 Resin/base metal	$186.00
02722 Resin/noble metal	$186.00
02740 Porcelain	$232.50
02750 Porcelain/high noble	$229.50
02751 Porcelain/base metal	$229.50
02752 Porcelain/noble metal	$229.50
02780	$177.00
02781	$177.00
02782	$177.00
02790 Gold (full cast)	$199.50
02791 Gold (full cast)	$199.50
02792 Gold (full cast)	$199.50
02810 Gold (3/4 cast)	$177.00
02900 OTHER RESTORATIVE SERVICES	
02910 Recement-inlay	$15.00
02920 Recement-crown	$30.00
02930 Crown-Prefabricated stainless steel primary	$48.00
02931 Crown-Prefabricated stainless steel permanent	$48.00
02940 Sedative filling	$16.50
02952 Cast post and core	$64.50

TABLE OF ALLOWANCES

ENDODONTICS (03000-03999)

03110 Pulp cap-direct (over pulp exposure)	$9.00
03200 **Pulpotomy**	
03220 Vital pulpotomy (excluding final restoration)	$28.50
03300 ROOT CANAL THERAPY (INCLUDES TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW UP CARE)	
03310 Anteriors (excludes final restoration)	$150.00
03320 Pre-molars (excludes final restoration)	$200.00
03330 Molars (excludes final restoration)	$250.00
03351 Apexification-initial visit	$ 55.50
03352 Apexification-interim medical replacement	$ 55.50
03353 Apexification-final visit	$ 55.50
03440 PERIAPCIAL SERVICES	
03410 Apicoectomy, performed as separate surgical procedure	$67.50
03421 Apicoectomy-bicuspid-first tooth	$67.50
03425 Apicoectomy-molar-first root	$67.50
03426 Apicoectomy-(per tooth)-each additional root	$67.50
03430 Retrograde filling-per root	$55.50

PERIODONTICS (04000-04999)

04200 SURGICAL SERVICES	
04210 Gingivectomy or gingivoplasty-per quadrant	$ 91.50
04211 Gingivectomy or gingivoplasty-1 tooth	$ 19.50
04212 Gingivectomy or gingivoplasty-2 teeth	$ 54.90
04213 Gingivectomy or gingivoplasty-3 teeth	$ 54.90
04214 Gingivectomy or gingivoplasty-4 teeth	$ 91.50
04220 Gingival curettage	$ 15.00
04225 Curettage-1 tooth	$ 9.00
04226 Curettage-2 teeth	$ 9.00
04227 Curettage-3 teeth	$ 9.00
04228 Curettage-4 teeth	$ 15.00
04260 Osseous surgery per quadrant	$108.00
04284 Osseous surgery-1 tooth-prorated	$ 64.80
04285 Osseous surgery-2 teeth-prorated	$ 64.80
04286 Osseous surgery-3 teeth-prorated	$ 64.80
04287 Osseous surgery-4 teeth-prorated	$108.00
04300 ADJUNCTIVE PERIODONTAL SERVICES	
04341 Periodontal scaling and root planing (per quadrant)	$40.00
04345 Scaling-gingival inflamation	$32.00
04346 Scaling and root planing-1 tooth	$24.00
04347 Scaling and root planing-2 teeth	$24.00

TABLE OF ALLOWANCES

Code	Description	Allowance
04348	Scaling and root planing-3 teeth	$24.00
04349	Scaling and root planing-4 teeth	$40.00
04355	Full mouth debridgement for evaluation/diagnosis	$32.00
04381	Delivery of chemotherapeutic agents-1 site	$28.00
04382	Delivery of chemotherapeutic agents-2 sites	$40.00
04383		$ 7.50
04384		$11.25
04910	Periodontal maintenance following active therapy	$15.00

PROSTHODONTICS, REMOVABLE (05000-05999)
05100 COMPLETE DENTURES

Code	Description	Allowance
05110	Complete upper	$327.00
05120	Complete lower	$327.00
05130	Immediate upper	$367.50
05140	Immediate lower	$367.50

05200 PARTIAL DENTURES-INCLUDING SIX MONTHS POST-DELIVERY CARE

Code	Description	Allowance
05211	Upper, without clasps, acrylic base	$279.00
05212	Lower partial-acrylic base (including any conventional clasps and rests)	$279.00
05213	Upper partial-predominantly base cast base with acrylic saddles (including any conventional clasps and rests)	$396.00
05214	Lower partial-predominantly base with cast base with acrylic saddles (including any conventional clasps and rests)	$396.00

REPAIR TO COMPLETE DENTURES

Code	Description	Allowance
05610	Repair broken complete or partial denture	$ 39.00
05620	Repair cast framework	$ 60.00
05640	Replace broken teeth-per tooth	$ 15.00
05650	Add tooth to existing partial denture	$ 28.50
05660	Partial add clasp	$ 84.00
05730	Relining upper or lower complete denture (office)	$ 75.00
05731	Reline lower complete	$ 75.00
05740	Relining upper or lower partial denture (office)	$ 75.00
05741	Reline partial lower (office)	$ 75.00
05750	Relining upper or lower complete denture (lab)	$125.00
05751	Reline lower complete (lab)	$125.00
05760	Relining upper or lower partial denture (lab)	$125.00
05761	Reline lower partial (lab)	$125.00

TABLE OF ALLOWANCES

PROSTHODONTICS, FIXED (06000-06999) Fixed Bridges (each abutment and each pontic constitutes a unit in a bridge)

06200 BRIDGE PONTICS

06210 Cast Gold	$225.00
06211 Pontic-cast/base metal	$225.00
06212 Pontic-cast/noble metal	$225.00
06240 Porcelain-fused-to-gold	$225.00
06241 Porcelain with base metal	$225.00
06242 Porcelain with noble metal	$225.00
06245 Pontic-porcelain	$225.00
06250 Plastic-processed-to-gold	$225.00
06251 Pontic-resin/base metal	$225.00
06252 Pontic-resin/noble metal	$225.00

06600 REPAIR OF FIXED BRIDGES

06770 CROWNS AS ABUTEMENTS

06720 Plastic-processed-to-metal	$225.00
06721 Plastic/nonprecious metal	$225.00
06722 Resin/base metal	$225.00
06750 Porcelain-fused-to-metal	$225.00
06751 Porcelain/base metal	$225.00
06752 Porcelain/noble	$225.00
06780 ¾ cast noble metal	$225.00
06781	$225.00
06782	$225.00
06790 Full cast/high noble	$225.00
06791 Full/base metal	$225.00
06792 Full/noble metal	$225.00

ORAL SURGERY (07000-07999)

07100 EXTRACTIONS

07110 Single tooth	$50.00
07120 Each additional tooth	$40.00

07200 SURGICAL REMOVAL

07210 Extraction of tooth, erupted	$16.50
07220 Extraction of tooth, non-impacted	$22.50
07230 Extraction of tooth, impacted	$42.00
07240 Extraction of tooth, impacted fully bony	$75.00
07250 Root recovery (surgical removal or residual root)	$45.00
07285 Biopsy and examination of oral tissue (hard)	$31.50
07286 Biopsy and examination of oral tissue (soft)	$31.50

07300 ALVEOPLASTY (surgical preparation of ridge for dentures)

07310 Alveoplasty in conjunction with extractions	$49.50
07320 Alveoplasty NOT in conjunction with extractions	$34.50

TABLE OF ALLOWANCES

07400 REMOVAL OF TUMORS, CYSTS, AND NEOPLASMS

07430 Surgical excision	$ 84.00
07431 Surgical excision	$139.50
07440 Surgical excision	$ 84.00
07441 Surgical excision	$139.50
07450 Removal of cyst	$ 55.50
07451 Removal of cyst	$139.50
07460 Removal of cyst	$ 39.00
07461 Removal of cyst	$ 84.00

07500 SURGICAL INCISION

07510 Incision and drainage of abscess, intraoral	$27.00
07520 Incision and drainage-extraoral abcess	$55.50

07600 TREATMENT OF FRACTURE-SIMPLE

07610 Fracture-u open reduction	$280.50
07620 Fracture-u closed reduction	$210.00
07630 Fracture-L open reduction	$280.50
07640 Fracture-L closed reduction	$210.00
07650 Fracture-zygo-open reduction	$421.50
07660 Fracture-zygo-closed reduction	$421.50
07670 Fracture-alveolus-open reduction	$112.50

07700 TREATMENT OF FRACTURE-COMPOUND

07710 Fracture u-open reduction	$280.50
07720 Fracture u-closed reduction	$210.00
07730 Fracture L-open reduction	$280.50
07740 Fracture L-closed reduction	$210.00
07750 Fracture zygo-open reduction	$421.50
07760 Fracture zygo-closed reduction	$421.50
07770 Fracture alveolus-open reduction	$112.50

07800 REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

07810 Surgical excision-open reduction	$55.50
07820 Treatment of dislocation-closed reduction	$22.50

07900 REPAIR OF TRAUMATIC WOUNDS

07910 Suture of recent small wounds up to 5 cm.	$27.00
07911 Suture of complicated wounds up to 5 cm.	$55.50
07912 Suture of complicated wounds greater than 5 cm.	$55.50

GENERAL SERVICES (09000-09999)

09110 Palliative (emergency treatment of dental pain, minor procedures	$ 25.00
09310 Consultation	$ 15.00
09940 Occlusal guard, by report	$141.00

Exclusions and Limitations: Services Not Covered by This Dental Plan

- To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. Your dental plan is designed to assist you in maintaining dental health. The fact that a procedure is prescribed by your dentist does not make it dentally necessary or eligible under this program. We may request proof (such as x-rays, pathology reports, or study models) to determine whether services are necessary. Failure to provide this proof may cause adjustment or denial of any procedure performed.
- Services for injuries or conditions which are compensable under Workers Compensation Employers Liability Laws; services provided to the eligible patient by any Federal or State Government Agency or provided without cost to the eligible patient by any municipality, county, or other political subdivision.
- Services with respect to congenital or developmental malformations (including TMJ and replacing congenitally missing teeth), cosmetic surgery, and dentistry for purely cosmetic reasons (e.g., bleaching, veneers, or crowns to improve appearance).
- Services provided in order to alter occlusion (change the bite); replace tooth structure lost by wear, abrasion, attrition, abfraction, or erosion; splint teeth; or treat or diagnose jaw joint and muscle problems (TMJ).
- Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils) are excluded and a benefit will be allowed for a conventional procedure (e.g., benefiting a conventional denture towards the cost of an overdenture and the root canals associated with it. The patient is responsible for additional costs.)
- Prescribed drugs, analgesics (pain relievers), fluoride gel rinses, and preparations for home use.
- Procedures to achieve minor tooth movement.
- Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of care.
- Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease. Oral hygiene instruction or any equipment or supplies required.
- Services rendered by anyone who does not qualify as a fully licensed *dentist.*
- Charges for hospitalization including hospital visits or broken appointments, office visits, and house calls.
- Services performed prior to effective date or after termination of coverage. Benefits are payable based on date of completion of treatment.
- Services performed for diagnosis such as laboratory tests, caries tests, bacterial studies, diagnostic casts, or photographs.
- Temporary procedures and appliances, pulp caps, occlusal adjustments, inhalation of nitrous oxide, analgesia, local anesthetic, and behavior management.
- Procedures or preparations which are part of or included in the final restoration (bases, acid etch, or micro abrasion).
- Transplants, implants, and procedures directly associated with implants including crowns and bridgework and their restoration and their maintenance or repair.
- Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts, and guided tissue regeneration.
- Post removal (not in conjunction with root canal therapy).
- Completion of claim forms, providing documentation, requests for pre-determination, and services submitted for payment more than twelve (12) months following completion.

- Separate fee for infection control and OSHA compliance.
- Maxillofacial surgery and prosthetic appliances.

This is a general description of your dental plan to be used as a convenient reference, and some exclusions and limitations may not be listed. All benefits are governed by your group contract.

Glossary Term	Definition
Alternate Benefit	A provision in a dental plan contract that allows the third-party payer to determine the benefit based on an alternative procedure that is generally less expensive than the one provided or proposed. Patient financial liability is dependent upon the treatment chosen.
Amalgam	A silver material used to fill cavities that is placed on the tooth surface that is used for chewing because it is a particularly durable material.
Birthday Rule	Coordination-of-benefits regulation stipulating that the primary payer of benefits for dependent children is determined by the parents' birth dates. Regardless of which parent is older, the dental benefits program of the parent whose birthday falls first in a calendar year is considered primary.
Bitewing	A dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.
Calendar Year	For benefit determinations based on a calendar year, this refers to the period of one year beginning with January 1 and ending December 31.
Claim Form	The paper form the dentist must file for reimbursement for services rendered.
COB	Coordination of Benefits. A method of integrating benefits payable under more than one plan.
COBRA	Consolidated Omnibus Budget Reconciliation Act. A law that requires certain employers to offer continued health insurance coverage to eligible employees and/or their dependents who have had their health insurance coverage terminated.
Completion Date	The date a procedure is completed. It is the insertion date for dentures and partial dentures. It is the cementation date (regardless of the type of cement used) for inlays, onlays, crowns, and fixed bridges.
Composite	White resin material used to fill cavities. It is used primarily because the color more closely resembles the natural tooth than does the color of amalgam.
Consultation	A discussion between the patient and the dentist where the dentist offers professional advice for the proposed treatment plan.

Contract Year	A period of one year beginning with the effective date of the group contract.
Covered Family Members	You and your spouse and dependent children who are covered under this program.
Deductible	The amount of dental expense your group requires you to pay before Delta Dental assumes any liability for payment of benefits. Deductible may be an annual or one-time charge, and may vary in amount from program to program.
Dentist	A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.
Endodontist	A dentist who specializes in diseases of the tooth pulp, performing such services as root canals.
Gender Rule	Coordination-of-benefits regulation stipulating that the primary payer of benefits for dependent children is determined by the gender of the parents. The dental benefits program of the parent of a specified gender is considered primary.
General Dentist	A dentist who provides a full range of dental services for the entire family.
IVR	Interactive Voice Response system. Information can be accessed by touch-tone telephone 24 hours a day on: eligibility, benefits, claim information, and ordering claim forms.
Maximum Benefit	The maximum dollar amount a program will pay toward the cost of dental care incurred by an individual or family in a specified period, usually a calendar year.
Non-Participating Dentist	A state-licensed dentist who does not have a written participation agreement with Delta Dental.
Notification of Delta Dental Benefits	A statement that explains how your claim was processed, payment by Delta Dental, your responsibility, and other pertinent information. Also referred to as an EOB (Explanation of Benefits) or Notification of Payment (NOP).
Oral Pathologist	A dentist who is concerned with recognition, diagnosis, and management of the diseases of the mouth, jaws, and surrounding structures.

Oral Surgeon	A dentist who removes teeth, including impacted wisdom teeth, repairs fractures of the jaw and performs surgery on the mouth, jaws, and surrounding structures.
Orthodontist	A dentist who corrects misaligned teeth and jaws, usually by applying braces.
Participating Dentist	A state-licensed dentist who has a written agreement with a Delta Dental Plan to perform services and receive payment under this program.
Participating Specialist	A participating dentist with Delta Dental of New Jersey who holds a specialty permit in endodontics, periodontics, prosthodontics, oral surgery, or orthodontics; limits his/her practice to that specialty; and has registered with Delta Dental as a specialist.
Pediatric Dentist	A dentist who generally limits his/her practice to children and teenagers and the handicapped. Also known as Pedodontist.
Periodontist	A dentist who treats diseases of the gums.
Pre-Treatment Estimate	Pre-authorized estimate of services detailing payment of allowable benefits.
Prevailing Fee	The lowest fee for a single procedure which equals or exceeds the fee for that procedure which Delta Dental has determined will satisfy the majority of dentists in the pertinent geographic location.
Prophylaxis	Prevention of disease by removal of calculus, stains, and other extraneous materials from the teeth. The cleaning of the teeth by a dentist or dental hygienist.
Pro-rated	For subscribers whose orthodontic coverage begins after treatment has begun, payments are divided proportionately over the course of the treatment and Delta Dental's payment is based on the portion during which the subscriber has coverage.
Prosthodontist	A dentist who generally specializes in ways to replace missing natural teeth with bridges and dentures.
Sealant	An adhesive material bonded to the tooth surface to retard decay by shielding the tooth from exposure to the oral environment. This includes preventive resin restorations.

Table of Allowance Program	A program under which a group's table of allowances represents the maximum fees which are recognized for benefit purposes by Delta Dental. The patient's out-of-pocket liability will depend upon the particular program in which the patient is covered.
Treatment Plan	A written report prepared by a dentist showing the dentist's recommended treatment of any dental disease, defect, or injury.
UCR	The Usual, Customary, and Reasonable fee level as determined by Delta Dental for the pertinent geographic location.

Product Descriptions

Table of Allowance Programs
With a Table of Allowances Program, Delta Dental will make payment based on the program described below, but in no event will Delta Dental's payment be greater than the Table of Allowances.

Notes:

P. O. Box 222
Parsippany, NJ 07054-0222

800-452-9310

www.deltadentalnj.com

The Plan That Keeps You Smiling.

Delta Dental of New Jersey, Inc.
NJ Delta Dental PPO℠
Fee Schedule - Effective 1/1/2013

*Important Note: All procedure codes may not be listed on this table. Fees for services which do not appear on the Table will be determined by the Corporation in a manner designed to generate approximately the same percentage of savings as analogous fee(s) set forth in this Table.
In addition, all procedures listed on this table may not be a covered benefit.
To verify coverage of a particular patient, visit us at www.deltadentalnj.com and click on "Dentists" icon to log onto Benefits Connection.

CODE	DESCRIPTION	FEE
	Diagnostic	
D0120	periodic oral evaluation-established patient	33
D0140	limited oral evaluation-problem focused	39
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	39
D0150	comprehensive oral evaluation - new or established patient	39
D0160	detailed and extensive oral evaluation-problem focused, by report	39
D0170	re-evaluation-limited, problem focused (established patient; not post-operative visit)	39
D0180	comprehensive periodontal evaluation-new or established patient	39
D0210	intraoral-complete series of radiographic images	81
D0220	intraoral-periapical first radiographic image	16
D0230	intraoral-periapical each additional radiographic image	11
D0240	intraoral-occlusal radiographic image	26
D0270	bitewing-single radiographic image	16
D0272	bitewings-two radiographic images	24
D0273	bitewings-three radiographic images	32
D0274	bitewings-four radiographic images	40
D0277	vertical bitewings-7 to 8 radiographic images	81
D0330	panoramic radiographic image	81
D0340	cephalometric radiographic image	70
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	30
D0460	pulp vitality tests	32
D0470	diagnostic casts	51
	Preventive	
D1110	prophylaxis-adult	67
D1120	prophylaxis-child	43
D1203	topical application of fluoride - child	24
D1204	topical application of fluoride - adult	24
D1206	topical application of fluoride varnish	24
D1208	topical application of fluoride	24
D1351	sealant-per tooth	33
D1510	space maintainer-fixed - unilateral	207
D1515	space maintainer-fixed - bilateral	290
D1520	space maintainer-removable - unilateral	209
D1525	space maintainer-removable - bilateral	273
D1550	re-cementation of space maintainer	40
D1555	removal of fixed space maintainer	40
	Restorative	
D2140	amalgam - one surface, primary or permanent	77
D2150	amalgam - two surfaces, primary or permanent	99
D2160	amalgam - three surfaces, primary or permanent	124
D2161	amalgam - four or more surfaces, primary or permanent	150
D2330	resin-based composite - one surface, anterior	85
D2331	resin-based composite - two surfaces, anterior	91
D2332	resin-based composite - three surfaces, anterior	129
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	162

CODE	DESCRIPTION	FEE
	Restorative - Continued	
D2390	resin-based composite crown, anterior	207
D2391	resin-based composite - one surface, posterior	107
D2392	resin-based composite - two surfaces, posterior	119
D2393	resin-based composite - three surfaces, posterior	155
D2394	resin-based composite - four or more surfaces, posterior	159
D2510	inlay - metallic - one surface	310
D2520	inlay - metallic - two surfaces	465
D2530	inlay - metallic - three or more surfaces	580
D2542	onlay - metallic - two surfaces	497
D2543	onlay - metallic - three surfaces	735
D2544	onlay - metallic - four or more surfaces	775
D2610	inlay - porcelain/ceramic - one surface	538
D2620	inlay - porcelain/ceramic - two surfaces	596
D2630	inlay - porcelain/ceramic - three or more surfaces	650
D2642	onlay - porcelain/ceramic - two surfaces	722
D2643	onlay - porcelain/ceramic - three surfaces	776
D2644	onlay - porcelain/ceramic - four or more surfaces	810
D2650	inlay - resin-based composite - one surface	513
D2651	inlay - resin-based composite - two surfaces	560
D2652	inlay - resin-based composite - three or more surfaces	609
D2662	onlay - resin-based composite - two surfaces	610
D2663	onlay - resin-based composite - three surfaces	642
D2664	onlay - resin-based composite - four or more surfaces	740
D2710	crown - resin-based composite (indirect)	688
D2712	crown - ¾ resin-based composite (indirect)	734
D2720	crown - resin with high noble metal	723
D2721	crown - resin with predominantly base metal	595
D2722	crown - resin with noble metal	668
D2740	crown - porcelain/ceramic substrate	776
D2750	crown - porcelain fused to high noble metal	800
D2751	crown - porcelain fused to predominantly base metal	658
D2752	crown - porcelain fused to noble metal	742
D2780	crown - ¾ cast high noble metal	880
D2781	crown - ¾ cast predominantly base metal	730
D2782	crown - ¾ cast noble metal	796
D2783	crown - ¾ porcelain/ceramic	810
D2790	crown - full cast high noble metal	828
D2791	crown - full cast predominantly base metal	656
D2792	crown - full cast noble metal	755
D2794	crown - titanium	828
D2799	provisional crown - further treatment or completion of diagnosis necessary prior to final impression	145
D2910	recement inlay, onlay, or partial coverage restoration	58
D2915	recement cast or prefabricated post and core	58
D2920	recement crown	58
D2929	prefabricated porcelain/ceramic crown - primary tooth	226

CODE	DESCRIPTION	FEE
	Restorative - Continued	
D2930	prefabricated stainless steel crown - primary tooth	180
D2931	prefabricated stainless steel crown - permanent tooth	228
D2932	prefabricated resin crown	215
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	226
D2940	protective restoration	56
D2950	core buildup, including any pins	155
D2951	pin retention - per tooth, in addition to restoration	37
D2952	post and core in addition to crown, indirectly fabricated	262
D2953	each additional indirectly fabricated post - same tooth	212
D2954	prefabricated post and core in addition to crown	222
D2955	post removal	162
D2957	each additional prefabricated post - same tooth	170
D2960	labial veneer (resin laminate) - chairside	310
D2961	labial veneer (resin laminate) - laboratory	490
D2962	labial veneer (porcelain laminate) - laboratory	646
D2970	temporary crown (fractured tooth)	144
D2971	additional procedures to construct new crown under existing partial denture framework	142
D2980	crown repair necessitated by restorative material failure	151
	Endodontics	
D3110	pulp cap - direct (excluding final restoration)	38
D3120	pulp cap - indirect (excluding final restoration)	38
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	124
D3221	pulpal debridement, primary and permanent teeth	53
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	145
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	160
D3310	endodontic therapy, anterior tooth (excluding final restoration)	455
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	590
D3330	endodontic therapy, molar (excluding final restoration)	764
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	176
D3333	internal root repair of perforation defects	202
D3346	retreatment of previous root canal therapy - anterior	500
D3347	retreatment of previous root canal therapy - bicuspid	630
D3348	retreatment of previous root canal therapy - molar	800
D3351	apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	210
D3410	apicoectomy/periradicular surgery - anterior	393
D3421	apicoectomy/periradicular surgery - bicuspid (first root)	500
D3425	apicoectomy/periradicular surgery - molar (first root)	596
D3426	apicoectomy/periradicular surgery (each additional root)	215
D3430	retrograde filling - per root	119
D3450	root amputation - per root	300
D3920	hemisection (including any root removal), not including root canal therapy	215

CODE	DESCRIPTION	FEE
	Periodontics	
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	300
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	174
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	174
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	335
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	205
D4245	apically positioned flap	300
D4249	clinical crown lengthening - hard tissue	475
D4260	osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	764
D4261	osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	453
D4263	bone replacement graft - first site in quadrant	274
D4264	bone replacement graft - each additional site in quadrant	230
D4265	biologic materials to aid in soft and osseous tissue regeneration	287
D4266	guided tissue regeneration - resorbable barrier, per site	358
D4267	guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	390
D4268	surgical revision procedure, per tooth	224
D4270	pedicle soft tissue graft procedure	418
D4271	free soft tissue graft procedure (including donor site surgery)	428
D4273	subepithelial connective tissue graft procedures, per tooth	440
D4274	distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	224
D4275	soft tissue allograft	418
D4276	combined connective tissue and double pedicle graft, per tooth	575
D4277	free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	428
D4278	free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	214
D4341	periodontal scaling and root planing - four or more teeth per quadrant	128
D4342	periodontal scaling and root planing - one to three teeth per quadrant	76
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	88
D4381	localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	50
D4910	periodontal maintenance	100
	Prosthodontics (Removable)	
D5110	complete denture - maxillary	956
D5120	complete denture - mandibular	956
D5130	immediate denture - maxillary	1052
D5140	immediate denture - mandibular	1052
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	690
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	690
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1114
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1114

CODE	DESCRIPTION	FEE
	Prosthodontics (Removable) - Continued	
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	900
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	900
D5281	removable unilateral partial denture - one piece cast metal (including clasps and teeth)	538
D5410	adjust complete denture - maxillary	44
D5411	adjust complete denture - mandibular	44
D5421	adjust partial denture - maxillary	44
D5422	adjust partial denture - mandibular	44
D5510	repair broken complete denture base	110
D5520	replace missing or broken teeth - complete denture (each tooth)	89
D5610	repair resin denture base	107
D5620	repair cast framework	126
D5630	repair or replace broken clasp	116
D5640	replace broken teeth - per tooth	89
D5650	add tooth to existing partial denture	114
D5660	add clasp to existing partial denture	140
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	533
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	533
D5710	rebase complete maxillary denture	220
D5711	rebase complete mandibular denture	220
D5720	rebase maxillary partial denture	205
D5721	rebase mandibular partial denture	205
D5730	reline complete maxillary denture (chairside)	170
D5731	reline complete mandibular denture (chairside)	170
D5740	reline maxillary partial denture (chairside)	170
D5741	reline mandibular partial denture (chairside)	170
D5750	reline complete maxillary denture (laboratory)	275
D5751	reline complete mandibular denture (laboratory)	275
D5760	reline maxillary partial denture (laboratory)	248
D5761	reline mandibular partial denture (laboratory)	248
	Implant Services	
D6056	prefabricated abutment - includes modification and placement	544
D6057	custom fabricated abutment - includes placement	630
D6058	abutment supported porcelain/ceramic crown	932
D6059	abutment supported porcelain fused to metal crown (high noble metal)	996
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	904
D6061	abutment supported porcelain fused to metal crown (noble metal)	960
D6062	abutment supported cast metal crown (high noble metal)	970
D6063	abutment supported cast metal crown (predominantly base metal)	904
D6064	abutment supported cast metal crown (noble metal)	949
D6065	implant supported porcelain/ceramic crown	955
D6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	1080
D6067	implant supported metal crown (titanium, titanium alloy, high noble metal)	1082
D6068	abutment supported retainer for porcelain/ceramic FPD	955

CODE	DESCRIPTION	FEE
	Implant Services - Continued	
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	992
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	966
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	1014
D6072	abutment supported retainer for cast metal FPD (high noble metal)	1032
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	899
D6074	abutment supported retainer for cast metal FPD (noble metal)	1006
D6075	implant supported retainer for ceramic FPD	955
D6076	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	1100
D6077	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	1088
D6094	abutment supported crown (titanium)	956
D6101	debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	205
D6102	debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure	453
D6103	bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	274
D6104	bone graft at time of implant placement	273
D6194	abutment supported retainer crown for FPD - (titanium)	1048
	Prosthodontics, Fixed	
D6205	pontic - indirect resin based composite	658
D6210	pontic - cast high noble metal	730
D6211	pontic - cast predominantly base metal	636
D6212	pontic - cast noble metal	684
D6214	pontic - titanium	732
D6240	pontic - porcelain fused to high noble metal	786
D6241	pontic - porcelain fused to predominantly base metal	636
D6242	pontic - porcelain fused to noble metal	705
D6250	pontic - resin with high noble metal	693
D6251	pontic - resin with predominantly base metal	586
D6252	pontic - resin with noble metal	644
D6545	retainer - cast metal for resin bonded fixed prosthesis	246
D6600	inlay - porcelain/ceramic, two surfaces	596
D6601	inlay - porcelain/ceramic, three or more surfaces	650
D6602	inlay - cast high noble metal, two surfaces	590
D6603	inlay - cast high noble metal, three or more surfaces	600
D6604	inlay - cast predominantly base metal, two surfaces	530
D6605	inlay - cast predominantly base metal, three or more surfaces	560
D6606	inlay - cast noble metal, two surfaces	540
D6607	inlay - cast noble metal, three or more surfaces	584
D6608	onlay - porcelain/ceramic, two surfaces	722
D6609	onlay - porcelain/ceramic, three or more surfaces	776
D6610	onlay - cast high noble metal, two surfaces	630
D6611	onlay - cast high noble metal, three or more surfaces	818
D6612	onlay - cast predominantly base metal, two surfaces	622

Prosthodontics, Fixed - Continued

CODE	DESCRIPTION	FEE
D6613	onlay - cast predominantly base metal, three or more surfaces	797
D6614	onlay - cast noble metal, two surfaces	596
D6615	onlay - cast noble metal, three or more surfaces	808
D6624	inlay - titanium	602
D6634	onlay - titanium	844
D6710	crown - indirect resin based composite	718
D6720	crown - resin with high noble metal	723
D6721	crown - resin with predominantly base metal	595
D6722	crown - resin with noble metal	668
D6750	crown - porcelain fused to high noble metal	800
D6751	crown - porcelain fused to predominantly base metal	658
D6752	crown - porcelain fused to noble metal	742
D6780	crown - ¾ cast high noble metal	880
D6781	crown - ¾ cast predominantly base metal	730
D6782	crown - ¾ cast noble metal	796
D6790	crown - full cast high noble metal	828
D6792	crown - full cast noble metal	755
D6794	crown - titanium	770
D6930	recement fixed partial denture	90
D6970	post and core in addition to fixed partial denture retainer, indirectly fabricated	262
D6972	prefabricated post and core in addition to fixed partial denture retainer	222
D6973	core build up for retainer, including any pins	164
D6980	fixed partial denture repair necessitated by restorative material failure	180

Oral & Maxillofacial Surgery

CODE	DESCRIPTION	FEE
D7111	extraction, coronal remnants - deciduous tooth	58
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	95
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	164
D7220	removal of impacted tooth - soft tissue	256
D7230	removal of impacted tooth - partially bony	350
D7240	removal of impacted tooth - completely bony	398
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	482
D7250	surgical removal of residual tooth roots (cutting procedure)	185
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	290
D7280	surgical access of an unerupted tooth	418
D7282	mobilization of erupted or malpositioned tooth to aid eruption	215
D7283	placement of device to facilitate eruption of impacted tooth	180
D7285	biopsy of oral tissue - hard (bone, tooth)	282
D7286	biopsy of oral tissue - soft	282
D7288	brush biopsy - transepithelial sample collection	65
D7290	surgical repositioning of teeth	335
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	150
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	100

Oral & Maxillofacial Surgery - Continued

CODE	DESCRIPTION	FEE
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	238
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	144
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	575
D7471	removal of lateral exostosis (maxilla or mandible)	458
D7472	removal of torus palatinus	560
D7473	removal of torus mandibularis	494
D7485	surgical reduction of osseous tuberosity	548
D7510	incision and drainage of abscess - intraoral soft tissue	110
D7511	incision and drainage of abscess-intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	180
D7520	incision and drainage of abscess - extraoral soft tissue	206
D7953	bone replacement graft for ridge preservation – per site	273
D7960	frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	252
D7970	excision of hyperplastic tissue - per arch	273
D7971	excision of pericoronal gingiva	217
D7972	surgical reduction of fibrous tuberosity	358

Orthodontics

CODE	DESCRIPTION	FEE
D8010	limited orthodontic treatment of the primary dentition	600
D8020	limited orthodontic treatment of the transitional dentition	1018
D8030	limited orthodontic treatment of the adolescent dentition	1281
D8040	limited orthodontic treatment of the adult dentition	1317
D8050	interceptive orthodontic treatment of the primary dentition	1404
D8060	interceptive orthodontic treatment of the transitional dentition	1446
D8070	comprehensive orthodontic treatment of the transitional dentition	3825
D8080	comprehensive orthodontic treatment of the adolescent dentition	4100
D8090	comprehensive orthodontic treatment of the adult dentition	4100
D8210	removable appliance therapy	706
D8220	fixed appliance therapy	706
D8660	pre-orthodontic treatment visit	200
D8693	rebonding or recementing: and/or repair, as required of fixed retainers	361

Adjunctive General Services

CODE	DESCRIPTION	FEE
D9110	palliative (emergency) treatment of dental pain - minor procedure	53
D9120	fixed partial denture sectioning	53
D9220	deep sedation/general anesthesia - first 30 minutes	191
D9221	deep sedation/general anesthesia - each additional 15 minutes	85
D9241	intravenous conscious sedation/analgesia - first 30 minutes	190
D9242	intravenous conscious sedation/analgesia - each additional 15 minutes	80
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	38
D9940	occlusal guard, by report	382
D9941	fabrication of athletic mouthguard	192
D9942	repair and/or reline of occlusal guard	146
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays	230